

# The Ten Worst Insurance Companies In America

*How They Raise Premiums,  
Deny Claims, and Refuse Insurance  
to Those Who Need It Most*



Formerly the Association of Trial Lawyers of America (ATLA®)

# Introduction

To identify the worst insurance companies for consumers, researchers at the American Association for Justice (AAJ) undertook a comprehensive investigation of thousands of court documents, SEC and FBI records, state insurance department investigations and complaints, news accounts from across the country, and the testimony and depositions of former insurance agents and adjusters. Our final list includes companies across a range of different insurance fields, including homeowners and auto insurers, health insurers, life insurers, and disability insurers.

## Allstate—The Worst Insurance Company in America

One company stood out above all others. Allstate's concerted efforts to put profits over policyholders has earned its place as the worst insurance company in America.

According to CEO Thomas Wilson, Allstate's mission is clear: "our obligation is to earn a return for our shareholders." Unfortunately, that dedication to shareholders has come at the expense of policyholders. The company that publicly touts its "good hands" approach privately instructs agents to employ a "boxing gloves" strategy against its own policyholders.<sup>1</sup> In the words of former Allstate adjuster Jo Ann Katzman, "We were told to lie by our supervisors—it's tough to look at people and know you're lying."

## The Insurance Industry's Wealth

- The insurance industry has so much excess cash it may spark a downturn in the industry. According to analysts at Standards & Poor's, U.S. insurers are sitting on too much capital, and will likely endure at least three years of negative performance as a result.<sup>2</sup>

## The Ten Worst Insurance Companies

1. Allstate
2. Unum
3. AIG
4. State Farm
5. Consec
6. WellPoint
7. Farmers
8. UnitedHealth
9. Torchmark
10. Liberty Mutual

- The U.S. insurance industry takes in over \$1 trillion in premiums annually.<sup>3</sup> It has \$3.8 trillion in assets, more than the GDPs of all but two countries in the world (United States and Japan).<sup>4</sup>
- Over the last 10 years, the property/casualty insurance industry has enjoyed average profits of over \$30 billion a year. The life and health side of the insurance industry has averaged another \$30 billion.<sup>5</sup>
- The CEOs of the top 10 property/casualty firms earned an average \$8.9 million in 2007. The CEOs of the top

10 life and health insurance companies earned even more—an average \$9.1 million. And for the entire industry, the median insurance CEO’s cash compensation still leads all industries at \$1.6 million per year.<sup>6</sup>

### **Profits Over Policyholders**

But some companies have discovered that they can make more money by simply paying out less. As a senior executive at the National Association of Insurance Commissioners (NAIC), the group representing those who are supposed to oversee the industry, said, “The bottom line is that insurance companies make money when they don’t pay claims.”<sup>7</sup>

One example is Ethel Adams, a 60-year-old woman left in a coma and seriously injured after a multi-vehicle crash in Washington State. Her insurance company, Farmers,

decided the other driver had acted intentionally and denied her claim, contending that an intentional act is not an accident. Another example is Debra Potter, who for years sold Unum’s disability policies until she herself became disabled and had to stop working. All along, Potter thought she was helping people protect their future, but when her own time of need came, she was told her multiple sclerosis was “self reported” and her claim denied—by Unum, the very company whose policies she had sold.

In cases like these, and countless others, the name of the game is deny, delay, defend—do anything, in fact, to avoid paying claims. For companies like Allstate, there are corporate training manuals explaining how to avoid payments, portable fridges awarded to adjusters who deny the most claims, and pizza for parties to shred documents.

# 1. Allstate

**CEO: Thomas Wilson**  
**2007 compensation \$10.7 million**  
**(predecessor Edward Liddy made**  
**\$18.8 million in compensation and an**  
**additional \$25.4 million in retirement**  
**benefits)**

**HQ: Northbrook, IL**

**Profits: \$4.6 billion (2007)**

**Assets: \$156.4 billion<sup>8</sup>**

**There is no greater poster child for insurance industry greed than Allstate. According to CEO Thomas Wilson, Allstate’s mission is clear: “our obligation is to earn a return for our shareholders.”<sup>9</sup> Unfortunately, that dedication to shareholders has come at a price. According to investigations and documents Allstate was forced to make public, the company systematically placed profits over its own policyholders. The company that publicly touts its “good hands” approach privately instructs agents to employ a hardball “boxing gloves” strategy against its own policyholders.<sup>10</sup>**

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Allstate’s confrontational attitude towards its own policyholders was the brain child of consulting giant McKinsey & Co. in the mid-1990s. McKinsey was tasked with developing a way to boost Allstate’s bottom line.<sup>11</sup> McKinsey recommended Allstate focus on reducing the amount of money it paid in claims, whether or not they were valid. When it adopted these recommendations, Allstate made a deliberate decision to start putting profits over policyholders.

The company essentially uses a combination of lowball offers and hardball litigation. When policyholders file a claim, they are often offered an unjustifiably low payment

for their injuries, generated by Allstate using secretive claim-evaluation software called Colossus. Those that accept the lowballed settlements are treated with “good hands” but may be left with less money than they need to cover medical bills and lost wages. Those that do not settle frequently get the “boxing gloves”: an aggressive litigation strategy that aims to deny the claim at any cost. Former Allstate employees call it the “three Ds”: deny, delay, and defend. One particular powerpoint slide McKinsey prepared for Allstate featured an alligator and the caption “sit and wait”—emphasizing that delaying claims will increase the likelihood that the claimant gives up.<sup>12</sup> According to former Allstate agent Shannon Kmatz, this would make claims “so expensive and so time-consuming that lawyers would start refusing to help clients.”<sup>13</sup>

Former Allstate adjusters say they were rewarded for keeping claims payments low, even if they had to deceive their customers. Adjusters who tried to deny fire claims by blaming arson were rewarded with portable fridges, according to former Allstate adjuster Jo Ann Katzman. “We were told to lie by our supervisors. It’s tough to look at people and know you’re lying.”<sup>14</sup>

Complaints filed against Allstate are greater than almost all of its major competitors, according to data collected by the NAIC.<sup>15</sup> In Maryland, regulators imposed the largest fine in state history on Allstate for raising premiums and changing policies without notifying policyholders. Allstate ultimately paid \$18.6 million to Maryland consumers for the violations.<sup>16</sup> In Texas earlier this year, Allstate agreed to pay more than \$70 million after insurance regulators found the company had been overcharging homeowners throughout the state.<sup>17</sup>

After Hurricane Katrina, the Louisiana Department of Insurance received more complaints against Allstate—1,200—than any other insurance company, and nearly

twice as many as the approximately 700 it received about State Farm—despite the fact that its rival had a bigger share of the homeowners market.<sup>18</sup>

Similarly, in 2003, a series of wildfires devastated Southern California, destroying over 2,000 homes near San Diego alone and killing 15 people. State insurance regulators received over 600 complaints about Allstate and other companies' handling of claims.<sup>19</sup>

Allstate says the changes in claims resolution tactics were only about efficiency.<sup>20</sup> However, the company's former CEO, Jerry Choate, admitted in 1997 that the company had reduced payments and increased profit, and said, "the leverage is really on the claims side. If you don't win there, I don't care what you do on the front end. You're not going to win."<sup>21</sup>

For four years, Allstate refused to give up copies of the McKinsey documents, even when ordered to do so repeatedly by courts and state regulators. In court filings, the company described its refusal as "respectful civil disobedience."<sup>22</sup> In Florida, regulators finally lost their patience after Allstate executives arrived at a hearing without documents they had been subpoenaed to bring. Only after Allstate was suspended from writing new business did the company, in April 2008, finally agree to produce some 150,000 documents relating to its claim review practices.<sup>23</sup> Still, some commentators believe many critical documents were missing.<sup>24</sup>

Allstate's "boxing gloves" strategy boosted its bottom line. The amount Allstate paid out in claims dropped from 79 percent of its premium income in 1996 to just 58 percent ten years later.<sup>25</sup> In auto claims, the payouts dropped from 63 percent to just 47 percent.<sup>26</sup> Allstate saw \$4.6 billion in profits in 2007, more than double the level of profits it experienced in the 1990s. In fact, the company is so awash in cash that it began buying back \$15 billion worth of its own stock, despite the fact that the company was simultaneously threatening to reduce coverage of homeowners because of risk of weather-related losses.<sup>27</sup>

Despite its treatment of policyholders, Allstate's recent corporate strategy has focused on identifying and retaining loyal customers, those who are more likely to stay with the company and not shop around. The target demographic, as former Allstate CEO Edward Liddy said, is "lifetime value customers who buy more products and stay with us for a longer period of time. That's Nirvana for an insurance company."<sup>28</sup>

Loyalty only runs one way, however. While Allstate focuses on customers who will stick with it for the long haul, the company is systematically withdrawing from entire markets. Allstate or its affiliates have stopped writing home insurance in Delaware, Connecticut, and California, as well as along the coasts of many states, including Maryland and Virginia.<sup>29</sup>

In Louisiana, Allstate has repeatedly tried to dump its policyholders. In 2007, the company tried to drop 5,000 customers just days after the expiration of an emergency rule preventing insurance companies from canceling customers hit by Katrina. Allstate dropped them for allegedly not showing intent to repair their properties. After an investigation by the Louisiana Insurance Department, Insurance Commissioner Jim Donelon said, "[A]t best, it was a very ill-conceived and sloppy inspection program. At worst, they wanted off of those properties."<sup>30</sup> Allstate also used an apparent loophole in the law by offering its policyholders a "coverage enhancement" which the company would later argue was a new policy, and thus exempt from non-renewal protection.<sup>31</sup>

In Florida, Allstate has dropped over 400,000 homeowners since 2004.<sup>32</sup> The move has landed Allstate in trouble with regulators because the company appears to be keeping customers if they also have an auto insurance policy with Allstate. Florida law prohibits the sale of one type of insurance to a customer based on their purchase of another line of coverage.<sup>33</sup> Allstate officials have acknowledged that most of the 95,000 customers non-renewed in 2005 and 2006 were homeowners-only customers. The company ran afoul of regulators in New York for the same reason, and was forced to discontinue the practice.<sup>34</sup>

In California, while other major homeowner insurers, including State Farm and Farmers, agreed to cut rates, Allstate demanded double-digit rate increases in what the former insurance commissioner described as an "exit strategy." John Garamendi, now the Lieutenant Governor, said, "[T]hey've said they want to get out of the homeowners business in a market that is competitive, healthy and profitable."<sup>35</sup>

Consumer advocates have also complained that Allstate put an ambiguous provision in homeowners' policies that may have deceived some policyholders into thinking they had coverage for wind damage when they did not. So-called "anti-concurrent-causation" clauses state that wind

and rain damage—damage covered under the policy—is excluded if significant flood damage occurs as well. Therefore, those with policies covering wind and rain damage and “hurricane deductibles” still faced the prospect of learning, only after a catastrophic loss, that they had no

coverage.<sup>36</sup> In 2007, then U.S. Senator Trent Lott sponsored legislation requiring insurers provide “plain English” summaries of what was and what was not covered in order to stop this kind of abuse. “They don’t want you to know what you really have covered,” said Lott.<sup>37</sup>

## 2. Unum

**CEO: Thomas Watjen**  
**2007 compensation \$7.3 million**

**HQ: Chattanooga, TN**

**Profits: \$679 million (2007)**

**Assets: \$52.4 billion<sup>38</sup>**

**Unum, one of the nation's leading disability insurers, has long had a reputation for unfairly denying and delaying claims. Unum's claims-handling abuses have consistently been the subject of regulator and media investigations.**

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There is no better example of Unum's treatment of policyholders than the case of Debra Potter. Potter, a financial services worker, developed multiple sclerosis and filed a disability claim with her insurer Unum. Unum denied the claim and told Potter her conditions were "self-reported." Potter's physician responded with a series of memos testifying to her problems, saying "there is no basis to support that her complaints are anything other than legitimate." Unum continued to deny the claim for three years, even after appeals from Potter's employer, BB&T, and after the Social Security Administration had concluded she was totally disabled. Only when Potter hired an attorney did Unum eventually agree to pay the claim.<sup>39</sup>

What makes Potter's case unique is the fact that she had spent years faithfully selling Unum disability policies as part of a financial services package. "People need safety nets, and that's what I thought I was selling them," Potter would later say. "But here I am with all my knowledge of insurance and I couldn't make it work for me."<sup>40</sup>

Unum has a history of denying and delaying claims. In 2003, then CEO Harold Chandler was forced out after much controversy over Unum's claims-handling policies. Former employees have gone on record saying Unum

ordered them to deny claims in order to meet cost-savings goals.<sup>41</sup> Internal memos would eventually come to light detailing the company's plan to move from "a claims-payment to a claim-management approach." Company executives wrote "[the] return on these claim improvement initiatives is expected to be substantial... [A] 1% decrease in benefit cost... translates into approximately \$6 million in annual savings."<sup>42</sup>

Despite the controversy, Chandler left with \$17 million in severance and pension benefits.

In 2005, Unum agreed to a settlement with insurance commissioners from 48 states over their claims-handling practices. Under the agreement, the company agreed to reopen more than 200,000 cases and pay \$15 million.<sup>43</sup>

In California, where nearly one in every four claims for long-term care insurance was denied, the California Department of Insurance launched an investigation into Unum.<sup>44</sup> The investigation concluded in 2005, and found widespread fraud by the company. According to the report, Unum systematically violated state insurance regulations and fraudulently denied or low-balled claims using phony medical reports, policy misrepresentations, and biased investigations.<sup>45</sup> California Insurance Commissioner John Garamendi described the insurer as an "outlaw company."

Yet more recent cases show Unum up to their old tricks. In 2007, the company admitted it had only reviewed 10 percent of the cases eligible for reopening under the terms of legal settlements reached three years earlier. In one recent case, the company denied the claim of a 43-year-old man who had to have a quintuple bypass and several stents put in to expand his arteries. Despite doctors' orders to stop working, Unum told him he was not disabled and could still work—a decision the U.S. 9th Circuit Court of Appeals would later describe as defying medical science.<sup>46</sup>

Unum's activities, and those of other notorious insurers such as Consec, arose the suspicions of Senator Charles Grassley (R-Iowa), who asked the Government

Accountability Office (GAO) to investigate, and also wrote to Unum CEO Thomas Watjen demanding answers regarding the company's policies and practices.<sup>47</sup>



# 3. AIG

**CEO: Robert Willumstad (former CEO Martin J. Sullivan was fired in June 2008, and is expected to receive as much as \$68 million, despite leading AIG to record losses over his three-year tenure—2007 compensation \$14.3 million)**

**HQ: New York, NY**

**Profits: \$6.2 billion (2007)**

**Assets: \$1.06 trillion<sup>48</sup>**

**The world's biggest insurer, AIG has a long history of claims-handling abuses for both individuals and business clients. AIG executives have also come under fire for opportunistically seeking price increases during catastrophes. Now the company has been labeled "the new Enron" because of charges of multi-billion dollar corporate fraud.**

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AIG has long had a reputation for claims-handling abuses.<sup>49</sup> Part of the reason for that reputation is AIG's reliance on underwriting results. Nearly every other insurance company relies on the income it makes from investing its policyholders' premiums. AIG has always focused on turning a profit on underwriting—in other words, taking in more money in premiums than it pays out in claims. To do that, the company has had to be extremely parsimonious about the claims it pays. Former AIG claims supervisors have alleged in litigation that the company used all manner of tricks to deny or delay claims, including locking checks in a safe until claimants complained, delaying payment of attorney fees until they were a year old, disposing of important correspondence during routine "pizza parties," and routinely fighting claimants for years in court over mundane claims.<sup>50</sup>

In 1999, after discovering AIG was losing as much as \$210 million on auto-warranty claims, CEO Greenberg installed a new team that began to systematically reject thousands of claims, even when its own claims-handling contractor recommended they be paid. Richard John, Jr., a vice-president at the contractor, would testified that the company used any excuse to deny a claim, including ruling that installing manufacturer-approved tires was a "modification" that invalidated the warranty.<sup>51</sup>

After an AIG-insured Safeway burned down in Richmond, Virginia, the supermarket was confronted with damage claims from nearby residents who had been affected by the fire. AIG denied the claims saying that the damage was caused not by fire but by smoke, which qualified as a form of air pollution and as such was not covered. In fact, in a series of high profile cases, AIG or its subsidiaries fought claims on tenuous bases, building its reputation as one of the most aggressive claims fighters in the industry.<sup>52</sup>

In 2005, AIG was sanctioned by a federal judge in Indianapolis for attempting to unfairly block discovery in an environmental case. AIG's lawyers went so far as to give instructions not to answer 539 times during one deposition of an AIG executive.<sup>53</sup> In January 2008, AIG agreed to pay \$12.5 million to several states after state insurance commissioners found that the company had conspired with other insurance brokers to submit fake bids in order to create an illusion of a competitive bidding process in commercial insurance markets. Businesses and local governments ended up paying artificially inflated insurance rates.<sup>54</sup> Even other insurance companies got the treatment. In 2007, an AIG reinsurance unit was forced by an arbitrator to pay more than \$440 million to five insurance companies who alleged the AIG unit tried to rescind their contract when it was time to pay, and then continued to refuse payment even after several courts had ruled against rescission.<sup>55</sup>

AIG is not alone in using strategies such as deny-delay-defend to enhance its bottom line at their customers' expense. What sets AIG apart, however, is the way it has so callously sought to take advantage of its policyholders' misfortunes.

In 1992, on the day Hurricane Andrew landed in Florida, AIG Executive Vice-President J.W. Greenberg, son of then-CEO Maurice Greenberg, sent a company-wide memo saying, "We have opportunities from this and everyone must probe with brokers and clients. Begin by calling your underwriters together and explaining the significance of the hurricane. This is an opportunity to get price increases now. We must be the first and it begins by establishing the psychology with our own people. Please get it moving today."<sup>56</sup>

Similarly, the September 11th terrorist attacks were to most people a terrible tragedy. To Maurice Greenberg, the "opportunities for his 82-year-old company have never been greater."<sup>57</sup> In the immediate aftermath of the attacks, prices for insurance soared by what Greenberg described as "leaps and bounds." "It's a global opportunity," the CEO said at the time. "It's not just in the United States, but rates are rising throughout the world. So our business looks quite good going forward."<sup>58</sup> Greenberg also said of the increased awareness of the need for insurance that the attacks prompted, "AIG is well positioned—probably as well as it's ever been in this marketplace."<sup>59</sup>

AIG executives are unapologetic about their reputation for opportunism. "We've always been opportunistic. When we see opportunities, we will never change. At AIG it's part of our culture."<sup>60</sup>

AIG's opportunism has also crossed the line into fraud. According to the Federal Bureau of Investigation (FBI), insurance fraud totals more than \$40 billion and costs the average family as much as \$700 per year. However, while the insurance industry only talks about fraud committed by its policyholders, what interests the FBI is the increase in corporate fraud by the insurance companies themselves, leading the agency to establish it as one of its top investigative priorities.<sup>61</sup> No company is a better example of this kind of fraud than AIG.

In 2006, AIG paid \$1.6 billion to settle charges of a variety of financial shenanigans that had commentators describing AIG as "the new Enron."<sup>62</sup> Two years later, five insurance executives were found guilty of fraud.<sup>63</sup>

The fraud accusations were traced back to longtime CEO Maurice Greenberg, who was ousted from the company he had led for 38 years.<sup>64</sup> Greenberg was identified by prosecutors as an "unindicted co-conspirator," and notified that the Securities and Exchange Commission, which had already fined the company \$126 million, was likely to pursue civil charges against him for two separate incidences of fraud.<sup>65</sup> AIG was also fined millions of dollars by state insurance regulators, and faces charges that they bilked pension funds out of billions of dollars.<sup>66</sup>

But that was not the end of the AIG fraud saga. Greenberg, who once described civil justice attorneys as "terrorists," launched an epic battle of lawsuits and countersuits with his former company.<sup>67</sup> Suddenly, the \$1.6 billion AIG paid to settle claims of fraud seemed to pale in comparison to the charges being exchanged between those who knew better than anyone the true extent of the fraud. AIG now claims Greenberg "misappropriated" \$20 billion, and Greenberg in turn says AIG concealed \$4 billion in losses.<sup>68</sup>

In 2006, AIG was implicated in the manipulation of local government bond issues. At least \$7 billion worth of "phantom bonds," which were intended to aid the poor and supply computers to inner city schools, have instead only benefited companies such as AIG. In one such "phantom bonds" case in Florida, an AIG unit conspired with other financial services firms to extract fees from a \$220 million bond issue that was intended to promote affordable housing for low income families. Unbeknownst to the local government agency involved, AIG's deal meant the less money that actually went to affordable housing, the more money AIG and its fellow companies would make. AIG and its co-conspirators eventually took \$12 million in fees. Not a penny went to the affordable housing. The deal also violated U.S. tax laws, which would eventually force AIG to settle with the IRS. AIG was involved in similar deals in Georgia, Oklahoma, and Tennessee.<sup>69</sup>

## 4. State Farm

**CEO: Edward B. Rust Jr.**  
**2007 compensation \$11.7 million**

**HQ: Bloomington, IL**

**Profits: \$5.5 billion (2007)**

**Assets: \$181.4 billion<sup>70</sup>**

**As the biggest property casualty insurance company in America, State Farm has become notorious for its deny and delay tactics. In many cases, the company has gone to extreme lengths to avoid paying claims, including forging signatures on earthquake waivers after the deadly Northridge earthquake, and altering engineering reports regarding damage after Hurricane Katrina.**

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Hurricane Katrina showed State Farm at its worst. One of the deadliest natural disasters in U.S. history, Hurricane Katrina made landfall on August 29, 2005, near Buras, Louisiana. The storm killed nearly 1,600 people and caused \$135 billion in damages.<sup>71</sup>

One of the legacies of the storm was the widespread dissatisfaction with the response of State Farm and other insurance companies. State Farm would later claim it had settled 99 percent of its cases, but regulators criticized the company for using misleading statistics.<sup>72</sup> The company claimed that any house that had what they considered water damage did not constitute a claim in the first place.<sup>73</sup> In fact, the Louisiana Department of Insurance reported that it was contacted by 9,000 consumers seeking help resolving disputes with their insurance companies.<sup>74</sup>

State Farm denied the claims of the Nguyen family of Mississippi, who lost their home in Hurricane Katrina. State Farm's own engineers concluded that the damage was caused by wind and even cited eyewitnesses who saw another house picked up by the wind and thrown into the

Nguyens' home. State Farm, however, hired another engineering firm to come to a different conclusion and then denied the claim, saying the damage was caused by flooding.<sup>75</sup> State Farm also denied the claims of Dean Barras in Louisiana. Barras's home was exposed to the elements for two weeks, but State Farm's response was "the chimney was not built properly."<sup>76</sup>

Bob Kochran, CEO of an engineering firm assessing Katrina damage for State Farm, said that he was asked to alter reports with which the company did not agree. In order to keep the State Farm contract, Kochran agreed to tell his engineers to "re-evaluate each of our assignments." One of the engineers, Randy Down, responded in an email, "I have a serious concern about the ethics of this whole matter. I really question the ethics of someone who wants to fire us simply because our conclusions don't match theirs." State Farm's attempt to unduly influence the engineers was exposed during litigation in Jackson, Mississippi.<sup>77</sup>

One such angry policyholder was United States Senator Trent Lott. Lott, who had long counted on insurance companies for support, became an industry critic after his beachfront house was destroyed by Hurricane Katrina and his subsequent claim was denied by State Farm. Lott eventually settled with State Farm, but went on to sponsor legislation requiring insurers to provide "plain English" summaries of what their policies did and did not cover. Hurricane Katrina had highlighted insurance company use of such things as anti-concurrent clauses, which led policyholders into believing they were covered from the risks of hurricanes, when in fact subsequent flooding might wipe out any chance of a claim being paid. "They don't want you to know what you really have covered," said Lott.<sup>78</sup>

In April 2007, State Farm agreed to re-evaluate more than 3,000 Hurricane Katrina claims, and within a few

months had paid nearly \$30 million in additional settlements.<sup>79</sup> When a grand jury later issued subpoenas probing new claims against State Farm, the company sued Mississippi Attorney General Jim Hood. Hood decried the lawsuit, saying the company's agreement to reopen claims had never been intended as "blanket immunity" from future probes.<sup>80</sup>

Like Allstate, State Farm used consulting giant McKinsey & Co. The McKinsey concept involves cutting spending on claims payments to boost profits. Agents steeped in the McKinsey way speak of the "three D's"—deny the claim, delay the payment, and then do anything to defend against a lawsuit.

In 1994, the Northridge earthquake in California killed 57 people, injured 9,000, and caused an estimated \$33.8 billion in damage. It was the costliest earthquake in U.S. history, and insurance companies such as State Farm did everything they could to avoid having to pay for it. After it hit, a State Farm employee testified that company officials forged signatures on earthquake waivers to avoid paying quake-related claims and then withheld evidence when the company was sued. State Farm and other insurers accused of mishandling Northridge claims were fined over \$3 billion in penalties; however, State Farm never actually paid the fines. Instead, an insurance department whistleblower would eventually reveal that the insurers donated \$12 million to two non-profit foundations created by insurance commissioner Chuck Quackenbush in what amounted to little more than a bribe.<sup>81</sup>

In 1999, a series of powerful tornadoes killed 44 people in Oklahoma and caused \$1.8 billion in damages. Homeowners brought a class-action suit against State Farm, alleging the company had tried to undervalue dam-

age to homes or claim damage was caused by other factors such as faulty construction. A jury eventually ruled that State Farm acted "recklessly" and "with malice" and disregarded its duty to policyholders. The firm that State Farm used to allegedly undervalue damage was Haag Engineering—the same firm that would be accused of mishandling Katrina claims six years later.<sup>82</sup>

In 1999, despite Oklahoma tornado claims, State Farm earned \$1.03 billion in profits after taxes.<sup>83</sup> In 2005, despite Hurricane Katrina, State Farm turned a \$3.24 billion profit. The following year, without a major catastrophe, profits increased to \$5.32 billion, for which CEO Ed Rust received an 82 percent pay raise.<sup>84</sup> In fact, since State Farm hired McKinsey, the company has seen profits more than double from its 1990s level to the \$5.4 billion it made in 2007.

Following the same tactic as Allstate, State Farm has embarked upon a campaign of market withdrawals and non-renewals in the aftermath of Katrina. State Farm has stopped writing new homeowners policies in Mississippi and Florida, and in the latter state non-renewed a further 75,000 policyholders.<sup>85</sup> Just as they did in the aftermath of Katrina, State Farm stopped writing new homeowner policies.<sup>86</sup>

While State Farm will do anything to fight a claim once it has been taken to court, the company has never been shy about using the courts to its own advantage, even when it has to first stack the deck. In the 2004 Illinois Supreme Court election, one justice—Lloyd Karmeier—received huge amounts from State Farm employees, lawyers, and groups to which the insurer belonged. Karmeier won the election and soon after cast a crucial vote reversing a \$9 billion judgment against State Farm.<sup>87</sup>

## 5. Conseco

**CEO: C. James Prieur**  
**2007 compensation \$2.6 million**

**HQ: Indianapolis, IN**

**Profits: \$179.9 million (2007)**

**Assets: \$33.5 billion<sup>88</sup>**

**Conseco sells long-term care policies, typically to the elderly. Unfortunately, Conseco uses the deteriorating health of its policyholders to its advantage because the company knows if it waits long enough to pay out claims, its customers will die.**

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Conseco's customers are some of the most vulnerable members of the population. The company sells long-term care policies, typically to the elderly, as insurance that the policyholder will be taken care of at the end of his or her life. Unfortunately, Conseco uses the imminent deaths of its policyholders to its advantage by delaying or denying valid claims of those who can no longer care or advocate for themselves. Mary Beth Senkewicz, a former senior executive at the National Association of Insurance Commissioners (NAIC), summed up the tactics of the long-term care insurance industry quite succinctly: "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."<sup>89</sup>

Long-term care insurance policies are usually purchased by senior citizens as assurance that they will be able to afford to live in an assisted living center or nursing home when they are no longer capable of living on their own. Conseco and its subsidiaries, Bankers Life and Casualty and Penn Treaty American, sell such policies. However, many policyholders have not been satisfied with

the way their claims have been handled. Conseco, Bankers, and Penn Life have had numerous complaints filed with state regulators over long-term care insurance, particularly in regard to claims handling, price increases, and advertising methods.<sup>90</sup>

Despite all their efforts to retain money by refusing to pay valid claims, Conseco has fallen on hard times financially. Throughout the 1990s, Conseco and its affiliates aggressively undercut their competitors and expanded their market share in the long-term care insurance market.<sup>91</sup> Around the time company founder Stephen Hilbert left in 2000, the market tightened and executives realized they had been underestimating how long policyholders would live once they entered nursing homes. In 2002, the company fell \$6.5 billion in debt and was forced into Chapter 11 bankruptcy.<sup>92</sup> Conseco sued Hilbert for more than \$250 million over company-backed loans and debt. In 2004, a court ordered Hilbert to return \$62.7 million plus interest to Conseco and allowed the company to foreclose upon his 25,000 square-foot mansion in Indiana.<sup>93</sup> Hilbert and Conseco agreed to a confidential settlement in 2007 that allowed the former CEO to keep his house.<sup>94</sup>

Two other Conseco executives faced civil and criminal charges for their roles in an accounting fraud scheme that overstated the company's earnings by hundreds of millions of dollars. Former CFO Rollins S. Dick and former chief accounting officer James S. Adams admitted to filing misleading financial statements with regulators between March 1999 and April 2000. In 2006, an Indiana court ordered that Dick and Adams be prohibited from serving as a director or officer of a public company for five years and ordered them to pay civil penalties of \$110,000 and \$90,000, respectively.<sup>95</sup>

Former employees of Conseco and its subsidiaries have spoken out about the company's claims-handling practices. Former Bankers Life agent Betty Hobel said Conseco

and Bankers Life “made it so hard to make a claim that people either died or gave up.”<sup>96</sup> Another former Bankers Life employee, Robert Ragle said “[t]heir mentality is to keep every dollar they can.”<sup>97</sup> In a 2006 deposition, Bankers Life claims adjuster Teresa Carbonel described how she was forbidden from calling physicians or nursing homes to request missing paperwork before denying claims. Another Consecos employee, Jose Torres, testified in a separate deposition that he was told to withhold payment on claims until the policyholder submitted documents not even required under the terms of the policy.<sup>98</sup>

In May 2008, NAIC announced it had brokered a settlement between Consecos and 39 states and the District of Columbia over a pattern of abuses in its long-term care business. As part of the agreement with state insurance commissioners, Consecos and its subsidiaries were fined

\$2.3 million and ordered to pay \$4 million in restitution to policyholders. The company also agreed to invest \$26 million in its claims processing system. If it fails to improve its service, Consecos will be ordered to pay an additional \$10 million in fines. In addition to meeting these monetary obligations, Consecos must review its handling of past claims and set up systems to insure that future claims are treated fairly and handled in a timely manner. The company must review and readjust 1,112 denied claims, notify an additional 18,000 policyholders regarding 49,000 claims that were partially denied or denied after an initial payment was made, revise its claim-handling procedures, and set up a toll-free call center for consumers who believe their claims were not handled in good faith.<sup>99</sup>



# 6. WellPoint

**CEO:** Angela F Braly  
**2007 compensation \$9.1 million**

**HQ:** Indianapolis, IN

**Profits:** \$3.2 billion (2007)

**Assets:** \$51.6 billion<sup>100</sup>

**WellPoint has a long history of putting its bottom line ahead of the welfare of its policyholders and their health care providers. Investigations have shown that Wellpoint routinely cancels the policies of pregnant women and chronically ill patients.**

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Indianapolis-based Anthem and Thousand Oaks, and California-based WellPoint completed a \$20.8 billion merger in late 2004, creating the nation's largest health insurer, covering approximately 28 million people.<sup>101</sup> The deal was widely criticized by consumers, doctors, pension managers, and state regulators, who feared the merger would create a monopoly that would both raise premiums and reduce payment on claims, in part to cover the cost of the massive severance packages offered to executives who brokered the deal.

California's State Treasurer Philip Angelides and Insurance Commissioner John Garamendi, as well as officials at the California Public Employees' Retirement System, or CalPERS, criticized the deal for providing excessive compensation to executives. The terms of the merger included a payout of over \$250 million to nearly a dozen executives at the company. Leonard Schaffer, WellPoint's Chairman and CEO at the time, received the largest windfall of all: nearly \$82 million in severance, an executive pension, and stock options.<sup>102</sup>

California is making an aggressive effort to force WellPoint to stop engaging in practices it believes are ille-

gal. In March 2007, the state's Department of Managed Health Care fined Blue Cross of California and its parent company, WellPoint, \$1 million after an investigation revealed that the insurer routinely canceled individual health policies of pregnant women and chronically ill patients. The practice, known as rescission, is illegal in California. In order to drop individual policies, which are usually purchased by consumers who cannot receive health insurance through their employers, 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.<sup>103</sup>

During the investigation, California regulators uncovered more than 1,200 violations of the law by the company in regard to unfair rescission and claims processing practices. In December 2007, Insurance Commissioner Steve Poizner announced his office was imposing a \$12.6 million fine against Blue Shield, saying the company had "committed serious violations that completely undermine the public trust in our healthcare delivery system."<sup>104</sup> Among these violations were improper rescissions, failure to pay claims on a timely basis, failure to provide required information when denying a claim, failure to pay interest on claims where required, and mishandling of member appeals.<sup>105</sup>

Despite a series of fines and reprimands from the state, Anthem did not change its claims-handling practices. The continuation of rescission practices forced Los Angeles City Attorney Rocky Delgadillo to sue Anthem Blue Cross of California in April 2008, for fraud, violation of state and federal insurance regulations, and violation of truth-in-advertising laws. Anthem's practice of canceling policies of sick patients prompted Delgadillo to claim 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.<sup>106</sup> He also alleged that “more than 500,000 consumers have been tricked into purchasing largely illusory healthcare coverage based upon the company’s false promise.”<sup>107</sup> The city is seeking civil penalties of between \$2,500 and \$5,000 for each violation, which could add up to over \$1 billion.

Other states have taken action against WellPoint and its subsidiaries over their claims-processing practices. In January 2008, Nevada Insurance Commissioner Alice A. Molasky-Arman announced a \$1 million settlement with Anthem Blue Cross and Blue Shield over systematic overcharging of policyholders.<sup>108</sup> Similarly, Colorado’s Insurance Commissioner, Marcy Morrison, secured a \$5.7 million refund for consumers of Anthem Blue Cross Blue Shield health insurance policies.<sup>109</sup> 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.<sup>110</sup>

Physicians have their own set of grievances against the insurance behemoth. WellPoint was one of several health insurers sued by 800,000 doctors who claimed they were routinely denied full payment for care they provided to policyholders. In two lawsuits, the physicians argued that insurance companies manipulated computer programs to systematically underpay physicians for the treatments they provided.<sup>111</sup>

Physicians in California have encountered a new reason to be outraged by WellPoint. Blue Cross California has recently sent letters to physicians instructing them to inform the company of any pre-existing conditions they come across when evaluating patients. The letter demanded that “[a]ny condition not listed on the application that is discovered to be pre-existing should be reported to Blue Cross immediately.”<sup>112</sup> The California Medical Association promptly forwarded the letter to state regulators complaining that the insurance company is “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.”<sup>113</sup>



## 7. Farmers

**CEO:** Paul N. Hopkins (Farmers Group Inc. US subsidiary of Zurich Financial Services. Zurich CEO James J. Schiro 2007 compensation \$10.3 million)

**HQ:** Los Angeles, CA

**Profits:** Zurich Financial—\$5.6 billion (2007)

**Assets:** \$387.7 billion<sup>114</sup>

**Swiss-owned Farmers Insurance Group consistently ranks at or near the bottom of homeowner satisfaction surveys. Given its tactics towards its policyholders, that comes as no surprise. The company even created an incentive program that offered pizza parties to adjusters who met low payment goals.**

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Farmers Insurance Group consistently ranks among the worst insurance companies for customers of homeowners or auto insurance in satisfaction surveys from the likes of JD Powers and Consumer Reports.<sup>115</sup> Nor is it just individuals who get the short end of the stick. U.S. businesses were victimized by Farmers' parent company, Swiss giant Zurich Financial Services, which in the last few years has paid out nearly half a billion dollars to settle bid-rigging and price-fixing cases. According to regulators, "businesses shopping for commercial insurance were deceived into believing they were getting the best deals available. The whole anti-competitive scheme was an intentional smoke screen by several insurance players to artificially inflate premiums and pay improper commissions to those who brokered the deal."<sup>116</sup>

No case is as illustrative of the Farmers attitude than that of Ethel Adams. The 60-year-old Washington State woman was involved in a multi-vehicle accident that put her in a coma for nine days, left her with devastating

injuries, and eventually confined her to a wheelchair. Incredibly, Farmers denied her claim, reasoning that the driver at fault had acted in a moment of intentional road rage, and thus the crash was not an accident. The company's denial caused an outcry, and Farmers Los Angeles headquarters was flooded with calls and emails from angry policyholders threatening to boycott the company. Farmers only caved when the Washington State Insurance Commissioner threatened the company with legal action.<sup>117</sup>

Adams' case is symptomatic of Farmers' attitude towards its policyholders. Internal company documents and testimony from former employees reveal a company that systematically places profits over policyholders. An example is Farmers' employee incentive program, "Quest for Gold."<sup>118</sup> The program offers token incentives, including \$25 gift certificates and pizza parties, to adjusters who meet goals, such as low payments and the rates at which they are able to dissuade claimants from retaining an attorney.<sup>119</sup> Employees' performance reviews and pay raises are also determined by their ability to meet claim payment goals.<sup>120</sup> Internal emails show one particular claims manager encouraging representatives to intentionally underpay valid claims, saying, "[a]s you know, we have been creeping up in settlements... Our [claims representatives] must resist the temptation of paying more just to move this type file. Teach them to say, 'Sorry, no more,' with a toothy grin and mean it."<sup>121</sup> The same email also indicated that claims representatives were financially rewarded for such behavior. The manager singled out an employee who consistently low-balled claims, saying, "[i]f he keeps this up during 2002, we will pay him accordingly."<sup>122</sup>

Such strategies have attracted the attention of state insurance industry regulators. In North Dakota, Farmers has been fined for "unfair practice in the business of insurance... and an unfair claim settlement practice," for

its use of employee incentive programs and for tying performance evaluations to arbitrary claims-handling goals.<sup>123</sup> In Oklahoma, Farmers agreed to limit its use of the claims-evaluation software Colossus, the same software used by Allstate, after the company was found to have repeatedly failed to pay claims in full.<sup>124</sup> The Texas Department of Insurance joined with the state's attorney general in 2002 to file a lawsuit against Farmers over violations of state consumer protection laws, including deceptive, misleading, and unfairly discriminatory homeowners' insurance practices.<sup>125</sup> While the company would not admit wrongdoing, it did agree to reduce rates and issue refunds.<sup>126</sup> However, Texas regulators were forced to take action against Farmers again just two years later, ordering the company "to cease and desist from charging excessive property rates for residential property insurance in violation of Texas law."<sup>127</sup>

Farmers' most high-profile run-in with state regulators occurred in California after the 1994 Northridge earthquake, which killed 72 people, injured nearly 12,000, and caused over \$12 billion in damages.<sup>128</sup> Many of the homeowners were covered by Farmers. Despite paying out over \$1.9 billion for 37,000 claims, the company was hit with a wave of bad faith lawsuits for failing to pay policyholders the full value of their homes.<sup>129</sup> In one case, a Farmers' subsidiary was sued for bad faith and fraud by a condominium homeowners association after the company refused to pay to rebuild the severely damaged building. The homeowners, who were mostly minorities, were helped in their case by the testimony of a former claims adjuster, Kermith Sonnier, who admitted that a supervisor told him to settle the claim for a target amount, despite never having seen the damage firsthand. In March 2000, over six years after the quake struck, a jury awarded the homeowners association \$3.98 million in compensatory damages and was deliberating punitive damages when Farmers agreed to settle the case for \$20 million. Sonnier,

who had been fired by Farmers, also successfully sued the company for compensatory and punitive damages.<sup>130</sup>

The reaction of California regulators was an example of the sometimes dubious relationship between the industry and those who are supposed to oversee it. California Insurance Commissioner Chuck Quackenbush issued a proposed order saying that the company mishandled claims and could potentially face \$450 million in fines. However, instead of pursuing the investigation, Quackenbush offered Farmers a deal that would absolve the company of all liability if it donated \$1 million to the California Insurance Education Project, a foundation created by Quackenbush. The company also contributed \$10,000 to one of the commissioner's political accounts.<sup>131</sup> In addition, Quackenbush's settlement required that Farmers survey all its policyholders to gauge satisfaction with the company's handling of their claims.<sup>132</sup> Incredibly, any policyholder who completed the Farmers survey automatically waived all rights to seek justice in court.<sup>133</sup> Quackenbush resigned under the threat of impeachment two months after the settlement was made public.<sup>134</sup>

Immediately following the earthquake, the company implemented a program asking employees to help recoup some of the losses and adopted the slogan "Bring Back a Billion," meaning that employees were expected to bring in a billion dollars for the surplus.<sup>135</sup> Some of these employees even signed pledges agreeing to work toward this goal.

More recently, Farmers have found California regulators less easy to manipulate. In 2007, California Insurance Commissioner Steve Poizner found that some Farmers customers who filed claims later had their insurance non-renewed or experienced premium hikes just because they used their insurance for its intended purpose. Farmers agreed to refund policyholders \$1.4 million and paid \$2 million in administrative fines, although it did not admit any wrongdoing.<sup>136</sup>

# 8. UnitedHealth

**CEO:** Stephen J Hemsley  
**2007 compensation \$13.2 million**

**HQ:** Minnetonka, MN

**Profits:** \$4.7 billion (2007)

**Assets:** \$53.5 billion<sup>137</sup>

**UnitedHealth is plagued by accusations that its greed has endangered patients. Physicians report that reimbursement rates are so low and delayed by the company that patient health is compromised. Money that should have been spent on medical treatment for policyholders has instead gone to the company's former CEO, who faced criminal and civil charges for backdating stock options. UnitedHealth has also used its association with AARP to jack up premiums on products aimed at seniors, even though they are no better than their cheaper counterparts.**

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William McGuire orchestrated UnitedHealth Group's rapid growth to become the largest health insurance company by premiums written in America.<sup>138</sup> Along the way, he ensured that he would be well compensated for his efforts. When McGuire became CEO in 1990, he immediately began to streamline the company by cutting back on coverage for treatment he deemed unnecessary and by bargaining with doctors to reduce payments.

UnitedHealth also became dominant in the burgeoning HMO market by investing in information technology and acquiring smaller companies.<sup>139</sup> The company's success under his leadership made it easy for McGuire to convince the board of directors to reward him for his performance. McGuire was allowed to choose when his stock options would be awarded, essentially allowing him to backdate his options to make it appear they were issued on days when stock prices were at their lowest.<sup>140</sup>

The *Wall Street Journal* conducted an analysis of McGuire's stock option grants between 1994 and 2002 and concluded that the probability the options were randomly awarded on dates when stock prices were at their lowest would be about 1 in 200 million.<sup>141</sup> An internal memo made public during litigation confirmed that on at least one occasion options were granted "with an advantageous price."<sup>142</sup> By backdating his options, McGuire was able to amass \$1.6 billion in options as UnitedHealth's stock price rose from 30 cents per share in 1990 to \$62.14 in December 2005.<sup>143</sup> Given the incredible performance of the stock, the board saw no reason to restrain McGuire.

Shareholders and the SEC did not share the board's view of McGuire's worth. The SEC opened an investigation into UnitedHealth's options granting process, which ultimately led to McGuire's ouster as CEO in 2006. Additionally, McGuire agreed to give back \$620 million in stock gains and retirement compensation in order to settle federal and shareholder claims.<sup>144</sup> The settlement left McGuire with just \$800 million in options and \$530 million in compensation.<sup>145</sup>

During his tenure as CEO, McGuire was meticulous about expanding the company's reach. One very profitable move was the decision to partner with AARP to sell insurance products. UnitedHealth Group understood the value of AARP's image as a trusted advocate for senior citizens' rights when it partnered with the non-profit organization in 1998 to market its insurance products. That year, the insurer won a 10-year contract to brand its supplemental Medicare insurance policies with the AARP name.<sup>146</sup> The deal was lucrative for both sides. UnitedHealth received \$4.5 billion in premiums from AARP-branded products in 2004, while the seniors' organization pulled in \$197 million in royalties and \$23 million in investment income that same year.<sup>147</sup>

Beginning in 2006, AARP licensed its name to three UnitedHealth Medicare prescription drug plans, covering 4.1 million people.<sup>148</sup> UnitedHealth also sells two other prescription drug plans not branded by AARP, and the enrollment numbers show just how effective the AARP name is. UnitedHealth's stand-alone plans cover only 600,000 people.<sup>149</sup>

While this partnership is advantageous for UnitedHealth, it laid AARP vulnerable to the charge of allowing financial gain to trump its members' best interests. The premiums charged by UnitedHealth's AARP plans are often far higher than those charged by other companies. The AARP reputation gives seniors the false sense of value and quality, even though there is little difference in services and the premiums are far higher.

In June 2007, UnitedHealth was forced to suspend marketing of its Medicare Advantage program after the federal government determined that the company was misrepresenting its products. Medicare audit reports found that UnitedHealth lacked an effective program to supervise its marketing representatives.<sup>150</sup> The reports also found that the company failed to notify policyholders about changes in costs and benefits.

UnitedHealth has repeatedly been accused of focusing on profits at the expense of its policyholders and their health care providers. The Nebraska Insurance Department reported a spike in complaints against the insurance giant for wrongful denials of claims and for failing to reimburse claims in a timely manner. Other state regulators have said UnitedHealth has acted improperly in denying claims. In one case, the company denied a doctor's request for an enclosed bed to protect a four-year-old with an abnormally small head. In another case,

the company rejected a request from a patient who lost 200 pounds after bariatric surgery and wanted to have flaps of excess skin removed to prevent infection.<sup>151</sup>

Physicians report that UnitedHealth's reimbursement rates are so low and delayed that patient health is being compromised. Many physicians in South Carolina have stopped accepting UnitedHealth coverage and others are forcing patients to pay up front. South Carolina is the only state that does not have a "prompt pay law," which requires insurers to pay claims within 90 days. Texas, which has a prompt pay law, has levied \$4 million in fines against UnitedHealth for late payment.<sup>152</sup> Regulators in Arizona fined the insurer \$364,750 for illegally denying over 63,000 claims by doctors.<sup>153</sup>

New York regulators and health care providers have taken an aggressive stance against UnitedHealth practices they believe to be unfair. The state Department of Health prohibited UnitedHealthcare of New York from enrolling new members until it improved practices, such as adding more customer relations staff, responding to claims faster, and updating financial reports.<sup>154</sup> The American Medical Association (AMA) and the Medical Society of the State of New York sued the insurer over its reimbursement rates.<sup>155</sup>

Perhaps the biggest hit to UnitedHealth will come from a lawsuit New York Attorney General Andrew Cuomo intends to file over how the company determines what portion of a doctor or hospital bill to pay. Cuomo alleges that UnitedHealth has systematically been forcing patients to pay more than they should for visits to out-of-network doctors and hospitals by intentionally low-balling reimbursement rates. A company called Ingenix calculates rates; however, this company is owned by UnitedHealth, which creates the potential for a conflict of interest.<sup>156</sup>

# 9. Torchmark

**CEO:** Mark S. McAndrew  
**2007 compensation \$4.7 million**

**HQ:** McKinney, Texas

**Profits:** \$527.5 million (2007)

**Assets:** \$15.2 billion<sup>157</sup>

**Founded, by its own admission, as little more than a scam, Torchmark has preyed upon low-income Southerners for over 100 years. Torchmark is the holding company for a variety of subsidiaries offering low cost burial insurance, cancer insurance, life insurance, and similar policies. The company has come under fire for a variety of transgressions, including charging minority policyholders more than whites.**

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According to its former CEO, Torchmark's very origins are as a scam. Founded in 1900, the group's purpose was to funnel money to its founders, according to former CEO Frank Samford. Then known as the Heralds of Liberty, it initially registered itself as a fraternal organization to circumvent Alabama's insurance laws. It was reorganized as a stock company in 1929 and absorbed several other insurance companies over the course of the century before adopting the name Torchmark for the holding company in 1982.<sup>158</sup>

Since then, Torchmark and its various subsidiaries have preyed upon low-income Americans all over the South. The various schemes and tactics it has engaged in, including race-based underwriting, refusing insurance to non-English speakers, and deliberate overcharging of premiums, have prompted frequent lawsuits from regulators and policyholders alike. Now Torchmark plans to expand into more states.<sup>159</sup>

In the 1990s, Torchmark subsidiary Liberty National Insurance was forced to pay several millions of dollars in

litigation alleging fraud in selling cancer insurance policies. The company had marketed the policies in the 1980s promising lifetime benefits, yet changed the policies without telling their customers.<sup>160</sup>

Torchmark subsidiaries Globe Life and Accident Insurance and United American Insurance also came under fire for their marketing of individual health insurance policies. Some of the tactics that were highlighted included selling replacement policies that did not actually replace all of a person's coverage. Company agents would convince policyholders that their current coverage would be discontinued at age 65, even when it was guaranteed for life, and then would offer new policies that were not worth as much. Another tactic involved offering "low-cost" policies at rates that quickly shot up. In one such case in 1989, a Greenville, Mississippi, man bought a policy with an \$86 a month "teaser rate." Torchmark did not disclose that the rate would immediately go up. Within two years, the rate had more than doubled.<sup>161</sup>

For years Torchmark and its affiliates have been involved in litigation concerning race-based pricing, particularly over "burial policies." In the mid-1980s, half of all Alabamans who died had a burial policy from Torchmark. These burial policies were sold at a higher price to black policyholders. In 2000, a Florida court ordered the company to stop collecting premiums on the old burial policies because black policyholders had been charged more than white policyholders. Alabama regulators followed with an investigation.<sup>162</sup> In 2006, Torchmark subsidiary Liberty National Life Insurance paid \$6 million to resolve a 2,000 member class action lawsuit. According to the allegations, Liberty National agents would market these policies with premiums of less than \$1 to attract low-income policyholders. However, black policyholders ended up paying 36 percent more than white policyholders.<sup>163</sup>



In 2003, Torchmark affiliate United American Insurance settled charges that it had defrauded senior citizens in the sale of Medicare policies. A two-year investigation in Minnesota concluded the company had misled hundreds of people into purchasing supplemental Medicare insurance policies. According to the report, United American aggressively pressured hundreds of seniors into buying insurance that was more expensive and less comprehensive than the insurance they already had, which was a violation of state law. Internal documents showed that company agents were encouraged to act as if they were representing federal agencies or senior service centers. United American used a subsidiary, Consumer Support Services, which sent mass mailings to elderly citizens signed from the “Medicare Supplement Division.” Agents would then set up meetings to offer information packets, which in reality were home-sales opportunities. The fraud was reported by United American’s own employees. The company also deliberately delayed premium refunds and lied to authorities about its reserves. The Minnesota Commerce Department Commissioner said of the case, “This is not a case of rogue agents. These are not technical violations. This is irresponsible corporate culture at work.”<sup>164</sup> A subsequent report from the state Office of the Legislative Auditor criticized the settlement because it had allowed United American several improper concessions. Among these were a confidentiality provision that kept the deal secret, an agreement not to report the company to the National Association of Insurance Commissioners (NAIC), and an agreement to characterize the company’s payment as a “fee reimbursement,” not a penalty or fine.<sup>165</sup> It was at least the third time United

American had been found to have broken Minnesota insurance laws. At the time, ten states had issued at least 26 enforcement actions against the company.<sup>166</sup>

Even Torchmark’s own employees are not immune from the company’s desire to put profits over people. In 1998, Liberty National incurred a multimillion dollar verdict for age discrimination claims put forward by its employees. Evidence presented at the trial highlighted one particularly aggressive manager, Andy King.<sup>167</sup> Ironically, in 2006, Torchmark CEO Mark McAndrew brought in Andy King to shake up Liberty National’s employees. Newly installed as President and Chief Marketing Officer of Liberty National, King would oversee what McAndrew described as a move from “socialistic” compensation to a “capitalistic” approach.<sup>168</sup> McAndrew went on, “There is no doubt moving Andy out there we will see an improvement in the recruiting and new agent hiring. As far as these people that are at extremely low production level, this has been a long term problem. It is something that has gone on for years, so it’s not anything new. Some of those are veteran agents. Most of those would be more veteran agents. It has been accepted for a number of years, and it is something we’re changing. So it’s really not a new problem.”

Torchmark got a taste of its own medicine in 2003 when Waddell and Reed, a unit that Torchmark itself had spun off in 1998, conspired to switch policyholders from United Investors Life, another Torchmark subsidiary, to rival Nationwide. When United Investors sued, Waddell and Reed filed a civil racketeering claim against Torchmark accusing its former parent of scheming to continue its hold over Waddell after it was spun off. Torchmark eventually prevailed.<sup>169</sup>

# 10. Liberty Mutual

**CEO:** Edmund F. (Ted) Kelly  
**2005 compensation** \$27 million

**HQ:** Boston, MA

**Profits:** \$1.5 billion (2007)

**Assets:** \$94.7 billion<sup>170</sup>

**Like Allstate and State Farm, Liberty Mutual hired consulting giant McKinsey & Co. and adopted deny, delay, and defend tactics. The company has also gone one further than simple claims-handling abuses by indulging in what regulators allege is systematic bid-rigging.**

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Like Allstate and State Farm before it, Liberty Mutual hired consulting giant McKinsey & Co. to boost its bottom line. The McKinsey strategy relies on lowering the amounts paid in claims, no matter whether the claims were valid or not. By all accounts, Liberty Mutual has not become as notorious as its rivals for the deny, delay, and defend tactics that McKinsey encouraged. However, that has not stopped the company from leading the way in complaint rankings and stories of short-changed victims.<sup>171</sup> In fact, Liberty Mutual is facing a glut of litigation from its own vendors who say the company's cost-cutting has resulted in poor claims processing and a spike in lawsuits.<sup>172</sup>

Like several other big property casualty insurers, Liberty Mutual has also begun abandoning policyholders

across the country. The company has pulled out of many states—not only hurricane susceptible states such as Florida and Louisiana, but also northern states such as Connecticut, Rhode Island, Maryland, Massachusetts, and much of New York. A 2007 *New York Times* article highlighted Liberty Mutual policyholders James and Ann Gray of Long Island. The Grays were “nonrenewed” by Liberty Mutual despite the fact that they lived 12 miles from the coast and had “been touched by rampaging waters only once, when the upstairs bathroom overflowed.” In fact, Liberty Mutual and its big name competitors have left more than 3 million homeowners stranded over the last few years.<sup>173</sup> New York regulators chastised Liberty Mutual for tying nonrenewals to whether a policyholder had an auto policy or other coverage, against state law.<sup>174</sup>

Liberty Mutual has also gone where even its big property casualty rivals Allstate and State Farm have feared to tread by trying its hand at massive corporate fraud. While the likes of AIG, Zurich, and ACE settled charges that they colluded with broker Marsh & McLennan in a huge bid-rigging fraud, Liberty Mutual remains the only insurance company that refuses to concede guilt. The fraud centered around fake bids that companies submitted to Marsh in order to garner artificially inflated rates. Liberty Mutual claims its business practices were lawful and that regulators' settlement demands are “excessive.”<sup>175</sup>

# Conclusion

The insurance industry is in dire need of reform. For too many insurance companies, profits have clearly trumped fair dealing with policyholders. The industry has done all it can to maximize its profits and rid itself of claims. Allstate CEO Thomas Wilson outlined the strategy when he said the company had “begun to think and act more like a consumer products company.”<sup>176</sup> Allstate has enjoyed a return double that of the S&P 500, but its policyholders have suffered cancellations, nonrenewals, and punishing loss-prevention techniques.<sup>177</sup> Wilson has been unrepentant: “Our obligation is to earn a return for our shareholders.”<sup>178</sup>

Wilson is one of many insurance leaders who have lost sight of their legal and ethical responsibility to policyholders. Now they answer only to Wall Street. The time is due for insurance reform that will level the playing field for consumers.

## Three Pro-Consumer Insurance Reforms

### 1. Require Insurers to Work in Good Faith with Consumers

Many states have introduced, and some have passed, “Insurer Fair Conduct” bills which establish a private right of action by a first and/or third party against insurers for failure to act in good faith. Insurers must be held

to fair conduct standards when evaluating and settling claims.

### 2. Require Prior Approval of Rate Increases

Require insurers to obtain commissioner’s approval of proposed rate increases of 10 percent or greater, and authorize interested parties to intervene in rate proceedings. In most states, insurers can raise rates without the approval of the Insurance Commissioner. Rates are either automatically approved absent action on the part of the Commissioner, or the Commissioner has no authority to disapprove increases. The goal is to explicitly authorize—or even require—the Commissioner to hold a hearing prior to approval.

### 3. Establish an Insurance Consumer Advocate

States should ensure there is a consumer advocate either on the state’s Insurance Commission or within the office of the Insurance Commissioner. Some states have already done so. For example, in 1991, the West Virginia legislature created the Office of Consumer Advocacy, charged with representing consumers’ interests in health care issues. The Consumer Advocate is also authorized to represent the public interest in matters coming before the Insurance Commission.



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