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Burned twice: 5 signs of bad faith in total-loss wildfire claims

More than a year after the Eaton and Palisades fires, many families still cannot rebuild because insurers quietly shortchange total-loss claims by delaying, minimizing or withholding benefits they owe.

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More than a year after the Eaton and Palisades fires, when the focus should be on rebuilding, the most persistent obstacle for many families remains their own insurance company. There is a common assumption that at this point in the recovery process, serious insurance disputes arise primarily in smoke, ash or partial-loss claims. Total losses, by contrast, are often viewed as straightforward: the home is gone, the carrier inspects the loss, policy limits are paid and the insured moves forward. In theory, there is little to dispute.

In practice, however, total loss wildfire claims are also plagued with bad faith conduct by insurance carriers: Insurers frequently pay certain obvious benefits early–dwelling limits, personal property advances and loss-of-use payments–creating the impression that the claim has been fully and fairly resolved. Policyholders –and the counsel assisting with them –are often relieved. The problems typically surface much later, when it becomes clear that critical additional coverages were never explained, never applied or quietly minimized.

This article, Part 1 of a two-part series, identifies five warning signs of bad faith in total-loss wildfire claims. Part 2 will address bad faith patterns unique to partial-loss and smoke-damage claims.

1. Failure to pay extended replacement costs

Policyholders purchase "extended replacement cost" coverage precisely to protect against catastrophic losses like a total burndown. This coverage increases dwelling/building coverage (and in some cases coverage for other structures as well) by a defined percentage. Insurers often overlook or fail to explain this coverage or simply manufacture reasons not to pay–blatantly lowballing the cost of rebuilding in order to minimize the amount owed under this coverage.

Common red flags include early settlement pressure after payment of initial policy limits before any meaningful inspection or reliance on woefully inadequate estimates. Practitioners should also scrutinize whether estimates were prepared by individuals with real-world construction experience, or instead generated by software untethered from the realities of construction costs–especially software called Xactimate.

2. Failure to pay full benefits when purchasing a replacement home

Policyholders have the right to buy a different home instead of rebuilding on their lot–and the policy's limits should be available to the homeowner if they do so. If a homeowner has $1.2 million in dwelling coverage and it would cost that much to rebuild the home, the insurer must pay $1.2 million towards the new home–they don't get to subtract land value. The policyholder is entitled to the same amount of coverage that would have rebuilt the home up to the policy limits. Insurers must explain this clearly. Many don't.

Warning signs include carriers creating confusion about whether proceeds can apply to a replacement property; deducting the value of the land from the available policy limits; and delays when a policyholder chooses to relocate rather than rebuild.

3. Failure to pay for code upgrade coverages

When homes are rebuilt, they must meet current building codes–not the codes from when the home was originally constructed–and this can get costly because it may often change the character of the home. Many policies include "code upgrade coverage" for exactly this reason–and is often listed separately on the policy and usually calculated as a percentage of the main dwelling coverage limit. This is especially important for older homes that were built before modern code requirements.

Insurers routinely fail to account for these costs, leaving policyholders to pay out of pocket or fight for what they're owed.

Common tactics include relying on estimates that assume the home can be rebuilt exactly as it was; claiming code upgrades are not covered; or refusing to pay unless the policyholder identifies specific line items and proves which code provisions apply despite the policyholder's estimate being prepared by a licensed contractor who is building in compliance with the code.

4. Failure to pay true alternative living expenses (Loss of Use)

When a home is uninhabitable, policyholders are entitled to maintain their standard of living. That means the carrier should pay the fair market rental value (FMRV) of the insured home–not just whatever cheaper housing the policyholder happens to find.

Look for: carriers paying less than the FMRV; and carriers demanding the policyholder produce a market report to prove the value of their own home–shifting the burden to the victim; insisting that the homeowner just live in a home (or sometimes a hotel) much smaller than what they lost.

5. Failure to acknowledge other coverages (debris removal, landscaping, contents)

Policies often include coverages that carriers conveniently fail to mention: debris removal, landscaping and more. When they do acknowledge these coverages, the execution is often designed to minimize payouts. These coverages often are a percentage of the structure limit. While they seem minimal in comparison to the other policy limits, they often add up to tens of thousands of dollars, funds that matter when trying to rebuild an underinsured home from the ground up.

The common playbook

Across carriers, the tactics are the same. It is all about wearing the insured down. Weeks turn into months. Reports arrive late–sometimes nearly a year after the loss–riddled with errors and omissions, with the expectation that the policyholder will do the work for the insurance company to prove their own claim.

In one instance, a carrier which had issued policies to victims in Pacific Palisades sued its own claims administrator, alleging a "deficit of funds" that left them "unable to disburse funds due and owing to third party insureds, including survivors of the devastating Eaton and Palisades fires." When an insurer is suing its own administrator in anticipation of bad faith exposure, it underscores the fundamental problem: Premiums are collected up front, while claims handling is delegated to low-cost vendors incentivized to delay and minimize payouts. If lawyers representing policyholders fail to confront–or even notice–these practices, the cycle of bad faith will continue unchecked.

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