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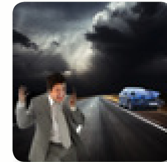

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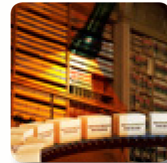

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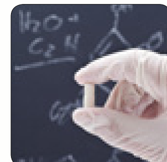

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Coalition Against Insurance Fraud

Shining a light on shady personal-injury claims

By Nora Freeman Engstrom

Settlement mills are personal-injury law firms that are unique in many important respects.[1] First, their case volumes are higher than average. While plaintiffs' personal-injury lawyers are known to have sizable caseloads compared to other lawyers in other specialties, settlement mills' claim volumes appear to be triple the personal-injury average; some settlement mill attorneys report simultaneously juggling hundreds of claims.[2]

Second, the kind of claims settlement mills process is distinctive. Namely, claims tend to be small and of a particular type — mostly soft-tissue injuries (sprains, strains, contusions and whiplash) sustained in automobile accidents.[3]

Third, settlement mills' client screening is also different. Most personal-injury lawyers expend significant resources vetting clients and, almost universally, decline far more cases than they accept. Settlement mills, by contrast, spend little time and effort screening clients and tend to take most comers.[4] At one Florida firm, for example, a former lawyer recounted that the "modus operandi was to sign everything up."[5]

Fourth and finally, settlement mill procedures

Abstract: *Over the last three decades, no development in the legal services industry has been more widely observed but less carefully scrutinized than the emergence of firms called "settlements mills." These are high volume personal-injury law firms that aggressively advertise and mass produce the resolution of claims, typically with little client interaction and without initiating lawsuits, much less taking claims to trial. This essay explains what settlement mills are, considers how settlement mills may – unwittingly or not – contribute to the significant problem of fraud and medical buildup in the auto-accident system. And finally, this essay proposes a policy reform that, if implemented properly, could help deter corrupt bodily-injury claims.*

are unusual; they are uniquely mechanized, routinized and systematized. Little attention is paid to fine-grained assessments of fault, and few resources are invested in each case's factual and legal development. As one former settlement mill founder said: "[I]t's a cookie-cutter. It is routine. You call and they offer you $500 and you ask for $2,000 a month, and then you go to $1,000. If you get $1,200, you do it, but it is just boom, boom, boom like that."[6]

Settlement mills represent a relatively new development in the legal-services industry — and they have many unique costs and benefits. To be sure, they do have benefits. Among their advantages, settlement mills offer their clients relative speed and predictability, while sparing clients from litigation's crushing expense, emotional entanglements and bruising ordeals.[7] They also confer societal advantages: By not filing lawsuits, they appear to alleviate court congestion and reduce the cost of processing and defending each claim. But there are drawbacks. Importantly, settlement mills create an environment that is susceptible to fraud and abusive medical buildup.

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Are fraud and buildup building?

It has long been said that the tort system, by virtue of payment for potentially large non-economic losses, is "marred by temptations to dishonesty that lure into their snares a stunning percentage of drivers and victims."[8] The tort system can encourage dishonesty, in part, because compensation for non-economic loss (mainly for "pain and suffering") leaves money in one's pocket — thus creating some incentive to feign or grossly exaggerate one's injury. The valuation of tort claims also can encourage corruption because, in the rough-and-tumble world of claims adjustment, a plaintiff's economic loss ("special damages") often is multiplied to calculate a plaintiff's total recovery.[9]

That multiplication creates a temptation to inflate special damages as high as possible. As a former California settlement mill attorney explained, "If a person goes to a chiropractor and gets some treatment, gets some medical specials, all of a sudden instead of having a case that is worth $1,500, you have a case that is worth $3,500."[10] Often called "medical buildup," this incentive structure has been called "[o]ne of the central flaws in the tort insurance market."[11] And it takes a tremendous toll. Fraud and medical buildup add billions of dollars to the cost of the auto-injury reparation system annually.[12]

Because of settlement mills' unique operation, they might be especially susceptible to encouraging fraudulent, built or unmeritorious claims.

First and most obviously, in contrast to more conventional counsel who spends significant resources vetting clients, as noted, settlement mills do not tend to engage in rigorous pre-retention review. At one Georgia settlement mill, for example, an attorney recalled that the "overwhelming" number of prospective clients were accepted.[13] At a Louisiana firm, meanwhile, statistics suggest that, in one year, roughly 95 percent of those who called the firm seeking compensation after an auto accident were, at least initially, signed up as clients.[14] Such open-door policies are not likely to turn fraudsters and malingerers away.

Second, as noted previously, settlement mills commonly represent claimants with soft-tissue injuries.[15] These injuries represent a class of injury that is notoriously difficult to verify and thus is easily — and studies suggest often — feigned. Indeed, one study concluded that approximately 42 percent of reported soft-tissue injury claims (narrowly defined as sprains and strains to the neck and back) in dollar-threshold no-fault and tort states were for nonexistent or preexistent injuries.[16]

Third, when it comes to encouraging fraud

and medical buildup, it appears that settlement mills maintain particularly close relationships with doctors and chiropractors, who are in positions to benefit handsomely from providing extra and unnecessary medical care. Overall, statistics suggest that relationships between many lawyers and medical providers are quite cozy.

Lawyers advise on providers

Nearly one-third (31 percent) of surveyed claimants who hired attorneys "indicated that their attorneys advised them on which medical care providers to visit," according to a recent Insurance Research Council (IRC) study.[17] Taking that a step further, some settlement mills make a physician's services part of the sell. One Louisiana firm, for example, made a 10-part "guarantee" to each client. One tenet was: "I will arrange all doctor care! No out of pocket expense!"[18] Going further still, another settlement mill had an ad that reportedly trumpeted: "Your doctor does not believe you're really injured. Call the People's Lawyer at 444-4441 for a lawyer and a doctor who are on your side, who will wait until the case settles to get paid, who know that people really do get hurt in car accidents."[19]

Settlement mills' unusually large case volume poses a fourth and final challenge. Here, the issue is that trained and observant insurance adjusters may well identify inflated or questionable claims.[20] Yet even then, adjusters may be tempted to tender a nuisance-value settlement rather than reject the claim altogether.[21]

This temptation may be especially strong and difficult to resist when adjusters negotiate with plaintiffs' attorneys (or non-attorneys) with whom they frequently bargain, because guaranteed future interaction creates an added incentive to engender goodwill to pave the way for future bargaining.[22] Given settlement mills' exceedingly high volumes, and the frequent adjuster-negotiator interaction on display, it is no surprise that some settlement mill negotiators reported that, in their experience, even questionable claims could be amicably resolved.[23]

To be sure, it is impossible to accurately gauge to what extent settlement mills encourage medical buildup or represent claimants with fraudulent or wholly non-meritorious claims. It also is vital to stress that the numbers will vary considerably between settlement mills, as some appear far more scrupulous than others.[24] But there are indications that settlement mills may, more often than most, blur ethical boundaries and bend to the temptations of fraud.

Proposal: Require closing statements

What can be done? For starters, it is important to get a handle on just how prevalent settlement mills are — a task that likely can be achieved only with insurers' cooperation. I have so far gathered data on 12 law firms that, in their prime, collectively

accounted for the settlement of some 15,000 claims annually. Is that the extent of the settlement mill phenomenon or merely the tip of the iceberg? There is strong reason to suspect the latter. But more — and better — research is needed.[25]

Moreover, even if settlement mills are scarce, the problem of fraud and medical buildup in the auto-accident system is, a load of research suggests, solidly entrenched and remarkably widespread.[26] And, though insurers, public-interest groups and government bodies are working hard to deter it in any number of ways — investing in medical audits, advocating and enforcing tough anti-fraud laws, funding public-education campaigns, and suing corrupt lawyers and medical clinics — claim abuse remains too common and is, some research suggests, still on the rise.[27]

This essay thus proposes a new mechanism, similar to reforms taking place in the health-care industry and loosely modeled on a longstanding requirement to file closing statements in parts of New York.[28] The mechanism, if properly implemented, would dramatically increase transparency and ease pressure on current fraud-detection and deterrence systems.

First, states should require all contingency-fee practitioners to file closing statements at the conclusion of each client representation where personal-injury or wrongful death claims are asserted (except where a class action is certified).[29] Closing statements should specify matters such as claim type (medical malpractice, product liability, auto accident, etc.); whether a suit was initiated and if so, how the suit was resolved (settlement, dismissal, summary judgment, verdict, etc.); the economic loss claimed; and the final recovery attained (if any).

Second, reporting should be mandatory, and its veracity should be policed. Plaintiffs' lawyers who fail to supply accurate information should be disciplined and subject to stiff penalties. To promote accuracy, clients, defendants and (if applicable) defense counsel and insurers also should be sent a copy of the closing statement. All recipients should be required to bring material errors or omissions to the attention of relevant authorities. Defense lawyers and insurers should be sanctioned for any willful failure to comply.

Third, unlike in New York where closing statement data remain confidential, here, statistics drawn from closing statements should be made public. Statistics should be published on the Internet and made searchable by plaintiffs' lawyer, law firm or other criteria (median net recovery attained, for

example). Certain steps should be taken, however, to preserve the confidentiality of potentially sensitive material: The identity of the plaintiff, defendant and insurer and the date of the accident and settlement should be concealed. And closing statement data should be made public only semi-annually to make it more difficult to associate a specific closing statement with a specific client or controversy.

Fourth, the data should be searchable by category (e.g., net recovery, time elapsed, etc.), lawyer or law firm. Prospective clients searching by category thus should be able to identify the top 10 plaintiffs' law firms in their state, as judged by the ratio of "economic loss" to "gross recovery." Alternatively, prospective clients who have narrowed their search and are interested in retaining a particular law firm to represent them in, say, an auto-accident case, should be able to see a detailed firm profile. This profile could include the percentage of the firm's caseload involving auto accidents, how often the firm obtains a recovery for its auto-accident clients, and the average gross and net recoveries obtained. The prospective client, additionally and importantly, also should be able to compare these measurements with other providers.

"If insurers reduce claim payments when they suspect fraud and improper inflation, law firms that facilitate or encourage such practices would have low net recoveries and low loss-to-recovery ratios."

Help deter fraudulent and inflated claims

Requiring that closing statements be filed, and filed publicly, could dramatically alter the tort system, mostly for the better. Among its advantages, the reform measure has potential to help level the playing field between sophisticated and unsophisticated claimants; deter deceptive attorney advertising; help researchers and policymakers devise and evaluate more thoughtful policy reforms; inject price competition into the contingency-fee marketplace; and curb settlement mills' worst abuses while preserving their core advantages.

Last but not least, for two important reasons, the proposal also would help deter fraudulent and exaggerated claims.

First, the mandated disclosure of abandoned claims, paltry settlements, dismissals and outright losses will discourage law firms from accepting clients with doubtful or unmeritorious claims, since those claims are most apt to be lost at trial or pretrial or, even if settled, are apt to be settled for substantially reduced sums.[30] Notably, the screening practices of high-echelon personal-injury firms would be relatively unaffected. Those firms already invest heavily in pre-retention review and accept only cases with a high likelihood of success. But lower-echelon firms that do not currently invest much in screening would have a new and powerful reason to give potentially fraudulent, abusive or long-shot claims a harder look.

Second, reporting ratios and net recoveries would spur firms to minimize clients' claimed economic losses. This would help to deter fraud and buildup for two reasons.

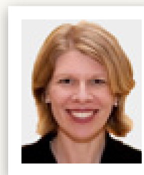
First, net recoveries would be calculated by subtracting attorney fees and a client's claimed economic loss from the client's gross recovery. So calculated, high fees and hefty medical bills would take a big bite out of net recoveries, meaning net recoveries are apt to be low when fees are high and medical bills are inflated. Publicizing net recoveries — and having intermediaries (such as the news media, bar groups and watchdog organizations) encourage potential clients to hire firms with high net recoveries — thus could exert a powerful positive influence.

Second, data suggest that insurers can identify at least some fraud and medical buildup. And when insurers do suspect fraud and buildup, they reduce general damage payouts accordingly. For example, IRC data suggest there has long been rampant fraud and buildup in New York City. Not surprisingly, then, injured third-party claimants there recover lower ratios than claimants in other parts of the state. In 2002, New York City metro-area claimants had an economic loss-to-recovery ratio of 1:32, while upstate claimants' ratio was significantly higher at

2:33. Built or suspicious claims, that study suggests, may be paid, but payment for clients' non-economic damages are heavily reduced.[31]

This discounting has an important implication: If insurers reduce claim payments when they suspect fraud and improper inflation, law firms that facilitate or encourage such practices would have low net recoveries and low loss-to-recovery ratios. So, again, to the extent that publicity draws attention to net recoveries and ratios, more-ethical plaintiffs' law firms would fare better, and closing statements could powerfully curb firms' inflationary impulses.

To be sure, this proposal is far from perfect. Despite safeguards, some firms will manipulate the data or fail to report altogether. Some clients still might retain bad and shady lawyers. The worst offenders might only be marginally deterred. But this is a low-cost reform with potential to create new disincentives for fraudulent and exaggerated bodily-injury claims — while having numerous other positive effects.



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endNOTES

[1] For a detailed description of ten characteristics that help to define settlement mills and distinguish these firms from conventional counsel, see Nora Freeman Engstrom, Run-of-the-Mill Justice, 22 Geo. J. Legal Ethics 1485, 1491-1514 (2009).

[2] Id. at 1492.

[3] Id. at 1500.

[4] Compare Herbert M. Kritzer, Holding Back the Floodtide: The Role of Contingent Fee Lawyers, 70 Wis. Law. 10, 13 (Mar. 1997), with Engstrom, supra note 1, at 1499-1500.

[5] Telephone Interview with D.R. (Apr. 3, 2008); see also Telephone Interview with R.J. (Apr. 8, 2008) ("Did they turn away any cases? Not many."); Telephone Interview with G.V. (Apr. 7, 2008) (Q: "What percentage of callers seeking legal representation were accepted as clients?" A: "Pretty much everyone."). But cf. Telephone Interview with H.G. (Apr. 29, 2008) (suggesting that the firm turned away a non-trivial number of prospective clients).

[6] Tr. of Louisiana Disciplinary Bd. Hr'g, In re Lawrence D. Sledge, No. 00-DB-135 (Feb. 16, 2001), at 335 [hereinafter Sledge Disciplinary Hr'g Tr.] (testimony of Lawrence D. Sledge).

[7] For consideration of settlement mills' myriad costs and benefits, see Nora Freeman Engstrom, Sunlight and Settlement Mills, 86 N.Y.U. L. Rev. 805 (2011).

[8] Robert E. Keeton & Jeffrey O'Connell, Basic Protection for the Traffic Victim: A Blueprint for Reforming Automobile Insurance 3 (1965).

[9] See H. Laurence Ross, Settled Out of Court 107-08 (1970) (describing the multiplication). But cf. James K. Hammitt, RAND, Automobile Accident Compensation Vol. II: Payments by Auto Insurers 33 (1985) (recognizing the "folklore" that general damages are a multiple of special damages but concluding, on the basis of 1977 closed claims data, that "actual payments cannot be predicted accurately using medical or economic loss alone").

[10] Telephone Interview with L.J. (Apr. 17, 2008).

[11] Joint Econ. Comm., 104th Cong., Improving the American Legal System: The Economic Benefits of Tort Reform, Executive Summary 3 (1996).

[12] IRC, Fraud and Buildup in Auto Injury Insurance Claims 5 (Nov. 2008) [hereinafter IRC, 2008 Fraud Study] (estimating that, in 2007, fraud and buildup added between $4.8 and $6.8 billion to the cost of auto-injury insurance claims). But see No-Fault Insurance Fraud: Hearing to Examine Ways to Reduce the Incidents of No-Fault Auto Insurance Fraud in New York Before the New York State Senate Standing Comm. on Insurance, Apr. 26, 2011, at 219 [hereinafter New York Senate Hearing] (testimony of Stuart Israel, President of New Yorkers for FAIR Automobile Insurance Reform) ("[T]he breadth of fraud, suggested by the industry, is simply exaggerated and untrue.").

[13] Telephone Interview with S.S. (July 16, 2007).

[14] Engstrom, supra note 1, at 1511.

[15] In contrast, according to a survey of Texas plaintiffs' lawyers, the majority of respondents would not accept a hypothetical case involving "a simple car wreck," clear liability, adequate insurance, and "soft tissue injuries worth $3000." Stephen Daniels & Joanne Martin, The Strange Success of Tort Reform, 53 Emory L.J. 1225, 1256 & tbl.8 (2004).

[16] Stephen Carroll & Allan Abrahamse, RAND, The Frequency of Excess Auto Personal Injury Claims, 3 Am. L. & Econ. Rev. 228, 228, 248 (2001); see also Herbert I. Weisberg & Richard A. Derrig, Fraud and Automobile Insurance: A Report on Bodily Injury Liability Claims in Massachusetts, 9 J. Ins. Reg. 497, 537 (1991) (highlighting the frequency with which claims for only sprains and strains involve apparent fraud).

[17] IRC, Auto Injury Insurance Claims: Countrywide Patterns in Treatment, Cost, and Compensation 54 (Jan. 2008).

[18] In re Guirard, No. 04-DB-005 (La. Sept. 23, 2004) (Disciplinary Hr'g Ex. ODC 5). Indeed, after this particular attorney was disbarred from the practice of law, his next career venture was apparently opening "a personal injury treatment center, a one-stop shop of sorts [chiropractor, doctor, pain management and orthopedist] for accident victims." Penny Font, Disbarred But Not Disbranded, BusinessReport.

com (May 18, 2009), http://www.businessreport.com/news/2009/may/18/disbarred-not-disbranded-lgl1/.

[19] Will Harper, Settling for Less, East Bay Express (Jan. 8, 2003), available at http://www.eastbayexpress.com/eastbay/settling-for-less/Content?oid=1069091.

[20] See New York Senate Hearing, supra note 12, at 168 (testimony of Neil Salters, ISG Recoveries) ("Every claims professional . . . out there can identify a fraudulent case within moments of looking at it. That is the truth.").

[21] See State No-Fault Automobile Insurance Experiences: Hearings Before the House Subcomm. on Consumer Protection and Finance, Comm. on Interstate and Foreign Commerce, 95th Cong. 225 (1977) (statement of Marsha Lyons, U.S. Attorney's Office, Miami, Florida) ("[W]e have found that the fraudulent claims were being paid by the insurance companies, and that the insurance companies by and large were aware of the fact, not necessarily that the claims were out-and-out phoney [sic], but that they were inflated or fraudulent to some extent. . . . [I]n looking at the cases on a one-by-one basis, it was always cheaper [for insurers] to pay the case than to try and fight it using their own attorneys or using extensive investigation."); id. at 229-30 (statement of Edward Carhart, State Attorney's Office, Miami, Florida) (pointing out the many risks and costs involved in denying fraudulent claims); accord IRC, Fraud and Buildup In Auto Injury Claims: Pushing the Limits of the Auto Insurance System 40 (Sept. 1996) [hereinafter IRC, 1996 Fraud Study] (stating that, when confronted with "opportunistic fraud," "demands by claimants . . . may be compromised" but "the chances of a zero payment are low"); IRC, 2008 Fraud Study, supra note 12, at 2 (reporting that 11% of bodily injury ("BI") claims closed—with payment—in 2007 "were found to involve apparent fraud").

[22] See Marc A. Franklin et al., Accidents, Money, and the Law: A Study of the Economics of Personal Injury Litigation, 61 Colum. L. Rev. 1, 14 & n.70 (1961) ("Attorneys who do any significant amount of plaintiffs' personal injury work become acquainted with the representatives and attorneys who handle the other side of these cases. In order to maintain a good working relationship, defendants may make small payments in some weak cases to give the plaintiff's attorney a fee."); Telephone Interview with K.E. (Apr. 3, 2008) (observing that "there are some real benefits of the wholesale business," partly because of the repeat "relationships with the insurance claims adjusters").

[23] See, e.g., Sledge Disciplinary Hr'g Tr., supra note 6, at 128 (testimony of Lillian Lalumandier) (testifying that adjusters would indeed settle claims even if there was "a real legal dispute" over the claim's validity, saying: "Well, look, just to make this thing go away, I'm still willing to give you $5,000, $6,000"); Telephone Interview with A.E. (Aug. 16, 2008) (reporting that adjusters would pay small nuisance-value settlements to resolve even questionable claims).

[24] Compare Telephone Interview with A.M. (May 14, 2008) ("In my entire time there, I never signed up a client that I thought was not in a bona fide accident or did not have bona fide injuries."), with Telephone Interview with T.R. (Apr. 16, 2008) ("A lot of these people are not hurt. . . .").

[25] For an extended discussion of why I suspect settlement mills are quite prevalent, see Engstrom, supra note 1, at 1514-21.

[26] See supra note 12; see also IRC, 1996 Fraud Study, supra note 21, at 2 (reporting that excess injury payments as a result of fraud and/or buildup comprised between 17% to 20% of total paid losses in 1995); IRC, Fraud and Buildup in New York Auto Injury Insurance Claims 55–57 (Mar. 2006) [hereinafter IRC, Fraud and Buildup in New York] (reporting that 34% of BI claims in New York involved apparent buildup and 17% involved apparent fraud); Insurance Information Institute, No-Fault Auto Insurance in Florida: Trends, Challenges, and Costs 2 (Jan. 2011) (chronicling Florida's "rampant no-fault fraud").

[27] See IRC, 2008 Fraud Study, supra note 12, at 2, 53 (reporting a slight uptick in the proportion of paid claims that appeared to involve fraud and medical buildup between 2002 and 2007); Robert P. Hartwig, Insurance Information Institute, New York PIP Insurance Update: Is New York's No-Fault Crisis Returning?, Presentation, Nov. 5, 2009, available at http://www.iii.org/presentations/new-york-pip-insurance-update-is-new-yorks-no-fault-crisis-returning.html (reporting an increase in no-fault fraud reports in New York between 2006 and 2008); New York Senate Hearing, supra note 12, at 150 (testimony of Floyd Holloway, New York State Counsel for State Farm Insurance Co.) ("Fraud is an enterprise whose business model is thriving.").

[28] For more on this reform proposal, see generally Engstrom, supra note 7. As noted in the text, this closing statement proposal is loosely modeled on a rule (in place since 1957) requiring the filing of confidential closing statements in parts of New York. For more on New York's closing statement requirement, see N.Y. Comp. Codes R. & Regs. Tit. 22, § 603.7 (1st Judicial Department); id. at § 691.20 (2nd Judicial Department). For more on the recent transparency revolution in health-care, see Kristin Madison, The Law and Policy of Health Care Quality Reporting, 31 Campbell L. Rev. 215, 216–21 (2009).

[29] Like in parts of New York, the obligation to file a closing statement should be triggered at the conclusion of any claim "for damages for personal injuries or for property damages or for death or loss of services resulting from personal injuries" where an attorney had "accept[ed] a retainer or enter[ed] into an agreement" whereby the attorney's "compensation [was] to be dependent or contingent in whole or in part upon" the claim's "successful prosecution or settlement." N.Y. Comp. Codes R. & Regs. Tit. 22, § 603.7(a).

[30] See Ross, supra note 9, at 183–84 (showing, in auto cases, that coders' conclusion of "apparent liability" was strongly related to "payment outcome").

[31] IRC, Fraud and Buildup in New York, supra note 26, at 37–38, 55–62 & fig. 7–1 (showing that 20% of New York City metro-area BI claims involved apparent fraud, as compared to 9% of BI claims in the rest of the state, and "when compared to claimants in the New York City area, claimants from other areas of the state received one additional dollar in 2002 for every dollar of economic expenses they incurred in that year"); accord IRC, 2008 Fraud Study, supra note 12, at 49 (reporting that claims with the appearance of fraud or buildup received higher total payments than claims without such markers, but that the payment differential was smaller than the claimed economic loss differential and speculating: "This may be the result of insurer efforts during the BI claim settlement process.").