



CLAIM DENIED

**HOW INSURANCE COMPANIES
DENY, DELAY, CONFUSE AND REFUSE**

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Executive Summary

The U.S. insurance industry has trillions of dollars in assets, enjoys average profits of over \$30 billion a year, and pays its CEOs more than any other industry.¹ But insurance companies still engage in dirty tricks and unethical behavior to boost their bottom line even further.

The current economic turmoil affecting the insurance industry on Wall Street has only made the outlook bleaker for consumers living on Main Street. Insurance companies are likely to demand huge rate hikes and refuse more claims than ever.

Some of America's most well-known insurance companies—the same ones that spend billions on advertising to earn your trust—have endeavored to deny claims, delay payments, confuse consumers with incomprehensible insurance-speak, and retroactively refuse anyone who may cost them money.

This report describes some of the most egregious ways the insurance industry attempts to make money at the expense of consumers. These are some of the tricks of the trade:

Denying Claims

Some of the nation's biggest insurance companies—Allstate, AIG, and State Farm among others—have denied valid claims in an attempt to boost their bottom lines. These companies have rewarded employees who successfully denied claims, replaced employees who would not, and when all else failed, engaged in outright fraud to avoid paying claims.

Delaying Until Death

Many insurance companies routinely delay claims, knowing full well that many policyholders will simply give up. Some have gone so far as to lock paperwork

away in safes.² Undoubtedly, the most shameful use of delay tactics has been by long-term care insurers, who often take advantage of their policyholders' age and ill health. In the words of one regulator, "the bottom line is that insurance companies make money when they don't pay claims... They'll do anything to avoid paying, because if they wait long enough, they know the policyholders will die."³

Confusing Consumers

Insurance contracts are some of the most dense and incomprehensible contracts a consumer is ever likely to see.⁴ More than half of all states have enacted "plain English" laws for consumer contracts, yet many Americans still do not fully understand the risks they are subject to.⁵ After Hurricane Katrina, insurance companies used obscure "anti-concurrent" clauses to get out of paying claims. Consumers who purchased hurricane insurance and thought they were covered suddenly found the coverage eliminated by an obscure clause they could not hope to understand.

Discriminating by Credit Score

Increasingly, insurance companies are using credit reports to dictate the premiums consumers pay, or whether they can even get insurance in the first place. The practice penalizes the poor, senior citizens with little credit, and those who have suffered financial crisis through no fault of their own. Insurance companies have denied fiscally responsible people who paid their bills in cash, but refused renewals because of a lack of credit history. Others have seen auto rate hikes near 600 percent despite clean driving records after falling on economic troubles.

Abandoning the Sick

Health insurers looking to cut costs have taken to canceling retroactively, or rescinding, the policies of people whose conditions have become expensive to treat. Some insurance companies have even offered bonuses to employees who meet “cancellation goals.” Rescission targets patients in the midst of treatment when they are at their most vulnerable—even cancer patients in the midst of chemotherapy have been targeted.

Canceling for a Call

Many people are rightly reluctant to make small claims on their home insurance for fear their insurance company will raise their premiums. But few realize that insurance companies often refuse to renew a policy because the policyholder did as little as inquire about the possibility of making a claim. Many times an insurance company will count an inquiry over the phone as the same as a claim, and then they will do everything in their power to drop the policyholder.

Denying Claims

You are in your car running an errand for your job, when all of a sudden a pickup truck crosses the centerline from the other direction and smashes into you. The accident is catastrophic. You are seriously injured and left in a coma. When you wake nine days later you have multiple broken bones, collapsed lungs, and are destined to spend the next few agonizing months under constant care.

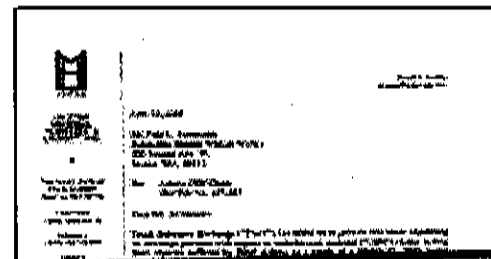
And then comes the real kick in the teeth. The insurance company denies your claim. They claim the driver who caused the crash acted in a moment of deliberate road rage, and so the accident was not an "accident." Your hospital bills pile up, you are too injured to go back to work, and your insurance company has deserted you.

For 60-year-old Ethel Adams from Seattle, that nightmare scenario became a horrifying reality in 2004. She had a \$2 million policy with a subsidiary of insurance giant Farmers, the nation's third largest personal lines insurance group. However, the company denied her claim under the tortured logic that it was never an "accident."⁶

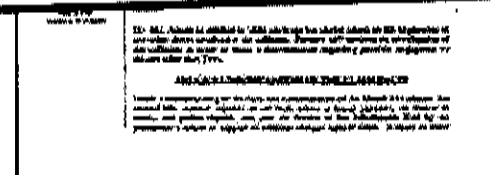
"The insurance companies say they're here to protect people," said a wheelchair-bound Adams during the battle with Farmers, "but then when you need them most, they do something like this."

[Farmers] even ran an employee incentive program, "Quest for Gold," that offered incentives, including \$25 gift certificates and pizza parties, to adjusters who met low payment goals.

Insurance company letter denying Ethel Adams' claim



(2) Ms. Adams is not entitled to UIN coverage for claims based on the fault of Michael Testa. Truck concludes the Testa's conduct causing the collision was intentional and therefore does not satisfy the business auto policy definition of "accident". Testa's conduct does not give rise to a UIN claim for that reason. Because umbrella UIN coverage follows from with the business auto policy, Truck is denying UIN coverage under both policies for any UIN claim based on Testa's conduct.



Adams' insurance company, Farmers, was in the business of denying claims as a way to boost its bottom line. Farmers even ran an employee incentive program, "Quest for Gold," that offered incentives, including \$25 gift certificates and pizza parties, to adjusters who met low payment goals.⁸ One Farmers' executive told claims representatives to stop paying claims, saying, "Teach them to say, 'Sorry, no more,' with a toothy grin and mean it."⁹

Farmers was by no means the only insurance company systematically denying claims. Some of the nation's biggest insurance companies—Allstate, AIG, and State Farm among others—have earned reputations

as aggressive claims fighters in an attempt to boost their bottom lines. Allstate gave employees who denied valid claims rewards such as portable fridges, and used a “boxing gloves” approach to policyholders who refused to accept lowball offers.¹⁰ When AIG units lost money, former CEO Maurice Greenberg would put in place new teams of staff to systematically reject thousands of valid claims.¹¹ State Farm went so far as to engage in fraud to deny claims. After the 1994 Northridge earthquake in

California, which killed 57 people, injured 9,000, and caused an estimated \$33.8 billion in damage, company officials forged signatures on waivers of earthquake coverage to avoid paying quake-related claims.¹²

Ethel Adams eventually prevailed after Farmers’ denial sparked an outcry and intervention from the state insurance commissioner. However, for many others whose valid claims have been denied, there is no such luck.

Delaying Until Death

Ill health has left your mother unable to care for herself. She needs home care to get by. Thankfully she purchased a long-term care insurance policy over a decade ago and has been faithfully paying the premiums ever since. She was determined her children should not suffer the burden of paying for her care later in life.

But the payment from the insurance company never arrives. You call the insurance company over and over and send them document after document. They deny the claim, citing reasons from “the claim is too late,” to “you did not fill out the paperwork,” to “you filled out the wrong paperwork.” The denials change each time, often citing provisions in the policy that do not exist, and often contradicting previous denials. Meanwhile, the cost of the care has quickly depleted your mother’s savings, and now the bills fall to you, the very prospect she sought to avoid.

“[T]he bottom line is that insurance companies make money when they don’t pay claims... They’ll do anything to avoid paying, because if they wait long enough, they know the policyholders will die.”

— Mary Beth Senkewicz, former senior executive at the National Association of Insurance Commissioners (NAIC)

The case of 77-year-old Mary Rose Derks from Montana attracted congressional attention after the New York Times highlighted her plight at the hands of insurance company Consec.¹⁷ Her family was forced to sell their small business after Consec denied the claim one way or another for more than four years. Insurance companies have long embraced delaying tactics to avoid



Photo Courtesy of: Anne Sherwood/The New York Times/Redux

paying claims, but undoubtedly the most shameful use of delay tactics has been by insurance companies involved in long-term care insurance. According to Mary Beth Senkewicz, a former senior executive at the National Association of Insurance Commissioners (NAIC), “the bottom line is that insurance companies make money when they don’t pay claims... They’ll do anything to avoid paying, because if they wait long enough, they know the policyholders will die.”¹⁴

For you, making an insurance claim is likely to happen at a time when you are most vulnerable. Filing a claim with your insurance company usually follows an upset to everyday life, that could involve a car accident, a tree falling on your house, or hospitalization from a serious illness. For the insurance company it is business as usual. Many insurance companies routinely delay claims to try to avoid paying. By delaying as long as possible, the insurance company knows many of its claimants will eventually give up, or in some cases die.

Internal documents from Allstate featured an alligator and the caption “sit and wait”—a reference to delaying claims to increase the likelihood that a claimant would give up.¹⁵

Claims supervisors at AIG have reported locking checks in safes until claimants complained, delaying payments until they were a year old, and disposing of important correspondence during routine “pizza parties.”¹⁶

“[The insurance company] made it so hard to make a claim that people either died or gave up.”

— Betty Hobel, former Conseco agent

Employees at long-term care insurer Conseco and its subsidiaries have testified to a variety of tricks used to deny claims: deliberately mailing the wrong forms and then denying claims on the basis of incorrect paperwork; declaring policyholders have abandoned the claim if they fail to submit forms within 21 days; and withholding payment until the policyholder submitted documents not even required under the terms of the policy.¹⁷ In the words of former agent Betty Hobel, the company “made it so hard to make a claim that people either died or gave up.”¹⁸

Confusing Consumers

Your house sustains heavy damage from wind and rain during a hurricane. The storm surge floods the lower level of your home three hours later. Despite the destruction, you are consoled by the fact you purchased hurricane insurance as part of your homeowners policy. Your home sustains hundreds of thousands of dollars in damages, but you are confident it will be covered.

You're wrong. The insurance company points to the "anti-concurrent" clause in your policy. "I had hurricane insurance," you counter. But it does not matter. The flood negates the coverage. How could you have known that hurricane damage would not be covered, even by hurricane insurance, if there was a flood? "You should have read your policy," says the insurance company, and points to some incomprehensible legalese headlined as an "anti-concurrent" clause in your policy. The kicker? You did not even get the policy until after you bought it.

Pascagoula, Mississippi police lieutenant Paul Leonard found himself in this very situation after Hurricane Katrina. Leonard testified that in 1999 his Nationwide Insurance agent told him he did not need flood insurance. Leonard's home later suffered over \$130,000 worth of damage in Hurricane Katrina. Nationwide sent him a check for \$1,600.¹⁹

"[I]nsurers generally are attempting to convince the customer when selling the policy that everything is covered and convince the court when a claim is made that nothing is covered."

— South Carolina Supreme Court

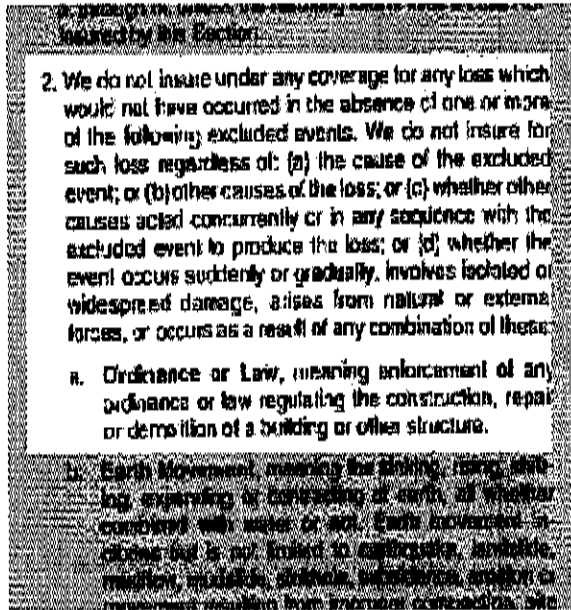
Leonard was in part a victim of the murky world of the insurance policy. Insurance contracts are

traditionally some of the most dense and hard to comprehend contracts a consumer is ever likely to see.²⁰ In the words of one commentator, the contracts "may as well be written in hieroglyphics. They are nearly impossible to decipher, [with] one incomprehensible clause after another."²¹ In trying to make sense of insurance contracts in a South Carolina case, the State Supreme Court concluded, "insurers generally are attempting to convince the customer when selling the policy that everything is covered and convince the court when a claim is made that nothing is covered."²²

Lawmakers in more than half of all states have enacted "plain English" laws for consumer contracts, yet many Americans still do not fully understand the risks they are subject to.²³ Nearly half of all Americans mistakenly believe that if a new car is totaled only a few weeks after purchase, the insurance company will pay for the full replacement—when in fact, insurance companies will deduct for depreciation, leaving consumers owing thousands of dollars on a car loan. Similarly with homeowners insurance, more than seven out of ten Americans believe their insurance company will pay for the full cost to rebuild from a natural disaster or fire, and would reimburse them for the full replacement cost of personal belongings. But, insurance companies "cap" the amount they will pay for a total loss, and will deduct for depreciation when assessing damage to personal belongings.²⁴

Hurricane Katrina highlighted the insurance industry's use of opaque language to avoid paying claims. At issue were so called "anti-concurrent clauses." The clauses dictate that not only is damage from a flood, earthquake or other event not covered, but that such damage eliminates coverage for damage that is covered in the policy.

“Anti-concurrent” provision from a State Farm Policy



So if heavy winds caused a tree to fall onto the roof of your house, and then rain water trickled in causing damage—you would be covered. But if a storm surge came hours later and flooded the house, everything below the water line would no longer be covered.

When confronted with just such a hypothetical scenario during a trial following Hurricane Katrina, Nationwide executive Jeffrey Kline Gilbert confirmed the coverage would be eliminated and said the policyholder should have read the policy.²⁶ However, it is hard for an attorney, let alone a layman, to fully grasp the implications of clauses such as these.²⁶

In 2007, then-U.S. Senator Trent Lott railed against what he called “a bunch of subterfuges” in insurance company policies, and sponsored legislation requiring insurers provide “plain English” summaries of what was and was not covered in order to stop these abuses. “They don’t want you to know what you really have covered,” said Lott.²⁷

Discriminating by Credit Score

You paid off your mortgage years ago. You have two cars, and even paid for them in cash. You pay all your bills by cash or check. You are a model of fiscal responsibility. When time comes to renew your auto insurance, your insurance company informs you that they have credit scored you. Even though most people would envy your financial situation, you find yourself facing a premium increase of over 100 percent.

This was the dilemma for Pat and Clyde Henry of Ohio. The Henrys had virtually no credit history on file with the three major credit agencies, and to their insurance company, no credit was the same as bad credit, even though it knew their particular financial details.²⁸

The seemingly bizarre situation the Henrys found themselves in is not as uncommon as you would probably believe. Few Americans realize that their credit history can affect their insurance premiums, or even whether they can get insurance in the first place.

For 34 years Mattie Grainger from South Carolina had an auto insurance policy with Allstate. The senior citizen had a clean driving record, few insurance claims, and was eligible for a variety of safe driver discounts. Yet Allstate raised her premiums and told her she would not qualify for a lower rate because of a low credit score. Grainger's credit score was low only because she did not have much use for extensive credit. "Many elderly persons do not like to borrow money, yet they pay their bills on time," says Philip Porter, a consumer advocate from the South Carolina Department of Consumer Affairs. "A model which looks at a person's credit history might have a negative impact on that segment of the population."²⁹

The problem does not just concern senior citizens. The insurance industry justifies the use of credit-scoring by speculating that a person who is reckless with credit

is likely to be a reckless driver or an irresponsible homeowner.³⁰ Yet this ignores the fact that many people find themselves in financial crises that damage their credit through no fault of their own. Anyone facing a financial crisis may find themselves further punished by their insurance company.

"They are victimizing the victims."

— Kathryn Perry, the Texas nurse whose insurance company raised her rates 600 percent after a financial crisis

Which is exactly what happened to Kathryn Perry. The Wimberley, Texas, nurse drove less than 1,000 miles a year, had no tickets, and only one accident—25 years earlier. But she fell behind on her bills after her daughter was murdered. She eventually got back on track, but it left a negative mark on her credit report. Then her insurance company told her it would cost a little more to renew her auto insurance policy. Nearly 600 percent more, in fact. Her yearly premium shot up from \$437 to \$3,000. "They are victimizing the victims," Perry told lawmakers when she testified at a hearing before the Texas House of Representatives.³¹

Credit reports are also notoriously unreliable. One study found 79 percent of reports contained errors, and 25 percent contained serious errors. Additionally, the secret nature of credit reports' inner workings leaves consumers confused. Having too many credit cards results in a negative effect on the credit score, but so does having too few.

The insurance industry is increasingly relying on credit-scoring to slice up the market of potential insureds. The insurance industry claims that the use of credit-scoring saves the consumer money, but in fact, independent analysis suggests the industry may have

squeezed an extra \$67 billion in profit from the practice between 2003 and 2006.³²

Credit-scoring disproportionately disfavors minorities and the poor, many of whom lack the credit history even to generate a credit score. The Consumer Federation of America uncovered documents from GEICO, one of the nation's biggest auto insurers, that showed a factory worker with just a high school diploma would pay 90 percent more for auto insurance than an attorney with a professional degree, even if their qualifications and driving record were identical.³³ Credit scoring is just the most recent example of discrimination from an industry

that has long been associated with practices such as redlining (refusing insurance to minority communities) and reverse redlining (charging more to minority communities).

Perhaps the most disturbing aspect of the insurance industry's use of credit scores is that it may only be the tip of the iceberg. Insurers are investigating whether they can predict who will make a claim by studying publicly retrievable lifestyle data. Your hobbies and grocery bills could be used along with your credit score to make insurance decisions.³⁴

Abandoning the Sick

You receive the devastating news that you have cancer. It is operable, and with prompt care, you have a chance to survive. You make it through the surgery and begin chemotherapy treatments. Then the insurance company suddenly cancels your insurance retroactively. The reason? They allege you lied about your weight on your insurance application. Now you are left with hundreds of thousands of dollars in medical bills, unable to afford the rest of your chemotherapy schedule, and facing an uncertain prognosis.

This is the situation Patsy Bates, a 51-year-old hair stylist from Gardena, California, found herself in after her health insurance was “rescinded.” Bates’ health insurance company, Health Net, Inc., rescinded her policy in the middle of her treatment for breast cancer, saying she provided inaccurate information on her insurance application.

“[A]n egregious scheme to not only delay or deny the payment of thousands of legitimate medical claims but also to jeopardize the health of more than 6,000 customers by retroactively canceling their health insurance when they needed it most.”

— Los Angeles City attorneys describing rescissions by Anthem Blue Cross

Insurers such as Health Net and Anthem Blue Cross of California have been accused of illegally retroactively canceling, or rescinding, the policies of people whose conditions are expensive to treat. The cancellation usually happens when people are in the midst of treatment and at their most vulnerable. In April 2008,

Los Angeles City attorneys sued Anthem Blue Cross to try to stop the company rescinding insurance policies. The city’s attorneys claimed that “[t]he company has engaged in an egregious scheme to not only delay or deny the payment of thousands of legitimate medical claims but also to jeopardize the health of more than 6,000 customers by retroactively canceling their health insurance when they needed it most.”³⁶

Bates already had health insurance when an agent from Health Net walked into her hair salon promising he could lower her monthly premiums if she would buy a policy with Health Net. The agent asked questions from the application while Bates worked on clients’ hair. She answered the questions as best she could and her application was approved.³⁶

Not long after, Bates was diagnosed with breast cancer and began aggressive treatment that included surgery to remove the tumor and months of chemotherapy. The night before her surgery, a hospital administrator walked into her room and told her that the hospital could not allow her surgery to proceed because it was not authorized by Health Net. The company would only authorize the procedure if she paid the next three months of premiums immediately.³⁷

Following the surgery, Bates began chemotherapy treatment. Not long after she started treatment, Bates was notified that Health Net was canceling her health insurance policy, saying she lied about her weight on her application and did not disclose that she had been screened for a heart condition in the past.³⁸ The rescission left Bates saddled with medical bills and forced her to suspend her chemotherapy for months until she could find a charity to pay for it.

Documents disclosed at Bates’ arbitration hearing revealed that Health Net rewarded employees who rescinded sick policyholders. The company paid bonuses

to employees who met cancellation goals and even commended one employee for having a “banner year” when she allowed the company to avoid “\$6 million in unnecessary health care expenses.”³⁹ Retired Los Angeles Superior Court Judge Sam Cianchetti, who arbitrated Bates’ case, called Health Net’s behavior “egregious,” saying the company “was primarily concerned with and considered its own financial interests and gave little, if any, consideration and concern for the interests of the insured.”⁴⁰

Others have faced similar problems with insurers cancelling health policies in their time of need. Barbara and Don Saxby of San Rafael, California, relied on their policy from Nationwide. Don required extensive and expensive knee surgery after a skiing accident. But Nationwide rescinded their policy when it found out Don had a blood clotting issue on record with his doctors. The clotting had never been a problem with obtaining insurance before, and the Saxbys thought they had been as thorough as possible with the company on their application. They even called Nationwide after the application had been approved to point out some errors in Don’s medical history records and were told by a representative that there would not be any problems. Unfortunately for the Saxbys, there was a serious problem. Nationwide rescinded their policy, leaving them with nearly \$400,000 in medical bills.⁴¹

Jennifer Thompson of Palm Desert, California, took extra steps to ensure her hysterectomy, which was needed as part of her treatment for endometrial cancer, would be covered under her health insurance policy with Anthem Blue Cross. Anthem Blue Cross approved the procedure but rescinded her policy three days after the surgery, saying Thompson had failed to report being treated for breast cancer 11 years earlier. Thompson had tried to report her cancer treatment but was told by an agent that the information was unnecessary because the company only required medical history dating back 10 years. Thompson’s rescission came just before Christmas and left her with \$160,000 in medical bills.⁴²

In March 2007, the California Department of Managed Health Care fined Anthem Blue Cross \$1 million after an investigation revealed that the insurer

routinely canceled individual health policies of pregnant women and chronically ill patients. In order to drop individual policies, the insurer must show that the policyholder lied about their medical history or preexisting conditions on the application. As part of the state’s investigation, regulators randomly selected 90 cases where the insurer had dropped the policyholder. In every single one, investigators found the insurer had violated state law.⁴³ During the investigation, California regulators uncovered more than 1,200 violations of the law by Anthem Blue Cross in regard to unfair rescission and claims processing practices.

But Anthem Blue Cross continued to rescind the policies of chronically ill patients. The company also sent letters to physicians demanding they inform the company of any pre-existing conditions they came across when evaluating patients.⁴⁴ Physicians were outraged. The California Medical Association forwarded the letter to state regulators complaining that the insurance company was “asking doctors to violate the sacred trust of patients to rat them out for medical information that patients would expect their doctors to handle with the utmost secrecy and confidentiality.”⁴⁵

Anthem Blue Cross eventually settled rescission accusations for \$10 million in July 2008. The company denied any wrongdoing and offered to reinstate the policies of 1,770 customers. In the reinstatement mailings, Anthem offered customers \$1,000 if they agreed to drop all legal claims against the company.⁴⁶

Other states have taken similar actions against Anthem Blue Cross and its affiliates over their claims-processing practices. In January 2008, Nevada Insurance Commissioner Alice A. Molasky-Arman announced a \$1 million settlement with Anthem Blue Cross over systematic overcharging of policyholders.⁴⁷ Similarly, Colorado’s Insurance Commissioner, Marcy Morrison, secured a \$5.7 million refund for consumers of Anthem Blue Cross insurance policies.⁴⁸ In Kentucky, the Office of Insurance ordered Anthem Health Plans of Kentucky to refund \$23.7 million to 81,000 seniors and disabled people over inaccurate Medicare claims payments.⁴⁹

Canceling for a Call

A storm causes a water leak in your roof. The damage is extensive, so you call your insurance company. But you are reluctant to make a claim on your homeowners insurance because you're afraid the company may raise your rates. So you pay for the repairs out of your own pocket. It is a big chunk of change, but in the long run, you figure, it will be worth it.

When it comes time to renew your policy, the insurance company has a nasty surprise for you. They are not raising your rates, they are dropping you altogether. Even though you never made a claim, the insurance company documented your phone call and treated it as a claim. Now you have to search around for a new insurance company. But, for some reason, no one wants your business. The only way to insure your home now is through the government-run insurer of last resort, which will cost you far more than you were paying. And all of this after making just a phone call.

That was the situation Marie Wagstaff found herself in after she paid for her California house repairs in 2000. Marie got lucky—she finally persuaded another company to take her business after showing proof of the repairs.⁵⁰

Few know that even calling the insurance company can land you in financial dire straits.

Many people are reluctant to make small claims on their home insurance for fear their insurance company will raise their premiums or refuse to renew their policy. Some might think the small repairs everyone has to make are exactly what insurance is supposed to be for, but in this day and age insurance companies operate under a “you use it, you lose it” policy. But few know that even calling the insurance company can land you in financial dire straits.

Just by making that phone call you have already determined that your insurance company may drop you at the first opportunity. Insurance companies treat the call just as they would a claim—as a black mark on your record. The call may go into the CLUE (Comprehensive Loss Underwriting Exchange) report on your house—the report that realtors and banks and anyone with a financial interest in your property can check to see the claims history.⁵¹ Even if you call your agent and not the insurance company directly, you are likely to face the same fate.⁵²

What you can do about it:

READ YOUR POLICY CAREFULLY: You should know exactly what is covered and how to appeal a denial by your insurance company.

BE VERY CAREFUL FILLING OUT FORMS: Even if you make an honest mistake your insurance company may seize on that as a reason to retroactively deny your coverage.

DO NOT CASH A PREMIUM REFUND CHECK: If your insurance company rescinds your insurance they may send you a refund for the premiums you paid. Cashing it may be interpreted as accepting their decision.

PUT EVERYTHING IN WRITING: Calling your insurance company is likely to be a frustrating experience, and you will not be able to prove anything that a company representative tells you over the phone. Keep records of all bills and correspondence.

CONTACT YOUR STATE INSURANCE DEPARTMENT: They may be able to help you. But they will not represent you in a private matter, so if all else fails you may need to consult with an attorney.

AND MOST OF ALL, DO NOT GIVE UP: Insurance companies count on you giving up. Fight for your rights.

Notes

1. The insurance industry's assets total \$3.8 trillion, more than the GDPs of all but two countries in the world (United States and Japan), "Insurers as Investors," Insurance Information Institute, <http://www.iii.org/economics/investors/intro/>; over the last 10 years the property casualty industry has averaged profits of over \$30 billion a year, and the life and health insurance industry has averaged another \$30 billion, "Industry Financials and Outlook," Insurance Information Institute (III), <http://www.iii.org/media/industry/>, "Life Insurance," Insurance Information Institute (III), <http://www.iii.org/media/facts/statsbyissue/life/>; the CEOs of the top 10 property casualty firms earned an average \$8.9 million in 2007, while CEOs at the top 10 life and health insurers earned an average \$9.1 million, and CEOs across the industry lead all industries with a median cash compensation of \$1.6 million, "CEOs Rake in Cash but not Stock," National Underwriter, January 2, 2008.
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3. Charles Duhigg, "Aged, Frail and Denied Care by their Insurers," The New York Times, March 26, 2007.
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20. Michelle E. Boardman, "Contra Proferentem: The Allure of Ambiguous Boilerplate," Michigan Law Review, Vol. 104:1105, March 2006.
21. William Shernoff, Payment Refused, NY: "Richardson & Steirman," 1986.
22. S.C. Ins. Co. v. Fid. & Guar. Ins. Underwriters, Inc., 489 S.E.2d 200, 206 (S.C. 1997) (citing *Universal Underwriters Ins. Co. v. Travelers Ins. Co.*, 451 S.W.2d 616, 622-23 (Ky. Ct. App. 1970)).
23. David Rossmiller, "Plainly Ambiguous: Have Plain English Laws Made Insurance Policies Less Ambiguous?" Oregon Association of Defense Counsel, Spring 2008.

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