

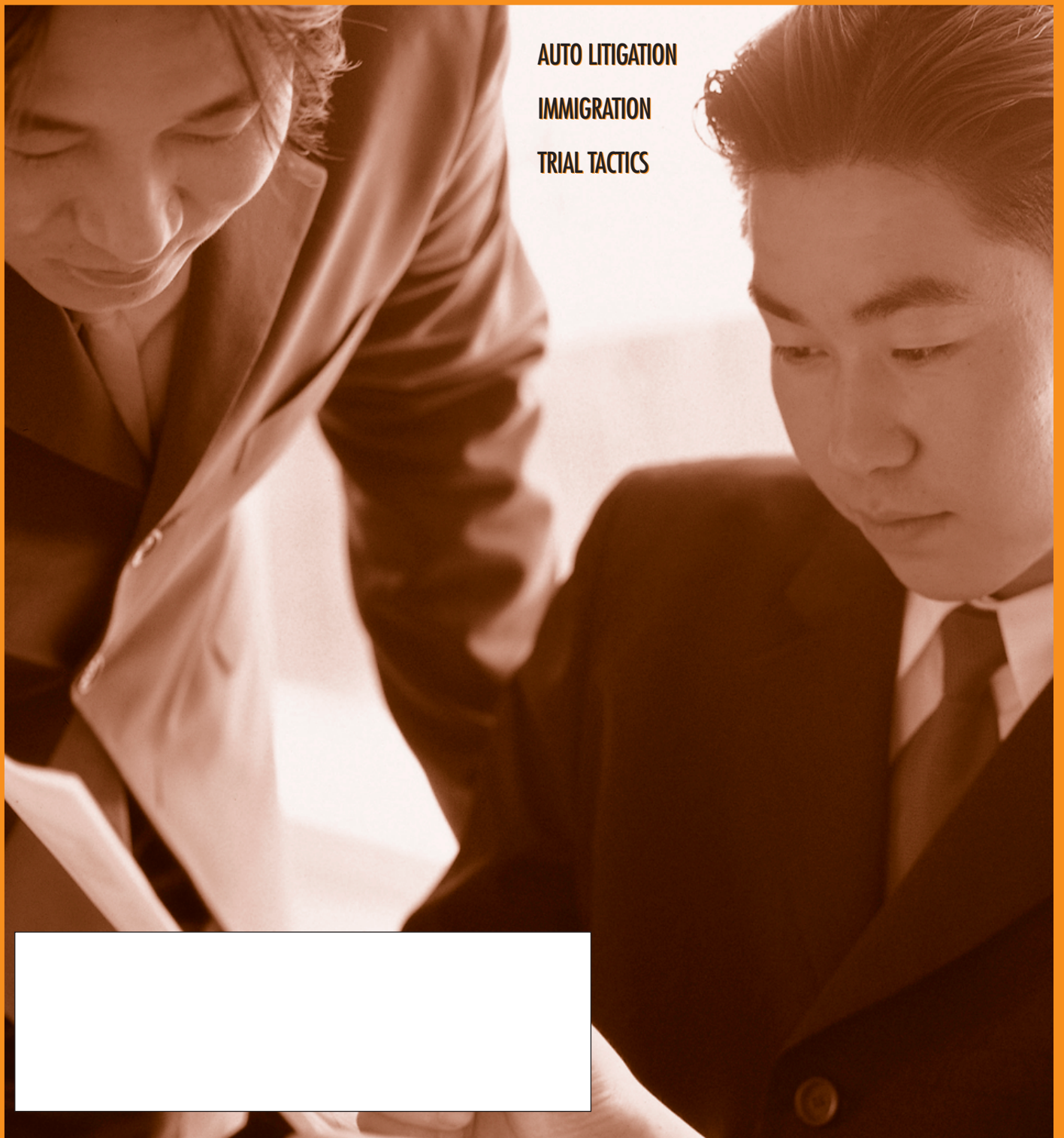
# TRIAL TALK

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AUTO LITIGATION

IMMIGRATION

TRIAL TACTICS

# Automobile Insurance Company Dirty Tricks

By Mac Hester, Esq.

## Introduction: The Insurance Fraud Epidemic

Everyday in America, scam artists defraud thousands of insurance consumers out of millions of dollars. Unfortunately, however, most insurance fraud victims don't even realize that they have been scammed. This article exposes some of the dirty tricks perpetrated upon consumers by the insurance industry.

## Dirty Trick #1: The "Tort Reform" Scam

Are tort claims out of control? Are jury verdicts and punitive damages out of control? The insurance industry would have you believe it to be so – despite overwhelming evidence to the contrary. Instead of dealing with facts, the insurance industry plays upon fear and emotion in order to pass "tort reform" legislation that restricts the ability of individuals to be reimbursed for the damage inflicted upon them by negligent persons and corporations. However, they certainly do not try to restrict the ability of **corporations** to recover damages against consumers or other corporations.

"Tort reform" has been based upon myths, misinformation and outright lies – designed to cover up the insurance industry's real motivation: to make up for huge investment losses and huge pay-outs for natural disaster claims. Insurance companies are private, for-profit businesses, and they don't make

much profit on insurance sales – the bulk of their profit comes from investments. Every time their investments start losing money they start firing up "tort reform" campaigns:

- Insurance researcher Robert Hunter studied insurance premiums and pay-outs for the past 30 years and discovered that the rise and fall of insurance premiums was not related to damage awards, but instead fluctuated with bond markets. When interest rates are high, insurance companies make profits by investing in bonds. During periods of high interest, insurance companies often lower their premiums to attempt to achieve greater market share. When interest rates are low, however, they lose money and they attempt to cover their losses by raising premiums. Hunter also studied tort reform in all 50 states and found no correlation between tort reform and lower insurance premiums.

- Maurice Greenberg, President and CEO of American International Group, Inc., a leading insurance company, stated that the insurance "crisis" was caused by price cuts "to the point of absurdity" in the 1980's. He also stated that the criticism of the tort system was simply an excuse for industry mismanagement. Greenwald, *Insurers Must Share Blame: AIG Head, Business Insurance*, March 31, 1986.

- "The profit crunch of the early 1980's prompted insurance industry

pressure on state regulators and legislatures; these pressures led to successful rate hikes and "tort reform" proposals. Some states apparently passed "tort reform" with the hope of alleviating upward insurance cost pressures supposedly exerted by runaway tort liability. In the aftermath, however, insurance studies now claim the new "tort reform" laws actually create no significant opportunities for rate cutting. Premium charges, industry studies now tell us, are scarcely affected by the liability payouts curbed in "tort reform" schemes. [Citing Insurance Services Office, Claim Evaluation Project (1986)]. Far from solving a public crisis in insurance rates, "tort reform" begins to look more like a windfall for insurers, paid for at the expense of tort victims."<sup>1</sup>

- This section addresses several of the "tort reform" myths foisted upon the public by the insurance industry:

### MYTH:

**Tort claims are out of control.**

### REALITY:

- The National Center for State Courts conducted a study, entitled "Examining the Work of the State Courts, 1993: A National Perspective from the Court Statistics Project" which analyzed state court caseload statistics from 1984 to 1993 (the peak of the tort reform frenzy). The NCSC found no evidence of a tort litigation explosion and, in fact, revealed a 6% decline in

nationwide tort filings since 1991.

- The major increase in litigation has been businesses suing other businesses. Half of all federal cases filed between 1985 and 1991 were businesses suing businesses according to *The Wall Street Journal*.

- The RAND Institute for Civil Justice report – entitled “Trends in Civil Jury Verdicts Since 1985 – examined all jury verdicts from 1985 to 1994 in 15 jurisdictions in California, Illinois, Missouri, New York, Texas and Washington and concluded that there was no “litigation explosion” and that business cases accounted for the largest portion of punitive damages awarded.

- Tort claims comprised only 5% of all civil claims filed in state courts in 1992 (NCSC study). The two biggest groups were contract and property claims comprising 33% and domestic relations comprising 25%.

- From 1990 to 2000, Colorado’s population increased from 3.2 million to 4.3 million. Personal injury lawsuits in the same time period decreased from 17 filings per 10,000 persons to 12 filings per 10,000 persons. (Colorado Judicial Branch & State Demographer’s Website)

- In 2001, tort claims comprised about 9% of civil filings in Colorado. Professional malpractice claims comprised 0.62%. Money collection claims comprised 44%.

**CONCLUSION:**

**It is the insurance industry and its “tort reform” propaganda that is out of control.**

**MYTH:**

**Medical malpractice lawsuits are out of control.**

**REALITY:**

- Only 2% of those injured by physician’s negligence ever seek compensation through a lawsuit according to a 1991 *New England Journal of Medicine* article. The 1990 Harvard Medical

Practice Study concluded that “we do not have a problem of too many claims; if anything, there are too few.”

- Plaintiffs win about 30% of medical malpractice cases.<sup>2</sup>

- Medical malpractice premiums are less than 1% of national health care costs according to the U.S. Congressional Budget Office.

- Only 7% of all tort claims involve professional malpractice - medical, legal and all other professions (1995 U.S. Dept. of Justice study).

- Less than 8% of diagnostic procedures are related to a concern about malpractice liability according to the U.S. Congress Office of Technology Assessment. Physicians with financial interests in labs order 34 to 96% more tests than physicians with no financial interests in labs according to the Consumer Federation of America.

- Medical malpractice claims declined at an average annual rate of 8.9% since 1985 according to a 1992 American Medical Association publication.

- Medical malpractice insurance is the most profitable line of insurance written nationwide. The average profit for Minnesota medical malpractice insurers over the period from 1985 to 1994 was 41% - nearly double that of any other line of insurance. Minnesota Attorney General’s report entitled “Medical Malpractice Reform and Health Care Costs.”

**CONCLUSION:**

**The insurance industry is soaking the doctors while blaming the lawyers.**

**MYTH:**

**Product liability lawsuits are out of control.**

**REALITY:**

- Product liability cases account for only 4% of all tort cases in state courts

according to the National Center for State Courts. Product liability claims comprised only 0.21% of all civil cases.

- Plaintiffs won 41% of product liability cases in a study of 360 cases in the nation’s 75 most populous counties according to the 1995 U.S. Department of Justice study. Of the 142 winning cases for plaintiffs, 3 resulted in punitive damages awards. The total punitive damages awarded for all three cases was \$40,000.

- In cases in which punitive damages were awarded, 80% of the product manufacturers took subsequent safety measures regarding the product, according to a study by law professor Michael Rustad of Suffolk University.

- Product liability insurance only costs consumers 26 cents out of a purchase of \$100 according to a 1995 report by the Consumer Federation of America.

- The National Insurance Consumer Organization found that product liability insurance premiums in 1991 accounted for only fourteen one-hundredths of 1% of product retail sales.

**CONCLUSION:**

**Product manufacturers (and their insurers) are manufacturing the product liability “crisis.”**

**MYTH:**

**Jury verdicts and punitive damages are out of control.**

**REALITY:**

- Plaintiffs win about half the time, with the highest success rate in automobile cases (60%) and the lowest in medical malpractice cases (30%). The median award in all tort cases is \$52,000. (NCSC study)

- Business cases account for 47% of all punitive damage awards. Product liability cases account for 4.4% and medical malpractice cases account for 2%. (RAND Institute for Civil Justice, 1996)



- There is compelling evidence that victims with extremely serious injuries are being *under compensated*. The average plaintiff's verdict in New York in all tort cases, according to the New York Jury Verdict Reporter, is not in the millions – it is approximately \$50,000. The portion of tort recoveries attributable to “pain and suffering” has been steadily decreasing.<sup>3</sup>

- Punitive damages are awarded in less than 5% of civil jury verdicts. And more than half of those awards are overturned on appeal.<sup>4</sup>

- Only 57% of punitive damage dollars awarded between 1990 and 1994 were actually paid out. (RAND study)

### MYTH:

**Tort claims cost our economy \$X billion per year.**

### REALITY:

**The insurance industry's assertion that tort claims cost our economy \$X billion per year is erroneous and actually meaningless, as the assertion is based upon a complete misunderstanding (or purposeful misstatement) of tort “costs” to our economy. That is, what the insurance industry calls a tort “cost” is usually not really a cost, but possibly a benefit.**

For example, assume that a plumber who earns \$50,000 per year is injured (paralyzed and unable to ever work again) by a careless driver who has \$25,000 of insurance coverage. The insurance industry would assert that the plumber's \$25,000 tort recovery against the careless driver is a \$25,000 “cost” to society. That is patently absurd. The actual cost to society and the economy is the lost production of the plumber caused by the careless driver – which may be \$1 million in lost income – plus the loss of the multiplier effect of the \$1 million as it is consumed and/or invested through many hands throughout the course of the plumber's life. Thus, the cost to society – which is never recovered (or, recovered only to the extent of the \$25,000 benefit) is \$1 million plus

the many fold multiplied loss of the \$1 million. Consequently, the cost to society of the careless driver's tort is not \$25,000, but maybe several million dollars. Society would be better off if the careless driver had \$1 million in coverage to compensate the plumber (with that money subsequently being multiplied), but the insurance industry would call that a \$1 million “cost” to society instead of a pay-out which multiply benefits society.

Another example: ABC Corp. earns \$1 million per year on its patent. The next year, XYZ Corp. infringes on the patent and earns \$1 million and ABC Corp. earns nothing. ABC Corp. sues XYZ Corp. and obtains a \$1 million jury verdict. Question: Is the \$1 million jury verdict a \$1 million cost to society? Insurance industry logic would say so, but that is ridiculous. The cost to society is the lost productivity caused by XYZ Corp. plus XYZ Corp.'s incidental and consequential damages. The verdict is not a cost, but a benefit which may or may not adequately address the damage caused.

### CONCLUSION:

The insurance pay-out is a cost to the insurance company re-captured through premiums and the premiums are a cost to the insured, but it would take a very sophisticated analysis on a case by case to determine whether there is ultimately a cost or a benefit created by the insurance pay-out. And it may be impossible to determine the question on a societal level. Thus, the insurance industry's assertion of billions of dollars of tort “costs” to society is meaningless.

### Dirty Trick #2: The Non-Disclosure Scam

Have you ever read your insurance policy? Do you understand it? No? That's what the insurance company is counting on. Oh yeah, they provide you with the disclosures mandated by law, but do they explain them? Only if you ask. And then, usually, the explanation is not adequate.

For example, basic Colorado no-fault (PIP) insurance under the “old law” mandates coverage of:

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- Up to \$50,000 in reasonable and necessary accident-related medical expenses incurred within 5 years of the date of accident; [What they don't tell you about is the "Reasonable and Necessary" Scam. Dirty Trick #3.]

- Up to \$50,000 in reasonable and necessary accident-related rehabilitation expenses incurred within 10 years of the date of accident; [What they don't tell you about rehabilitation: everything. In other words, they don't tell you anything about rehabilitation. In theory, rehabilitation would include re-training you for a new job if you could not continue doing your old job because of injury. But just try getting re-training authorized through the insurance company! They interpret rehabilitation as rehabilitative medical treatment. For example, a bill for surgery would be a medical bill, but a bill for physical therapy might be a rehabilitation bill. A bill for vocational re-training would most likely be a rejected bill (unless you successfully threaten or take legal action to enforce your insurance policy).

- Lost wages for the year following the date of the accident limited to % of the first \$125, % of the next \$125, and % of the balance over \$250 per week up to a maximum of \$400 per week for 52 weeks (total limit: \$20,800). [What they chisel you on: overtime, sick pay, bonuses, cost of replacement labor.]

- Up to \$25 per day in "essential services." Essential services are those services such as house cleaning, dish washing, laundry, shopping, driving, lawn mowing, etc., which you cannot do because of your injuries but which have to be done by someone else. The insurance company will pay market rate for these services and, yes, your spouse, friends or children can do these services (but remember; only \$25 in a given day and the services must be reasonable, necessary and accident-related).

Although no-fault insurance coverage was repealed in 2004, many insureds will continue to have PIP coverage in place for several years – especially if

rehabilitation services are involved. However, the insurance industry is impatiently awaiting the death of PIP coverage. Or rather, the industry is not just awaiting the death of PIP; it is hastening it by not adequately disclosing all available coverages and by discouraging utilization of coverages by dubious methods and dirty tricks – some of which are discussed in this article.

As to non-disclosure regarding insureds who are being sued, what the insurance company doesn't tell you is that they are in total control of defending your lawsuit and what you think, feel, or say doesn't mean a damn, unless they don't like what you have to say - in which case they may threaten to terminate your coverage for "non-cooperation." For example, suppose you were not paying attention while driving and you slammed into the rear of a car stopped at a red light. The car's brake lights were on. Is it your fault? Of course. Will the insurance company allow you to say that it was your fault? Absolutely not. What will happen if you say, against the insurance company's instructions, that it was your fault? Most likely, the insurance company would terminate your coverage for non-cooperation with their defense of your lawsuit and you would be responsible for hiring and paying for your own attorney.

Non-disclosure of "Uninsured" and "Underinsured" Motorist (UM) is even worse.

### Dirty Trick #3: The UM Scam

"UM" means "uninsured motorist" or "underinsured motorist."

UM coverage protects you in the event that you are injured or damaged by an uninsured or underinsured driver.

Let's look at uninsured coverage first. Let's say that you have \$25,000 in liability coverage and \$25,000 in UM coverage. You are injured by an uninsured driver. The uninsured driver has no job and no personal assets (he is "judgment proof"). Since you cannot,

as a practical matter, recover against the uninsured driver, you make a claim on your own UM coverage. If your damages equal or exceed \$25,000, then your own insurance company will pay \$25,000 in uninsured coverage benefits to you (theoretically).

Now let's look at underinsured coverage. Assume you have \$100,000 in liability coverage and \$100,000 in UM coverage. You are injured by a driver with liability insurance with policy limits of \$25,000. Assume that your damages equal or exceed \$100,000. The other driver is "underinsured" because your damages exceed his insurance coverage, *and* your UM coverage exceeds his liability insurance. You can settle with the at-fault driver for \$25,000 and recover \$75,000 from your own insurance company under your underinsured coverage (theoretically).

The UM recoveries discussed above are "theoretical" because your own insurance company will fight you tooth and nail to not have to pay, or to pay as little as possible, on your UM claim.

UM coverage is not required in Colorado. However, Colorado law requires that the insurance company offer UM coverage to you. The offer must be in writing and the insurance company must offer to match the amount of liability coverage up to a maximum of \$100,000 per person and \$300,000 per occurrence.

As you can see from the above examples, UM coverage is extremely valuable – especially considering that the minimum required liability coverage in Colorado is \$25,000. If you are injured by an uninsured judgment proof driver and you don't have UM coverage then you may be out of luck. If you buy only \$25,000 in UM coverage (matching the minimum liability limits of \$25,000) and you are injured by a driver with minimum limits of \$25,000 and your damages are significantly greater than \$25,000 (say \$100,000), then you could recover \$25,000 from the at-fault driver, but you could not

recover any UM benefits because the at-fault driver is not “underinsured” (your UM coverage is the same as his liability coverage). You are out of luck to the tune of \$75,000.

So what’s the UM scam?

Here it is: Insurance agents tell you:

“You don’t need UM coverage.”

Most agents don’t say this because it is so preposterous. However, some do – and leave you with no protection against uninsured drivers. OR

“You only need \$25,000.” They say this to match the minimum liability limits of \$25,000 which you are required to have. This will protect you against uninsured drivers to the extent of \$25,000, but it will not protect you against underinsured drivers. If you have \$25,000 UM coverage and you are injured by a driver with \$25,000 liability coverage, then the at-fault driver is not underinsured and you cannot recover any UM benefits.

So the scam is not selling or under-selling UM coverage. The scam is accomplished by non-disclosure of this valuable information, playing down the value of UM coverage, and sometimes expressly misrepresenting the coverage.

The purpose of the scam is to reduce the sale of UM coverage in order to reduce the pay-out of UM claims.

UM coverage is cheap and it is extremely valuable. It’s probably the only good deal in insurance. So consider buying it. And buy more than \$25,000.

### **Dirty Trick #4: The Legal Advice Scam**

This scam usually takes two forms: First, the insurance company tries to persuade injured claimants not to retain an attorney to represent them. Second, the insurance company advises injured claimants about the law and their legal rights.

Some companies actually provide literature to injured persons who may have a claim against their insured in an

attempt to prevent them from retaining an attorney. Example: Suppose Walker was crossing a street and was hit and run over by Driver, who ran a red light. Walker’s insurance company, Ball State, mails a letter and brochure to Walker advising Walker that Ball State will investigate Walker’s injuries and damages and will make a reasonable offer to pay Walker’s claims, that Walker doesn’t need an attorney, and that an attorney will take a percentage, usually a third, of the claimant’s recovery – the result being that Walker will be worse off by hiring an attorney. This literature will usually be followed up by telephone conversations to the same effect. These actions constitute the practice of law; however, the insurance company, and its insurance adjusters, are not authorized to practice law (Also note, a study – funded by an insurance company – revealed that claimants represented by attorneys receive, on average, three times as much as unrepresented claimants).

The legal advice scam involves the giving of erroneous legal advice by an insurance company to a claimant. When the erroneous legal advice is intentionally given, the insurance company is committing fraud. When the erroneous legal advice is carelessly given, the insurance company is committing legal malpractice.

Here is a common example of erroneous legal advice routinely given regarding “old law” claims under the no-fault system: “You can’t file a lawsuit for injuries from a car accident until you have reached “threshold” – which is \$2500 in medical expenses.”

There *is* a “threshold” requirement under the “old law” regarding the maintenance of a legal action for auto accident injuries; however, it *is not* as stated in the preceding paragraph. First of all, the \$2500 medical expense requirement is only one of several ways to satisfy the “threshold,” and second, an injured person can file a lawsuit without incurring *any* medical expenses (if no other threshold requirement applies, then the

\$2500 threshold requirement has to be satisfied by the time of trial).

### **Dirty Trick #5: The PPO Scam**

How this scam works: The insurance company promises to save you if you choose the Preferred Provider Organization (PPO) option. A PPO is a network of approved health care providers. If you are injured in a car accident, then you are required to treat with health care providers within the network of approved PPO health care providers. If you do not treat with a PPO provider, then you are penalized. The penalty may be a deductible; e.g., you pay the first \$1000 in medical expenses - or, the insurance company will pay the PPO rate to your non-PPO provider. The PPO rate will be less than your provider’s charges and you will be responsible for the balance.

What the insurance company doesn’t tell you:

- Your file is assigned to a PPO Case Manager (a nurse) who monitors your treatment and charges to make sure they are within the PPO guidelines.

- The guidelines specify types of treatment approved and disapproved, frequency of treatment, duration of treatment and the approved charges for various treatments.

- Your doctor has to submit a treatment plan to the Nurse Case Manager for approval. If the nurse does not approve of your doctor’s plan, then the doctor will have to abide by the nurse’s decision or appeal to have his proposed treatment reviewed by a medical reviewer.

- Appealing the decisions of the Nurse Case Manager and medical reviewers is time consuming, frustrating, often expensive, and often futile.

- Being selected as a PPO health care provider is lucrative, as there are only a limited number of providers in any given field of care in a given geographic area selected for the PPO network. Typically, PPO treatment comes to comprise the vast majority of



the PPO provider's total practice. Because the insurance companies can select or de-select PPO providers at their whim, PPO providers have a strong economic incentive to keep the insurance company happy by usually going along with the PPO guidelines and not rocking the boat with the Nurse Case Manager. Thus, PPO providers sometimes sacrifice their patient's treatment in order to protect their pocketbook.

**CONCLUSION:** Saving a little money by choosing the PPO option is a good idea *if you are not injured in a car accident*. However, if you are injured in a car accident, then your loss of control over your health care is a huge price to pay – and your paltry premium savings may turn out to be detrimental to your well being.

### Dirty Trick #6: The Medical Release Authorization Scam

When you are injured in a car accident and make a claim for insurance benefits,

the insurance company requires you to sign a medical release form authorizing your doctors to provide medical records to the insurance company. This makes sense. They need to review your medical records to make sure that your claim is valid and that your treatment is "reasonable" and "necessary." Nobody wants the insurance company to pay bogus claims.

However, the release forms typically are not limited to medical records; they are usually all inclusive. That is, the form states that you authorize anyone to release any and all information about you to the insurance company. And if that's not bad enough, the release form also usually states that you authorize the insurance company to provide your records and information to, for example, anyone "who has a business need for the information!"

Think about it. You have authorized the insurance company to provide your confidential medical, employment, edu-

cation, tax, and governmental records to anybody who the insurance company wants to give it to. Or sell it to.

What? Did you think that your insurance claim information was confidential?

So what does the insurance company do with your records and information?

This is what they do:

- They store it in their internal database for the current claim and keep it stored in their archive for their future use.
- They sell it (or give it) to various national databases so that other insurance companies (actually, all members of the database) can use it (against you).
- They use it to defend against other claims you make. For example, your Medical Payments (med pay) coverage information will be used to defend against your Underinsured (UIM) claim.
- They provide it to your adversary!

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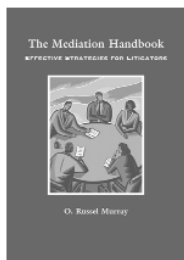
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For example, you are injured in a car accident by a careless driver. You make a claim against the careless driver. Your own insurance company will provide your confidential records and information to the careless driver's insurance company - which will then use the information against you. Really. No kidding. Did you seriously think that your insurance company has any iota of a feeling of loyalty to you? Absolutely not. Your insurance company and the careless driver's insurance company conspire to limit your claim. Why? Because the insurance industry is a conspiracy of con artists. Your insurance company scratches the other companies' backs and the other companies scratch your insurance company's back. If your insurance company helps the other company to pay out a smaller amount, then the other insurance company will help your insurance company to pay out a smaller amount when it is defending a careless driver.

It gets even better. Your own insurance company will actually hinder your PIP or med pay claim in order to hinder your potential liability claim against the careless driver. You are doubly cheated. You are cheated on your own medical treatment so that you are consequently cheated on your claim against the at-fault driver. If the entire industry is doing this, then all the insurance companies are saving money on both PIP and med pay claims **and** liability claims. What a beautiful scam!

Q. So what do you do about this incredible situation?

A. Revoke all outstanding release authorizations and replace them with a release authorization which limits the insurance company to obtaining records and information relevant to the accident, your injuries, and pre-existing medical conditions which are similar to your accident injuries. The release authorization should also state that your insurance company must maintain the confidentiality of your records and information and must not provide them to anyone unless expressly authorized by you.

## **Dirty Trick # 7: The “Reasonable and Necessary” Scam**

If you have automobile insurance and you are injured in a car accident, then Colorado law requires your PIP or med pay insurance to pay all “reasonable” and “necessary” accident-related medical expenses.

So what's wrong with that? Nothing. Insurance companies should not have to pay for unreasonable or unnecessary medical treatment.

So what's the problem? The problem is that there is no definition of “reasonable” or “necessary” in the law and the meaning of these terms, as a practical matter, is determined by – guess who? That's right, the insurance company.

But you say, “They gave me a piece of paper that says that they will pay for up to \$50,000 in medical expenses incurred within 5 years after the accident.”

That's theory rather than reality. A closer reading of the “PIP disclosure” form will reveal that they will pay for up to \$50,000 in “reasonable” and “necessary” accident-related medical expenses. So what? Again, they shouldn't have to pay for unreasonable or unnecessary medical expenses.

The “so what” is that the insurance company – not your doctor – determines what medical treatment is reasonable and necessary. Or more likely, the insurance company itself does not determine it, but they farm out the determination to nurses (and sometimes doctors) who review your medical records and other insurance claim documents. These “paper reviewers” determine – without examining you and without ever talking to you (and usually without ever talking to your doctor) what medical treatment is reasonable and necessary (and consequently what medical expenses should be paid).

Remember, this is your insurance which you paid for with your hard earned money. You have paid premiums for years and now the insurance company is screwing you out of medical

treatment because they control the meaning of two words: “reasonable” and “necessary.”

## **Dirty Trick #8: The Paper Review Scam**

If you chose the Preferred Provider Option (PPO) when you purchased your car insurance, then you “voluntarily” bought into this scam. “Voluntarily,” because you could have decided not to take the PPO option. However, having taken the PPO option, your medical treatment and medical expenses will be subject to review by nurses (and sometimes doctors).

If you did not chose the PPO option, then many insurance companies force you into a quasi-PPO anyway. That is, even though you are not in a PPO the insurance company still sends your medical records to nurses (and sometimes doctors) for review. Based upon their review of the paper in your file (medical records, treatment plans, insurance company documents), the medical reviewer approves or disapproves of your medical treatment and medical expenses.

How this scam works: The insurance company (or their PPO or quasi-PPO) establishes guidelines for medical treatment and expenses. For example, a mild back strain should resolve within 12 sessions of physical therapy. Consequently, the insurance company will “pre-approve” or “authorize” 12 sessions of physical therapy. If you have not recovered within the 12 sessions, then your doctor or physical therapist will have to request additional sessions.

The medical reviewer (usually a nurse) will approve or not approve the additional sessions. If you still insist on obtaining the additional physical therapy, then you will have to go through the PPO internal appeal process (and maybe through the quasi-PPO internal appeal process, although it is quite doubtful that quasi-PPOs have the legal authority to force you into this process). The internal appeal process will be more paper review. The PPO nurses and doctors



must be incredibly good, as they can diagnose and treat you without examining you or even seeing or talking to you, as your usual treating doctor has to do.

The multi-level appeal process may take months – and maybe years. Meanwhile, you are not getting the treatment you need or, you are getting the treatment but it's not going to be paid for by your insurance if you lose the appeal. After you lose the appeal (okay, somebody may win an appeal once in a great while), you are stuck with the bill or you are still incapacitated because you did not receive the necessary treatment.

But that's only the half of it. The insurance company sends all your medical records and bills to some medical review company somewhere. Somebody (usually a nurse) sits in a room with stacks of these records and bills and marks all over them with a red pencil. Do you think the nurse is suggesting additional treatment or tests or concluding that the charges are too low? Of course not, the sole mission of the paper reviewer is to cut down medical treatment and expenses. If they do not, how long do you think the insurance company will retain the medical reviewer? Also, do you think that the insurance company keeps tracks of the "savings" gained from paper reviews? And do you think that the compensation of medical reviewers is related to these "savings?"

### **Dirty Trick #9: The "IME" Scam**

"IME," in insurance company language, means "Independent Medical Examination." Nothing could be further from the truth.

In the bad old days before the PIP medical review system was implemented, the "IME" was a complete joke – as doctors routinely prostituted themselves by providing medical opinions bought and paid for by insurance companies. But it was no joke to the thousands, or hundreds of thousands, of injured patients whose treatment was abruptly terminated as a result of these bogus medical examinations and opinions.

This is how the old IME scam used to work: When the insurance company got tired of paying an insured's medical bills, it would schedule an "Independent Medical Examination" with a doctor of its choosing. The IME doctor would examine the insured one time and write a report stating that the insured needed no further treatment. Upon receipt of the IME report, the insurance company would immediately terminate payment of medical expenses. What the insurance company didn't tell you was that the vast majority of the IME doctor's income was derived from doing Time's for the insurance company.

The IME situation was such a travesty that the State finally intervened and created a State supervised IME program. Under the state PIP IME system, the State IME agency generated a list of 5 examiners chosen at random from the State database. The insurance company then struck 2 names off the list and the insured struck 2 names. The remaining doctor performed the IME.

Sounds fair, doesn't it? Procedurally, it is fair, but substantively it often was not. Why? Because the insurance companies still controlled doctors to a large extent. How? There were several professional IME groups which were listed in the State database and the doctors in these groups repeatedly appeared on the lists of 5 randomly chosen doctors. Although any doctor could sign up on the IME lists, most choose not to. Why? Because most doctors were reluctant to criticize or even comment on the medical care provided by another doctor. However, those doctors who wanted to make tons of money from insurance companies were not shy about providing IME reports which recommended termination of medical treatment.

With the repeal of PIP coverage, the PIP IME program went out of existence and we are back to the bad old days of insurance company run DIMES.

On the liability side (where an injured person is making a claim against the at-fault driver who caused the accident and injuries, and the case is in litigation),

the "IME" is really a joke. It's a joke to call it an "independent" medical examination because the at-fault driver, through his insurance company, is paying for the medical examination and report to be used against the injured person. The insurance companies don't hire an independent examiner; they go to their stable of hired guns to try to shoot down the medical treatment of the injured person. These hired guns earn hundreds of thousands of dollars a year just from doing "IMEs" for insurance companies. If you are being examined by a doctor who is being paid by the person you are suing, then what do you think the doctor will say?

### **Dirty Trick #10: The Managed Care Scam**

"Managed Care" is a fancy term for controlling doctors.

The "Preferred Provider Organization" (PPO) is the automobile insurance industry's predominant method of managing medical care. Control over your medical care is taken away from your doctor and transferred to a nurse who never sees you or speaks to you. Sometimes a doctor reviews your paperwork. Sometimes a medical reviewer whose identity will never be revealed manages your medical care from some cubicle in some far off state.

There are other methods for controlling your doctors. For example, forcing you into a quasi-PPO even though you did not choose the PPO option. They make you and your doctors jump through all the PPO hoops anyway. How can they do this? They can, and will, do almost anything to save a buck until somebody stops them. So, if you don't complain long and loud enough, then you and your doctors will be managed as if you were in a PPO.

Another method of controlling doctors is buying them.

PPO practice is lucrative, as there are only a limited number of providers in any given field of care in a given geographic area selected for the PPO

network. Because the insurance companies can select or de-select PPO providers at their whim, PPO providers have a strong economic incentive to keep the insurance company happy by usually going along with the PPO guidelines and not rocking the boat with the Nurse Case Manager.

IME practice is also lucrative. Doctors can make tons of money doing "Independent Medical Examinations." The insurance company pays for the IMEs, and the doctors know who butters their bread.

Litigation defense "IME" work is especially lucrative. In a lawsuit, the injured person (plaintiff) files a lawsuit against the at-fault driver (defendant) for injuries caused by the defendant. The defendant, through his insurance company, hires a doctor to examine the plaintiff and to write a report. Of course, the "IME" doctor states that the plaintiff is not injured, or barely injured, or that the injuries are not from the car accident but from something else, etc. These defense IME prostitutes earn hundreds of thousands of dollars a year from doing these bogus medical examinations.

Another method of controlling doctors is scaring them and misleading them about "malpractice crises" and "litigation crises" which exist only in the marketing plans of the insurance companies. Manufacturing such crises is a great way to make money. Insurance companies can then charge doctors higher premiums and they don't have to pay out higher claims because the "crises" are fictitious.

Finally, insurance companies pressure doctors to not testify in lawsuits. The economic leverage that insurance companies bring to bear on doctors is incredible. If a doctor's testimony angers an insurance company, then the insurance company can often devastate or seriously damage the doctor's practice.

### **Dirty Trick #11: The "Pre-Existing" Injury/Condition Scam**

Have you ever had an insurance company refuse to pay medical expenses or insurance benefits because you had a "pre-existing" injury or condition?

You may not have, but millions of other people have.

The refusal to pay based upon pre-existing injuries or conditions is actually legitimate in some cases, but in many cases it is not.

For example, assume that you tripped, fell down and broke your arm. You get in the car to go to the doctor. On the way, somebody carelessly slams into your car breaking your leg. The hospital emergency room treats both the arm and the leg. The hospital sends a bill for both injuries to your car insurance company. The careless driver's insurance company would be justified in refusing to pay for the arm injury as a "pre-existing" injury which was not caused by the car accident (assuming that the car accident did not worsen the arm injury), but it would have to pay for the leg injury.

Another example: assume that you have degenerative disc disease (DDD). DDD is a slow deterioration of the spine. Almost everybody over 30 years old has DDD to some degree, but very few realize it because they are not experiencing any symptoms. The spine may slowly deteriorate for years (even decades) without the appearance of pain, discomfort or restricted motion. Assume that you are 50 years old and have no symptoms of DDD. You are injured in a car crash. You have low back pain and receive treatment for it. X-rays show DDD. The insurance company refuses to pay for your back injury treatment because they say the DDD is a "pre-existing" condition. This is an invalid position. It is invalid because you did not have any back pain, discomfort or restricted range of motion before the car accident. Your back injury is compensable as a new injury

and/or an aggravation of a pre-existing condition.

Don't let the insurance company pull the wool over your eyes about "pre-existing" injuries and conditions. If an accident aggravates the pre-existing condition, then the insurance company must pay for the medical treatment.

Further, pre-existing conditions may make you more susceptible to injury. For example, an elderly woman with osteoporosis may suffer bone fractures from a minor collision whereas a NFL linebacker would be unscathed from the same collision. The at-fault person would be fully responsible for the elderly lady's injuries despite the argument that an "average person" would not have been injured. Consequently, the existence of pre-existing condition is often not a valid basis for denying insurance coverage.

### **Dirty Trick #12: The Apportionment Scam**

Insurance policies often provide that the insurer will pay reasonable and necessary accident-related medical expenses that its insured incurs as a result of an automobile accident.

The operative phrase for the Apportionment Scam is "accident-related."

The insurance companies do not want to (and do not have to) pay for medical expenses that are not related to the automobile accident. And rightly so.

Some people do have pre-existing injuries or conditions which they claim were caused by the automobile accident so that the insurance company will pay for their non-accident-related medical treatment when, in fact, the accident did not cause or aggravate their pre-existing condition. The insurance company should not pay for these fraudulent claims.

However, the insurance company also should not treat its insureds as presumptively fraudulent when they make certain claims; e.g., neck and back pain from rear end collisions. And, the

insurance company also should not try to characterize accident-related injuries as “pre-existing” or non-accident-related in an attempt to escape payment of accident-related injuries.

Apportionment is an attempt to assign percentages to accident-related injuries and treatment and to non-accident-related injuries and treatment. For example, 70% of your injuries and treatment is from the car accident and 30% is from non-accident-related conditions.

Here’s how the apportionment scam works:

**Example 1:** You have degenerative disc disease (DDD), but no symptoms. You are not undergoing any medical treatment at all. You are injured in a car crash. You have back pain and receive medical treatment. X-rays show DDD. The insurance company claims that you have a pre-existing condition of DDD and that your injury and treatment must be apportioned between the DDD and the car accident. This is an invalid position. Apportionment is not valid because you did not have symptoms before the accident and you were not receiving any medical treatment for the DDD. The insurance company must pay for 100% of the medical expenses.

**Example 2:** You have degenerative disc disease (DDD) and some occasional, minor back pain. You are not receiving any medical treatment at all. You are injured in a car crash. You have significant back pain and receive medical treatment. X-rays show DDD. The insurance company claims that you have a pre-existing condition of DDD and that your injury and treatment must be apportioned between the DDD and the car accident. This is an invalid position if the insurance company is attempting to pay less than 100% of the medical treatment. There are two types of apportionment: apportionment of injury and apportionment of treatment. It is proper to apportion the back pain (e.g., 80% to the car accident and 20% to the DDD), but it is not proper to apportion the medical treatment because you did not have to have any medical treatment

prior to the car crash. The insurance company must pay 100% of the medical treatment.

**Example 3:** You have degenerative disc disease (DDD) and some occasional, minor back pain. You are receiving occasional medical treatment for your back pain. You are injured in a car crash. You have significant back pain and receive medical treatment from the same doctor who was treating you for DDD related back pain. X-rays show DDD. The insurance company claims that you have a pre-existing condition of DDD and that your injury and treatment must be apportioned between the DDD and the car accident. This is a valid position. Your pre-existing DDD and medical treatment should be apportioned against the car crash back pain and medical treatment. The apportionment might be 80% to the car crash and 20% to the DDD. However, the apportionment of injury need not be the same as the apportionment of treatment. For example, the apportionment of injury might be 80% to the car crash and 20% to the DDD while the apportionment of treatment might be 90% to the car crash and 10% to the DDD – in which case the insurance company must pay 90% of the medical expenses. [If you were going to different doctors for the DDD treatment and the car crash treatment, then apportionment would not be necessary. The insurance company would not pay your DDD doctor and would have to pay 100% of the car crash doctor’s expenses.]

Apportionment can be confusing. Make sure that you, and especially your doctor, understand it.

### **Dirty Trick #13: The Surveillance Scam**

You’ve probably seen television shows about insurance fraud in which various insurance claimants were caught on videotape doing things that they could not (or should not) possibly do if they were really injured as they claimed. Some people defraud insurance companies. Those that do should be prosecuted.

By the same token, however, insurance companies that defraud people should be prosecuted too. But, that almost never happens. Why? Because an insurance company is not a person; it’s a corporation. Multi-million or billion dollar corporations have a lot of power. Most individuals do not. If surveillance cameras were trained on insurance companies and their adjusters, then the magnitude of the insurance fraud perpetrated by the insurance companies on their insureds would dwarf the fraud perpetrated by individuals on insurance hundreds of times over.

Here’s how the surveillance scam operates: The insurance company hires a private investigator to follow and videotape an insured for a few hours out of a day (sometimes a couple of days). The investigator does not videotape an entire day. The investigator videotapes when he thinks he is likely to capture something that the insurance company can use against the insured; e.g., manual labor or playing sports. What the videotape does not capture is the rest of the day. The videotape does not capture, for example, the pain and discomfort the person is going through after the activity as he lies immobile in bed. Yes, some of the people captured on videotape are frauds, but many are not; they are people who ill-advisedly tried to do something that they had formerly enjoyed. Of course, the videos shown on television are the egregious examples of fraud. The thousands of videos with nothing incriminating on them are not shown. The insurance company then sends the videotape, or an edited portion of it, to the insured’s doctor to try to convince the doctor that the insured is faking his injuries. This tactic is an interference of the physician/patient relationship. The insurance company may use the videotape against the insured, but it is bad faith to attempt to destroy or damage the insured’s relationship with his doctor. Don’t think that the insurance companies only videotape the crooks. Surveillance is more common than you think. Big Brother is watching you.



## **Dirty Trick #14: The Confidence Scam**

Have you ever heard of confidence scams? Here's how they operate: A confidence artist gains your confidence, convinces you to transfer money to him in a plan that will be to your and his mutual benefit, and then he absconds with the money. Another name for the confidence artist is "con" artist.

Insurance companies gain your confidence by pretending to be your good neighbor or by pretending that you will be in good hands with them. After they have gained your confidence and pocketed your premiums, they move on to the next John. Although the insurance company is always around, why do you think they keep changing adjusters on your claim?

True, insurance companies sometimes do a good job of adjusting a claim and paying a loss, but all too often – especially in injury claims – insureds are put through the wringer as if they are trying to defraud the insurance company. It is true that some people defraud insurance companies. But it is also true that insurance companies defraud their insureds. The difference is that insurance fraud by insureds is infrequent and involves a very small fraction of total claims while insurance fraud perpetrated by insurance companies is frequent, systematic and involves a very large percentage of total claims.

The paradox of insurance company fraud is that it is too massive and too pervasive to fight. Getting screwed by insurance companies just becomes the "cost of doing business." It's "not worth the trouble" to fight. It's not worth the trouble because it will probably cost you a heck of a lot more to fight than to walk away and swallow your loss. On the other hand, your small loss is multiplied thousands of times over as the insurance company screws many of its insureds in the same manner. For example, a common practice is to "chisel" claims. Instead of paying full value – whether for a car repair or a medical bill – they chisel the

claim by a small amount, say \$100. It's not worth your while to go to court for \$100 so you grumble about it and move on. Meanwhile, the insurance company moves on to its next victim – chiseling him or her out of \$100. After they have chiseled 1000 people, they have saved \$100,000. And \$1 million for screwing 10,000 people.

## **Dirty Trick #15: The Stonewalling Scam**

"Stonewalling" is the unreasonable delay in paying valid claims - typically by dragging out the claims process for months or even years.

Examples include:

- Ignoring the claim or claimant.
- Stating that the claim application or medical bill or whatever document is needed has "not been received."
- Requiring repetitive submissions of the application, bills, etc.
- Requiring additional documents or information.
- "Waiting on" documents or information from somebody else.
- Rubber ball express: bouncing the claimant from one adjuster to another.
- Claims maze: telling the claimant that the claim must go to a supervisor, committee, the nurse case manager, the medical reviewer, the home office, etc.
- Nickel and Dime: requesting documents and/or information in bits and pieces over a long period of time.
- Health insurance switcheroo: delaying payment and/or causing so much trouble that the insured submits medical bills to his or her own health insurance when the bills should be paid by PIP or med pay.
- Vehicle damage switcheroo: The at-fault driver's insurer refusing to pay, or delaying to pay, for the vehicle damage until the insured submits it to his or her own insurer when the at-fault driver's insurer should pay.
- Economic duress: delaying because

the claimant is in dire financial straits and will eventually cave in.

- Social duress: threatening to reveal potentially embarrassing information to others (spouse, employer, etc.).
- All or nothing: refusing to pay a valid, undisputed claim until the claimant agrees to settlement of all disputed claims.
- "The file is closed."
- Refusal to consider new information.
- "Further investigation" is needed.
- Sham mediations and settlement conferences: The insured goes to a mediation or settlement conference with the expectation of engaging in good faith negotiations. What happens: the insurance company gets as much information from the insured as possible and does not offer anything - or does not offer a penny more than already has been offered.
- Last minute offer: the insurance company waits until it is "on the courthouse steps" to make an offer. This tactic is to try to make the insured cave in or, if the insured does not cave in, to try to make the claim as expensive as possible so that the insured's eventual recovery is not economically viable.
- Statute of limitations: delay until the statute of limitations runs and the claimant loses the ability to sue in court.

The insurance company will beat you over the head with your "duty to cooperate" with them, but don't count on them cooperating with you.

## **Dirty Trick #16: The Low-balling Scam**

"Low-balling" is essentially the refusal to pay a reasonable amount for benefits owed to the claimant or for damages owed to an injured person.

**Typical PIP or med pay labeling examples include:**

- Failing to explain benefits – especially rehabilitation and

essential services.

- Failing to pay benefits which the insurance company knows the insured is entitled to but which have not been requested by the insured because the benefits have not been explained to the insured.
- Failing to pay benefits which have been requested by the insured but which the insured has not taken legal action upon.
- Not paying medical bills.
- Not paying the full amount of medical bills.
- Not paying for vocational rehabilitation.
- Paying only for the cost of books for vocational rehabilitation.
- Chiseling lost wage claims by omitting such things as overtime, bonuses, sick pay, benefits and labor replacement costs. Chiseling by selective and creative averaging of wages over arbitrary time periods.

*Typical property damage low-balling examples include:*

- a. Chiseling vehicle damage claims by using market survey companies to calculate vehicle damage averages within specific geographic regions while ignoring items which increase the value of your specific vehicle. Guess what; chiseling reduces the average value of vehicles - so that your getting cheated on your car contributes to the next poor Joe getting cheated on his car, etc., etc. Using used or re-conditioned parts to repair your car.
- b. Not giving you any credit for special items in your car.

*Typical Uninsured/Underinsured low-balling examples include:*

- Ignoring you.
- Denying your claim.
- Offering you peanuts.
- Forcing you into arbitration or litigation.

*Typical Liability insurance low-balling examples include:*

- Ignoring you.
- Denying your claim.
- Offering you peanuts.
- Forcing you into litigation.

Don't expect insurance companies to voluntarily pay full benefits or reasonable compensation. You have to know your rights and fight for them.

### **Dirty Trick #17: Creating, Using and Abusing Conflicts of Interest**

*Doctor vs. Patient (Interfering with the practice of medicine)*

Should your doctor be more concerned about your health or his or her income? Should your doctor be more concerned about your health or the insurance company's profits? The answers to these questions are clear in the ideal, but the reality may be somewhat different.

For example, doctors in preferred provider organizations (PPO) are under tremendous pressure to practice within the confines of the PPO "guidelines" because most of their income comes from treating PPO patients. If the PPO becomes unhappy with the doctor, then the PPO may drop them from the PPO network - damaging the doctor's practice and income. Insurance companies use this fact and threat, express or implied, to control PPO doctors.

The vast majority of doctors has your best interests at heart, but be aware of the potential conflict of interest that the insurance companies have created.

*Attorney vs. Client (Pre-empting legal representation)*

If you are injured in a car crash, should you hire an attorney? Insurance companies often tell you not to. They say that you don't need one and the attorney will just take 1/3 of your recovery. However, what they don't tell you is what will hurt you. What they don't tell you is that they are in an adversarial relationship with you. They

don't tell you that they will stonewall you, lowball you, and attempt to beat you into submission so that you will settle for peanuts. They also don't tell you that an insurance company study found that claimants recover on average about three times more when they are represented by attorneys.

*PIP/med pay vs. Liability (Backstabbing the insured)*

Your PIP or med pay insurer owes you a duty of good faith and fair dealing. Your PIP or med pay insurer does not owe any duty to the at-fault driver who injured you. Of course not, the at-fault driver is in an adversarial position to you. It necessarily follows that your PIP or med pay insurer does not owe any duty to the at-fault driver's insurance company. In fact, your PIP or med pay insurer's owes you the duty not to do anything to diminish your claim against the at-fault driver.

So, naturally your PIP or med pay insurer will jealously guard the confidentiality of your medical, employment and confidential information and not let the at-fault driver's insurer have access to it, right?

WRONG! PIP and med pay insurers routinely give your medical, employment and other confidential records to your adversary's insurer. They do this in two ways: 1) Directly. They simply give your confidential records and information directly to the at-fault driver's insurer! 2) Indirectly. They store your confidential records and information in a national database and the at-fault driver's insurer has access to the database.

Take a look at the release authorization you signed and gave to your PIP or med pay insurer. It basically says that they can obtain just about anything from anybody AND give it to anybody who "has a business need for the information." The insurance industry understanding is that liability insurers (at-fault driver's insurers) have a business need for the injured person's medical, employment and confidential records

and information. And I suppose that all subscribers to the database that your records were dumped into have a business need for the records and information. Smell a rat? I thought so.

What to do? First, don't sign a release authorization allowing your PIP or med pay insurer to give your medical, employment and other confidential records and information to anyone not directly involved in handling your PIP/med pay claim. Second, write a letter to your PIP/med pay insurer instructing them not to provide your confidential records and information to the at-fault insurer or to any external databases. Third, instruct your PIP/med pay insurer to not communicate with the at-fault insurer. Fourth, watch your back.

### **PIP/med pay vs. UIM (Back-dooring the insured's confidential information)**

In an underinsured motorist (UIM) claim, you are attempting to recover insurance benefits from your own insurer because the at-fault driver did not have enough insurance to cover your damages. For example, you have \$100,000 UIM coverage. The at-fault driver has \$25,000 liability insurance coverage. Your damages are \$100,000. The liability insurer pays you \$25,000.

You make a claim for \$75,000 under your UIM coverage. You would think that your insurer would willingly pay you \$75,000, right?

Wrong. Your own insurer has a split personality: Dr. Jekyll - who supposedly treats you fairly and in good faith, and Mr. Hyde - who destroys all the good created by Dr. Jekyll. The PIP/med pay side of your insurer is Dr. Jekyll. The UIM side of your insurer is Mr. Hyde. The UIM side tries to defeat your claim entirely, and if that is not possible then to pay you as little as possible. You might think that the Dr. Jekyll (PIP/med pay) side of your insurer would support you, or at least be neutral. But you would be wrong. The Dr. Jekyll personality of your insurer often transforms into Mr. Hyde. That is, the PIP/med pay adjuster gives your medical, employment and other confidential records and information to the UIM adjuster so that your UIM claim can be defeated or diminished. You have been "back-doored" by Dr. Jekyll and Mr. Hyde.

### **Insured vs. Insurer (Exposing the insured to personal liability)**

If you are not the plaintiff but the defendant, then your liability insurer owes you the duty to settle your claim

within your insurance coverage limits. For example, your liability coverage is \$25,000. The plaintiff's damages are \$50,000. The plaintiff offers to accept \$25,000 to settle the claim. Your liability insurer offers to pay only \$10,000. The case goes to trial. The jury renders a verdict for the plaintiff for \$100,000. You are now personally liable for \$75,000 plus interest plus the plaintiff's litigation costs. The plaintiff seeks to execute on the judgment by having the sheriff seize your house, cars and personal property. Your wages are garnished. All because your own insurer decided to play chicken with the plaintiff. The liability insurer put its own economic interests above yours in trying to settle cheaply. And therein lies the "excess verdict" conflict of interest.

These examples of conflict of interest are quite enlightening; they illustrate that the insurers on both sides of the litigation are willing to screw their insureds in order to pursue their own economic interests.

### **Conclusion**

Be careful. It's dangerous out there. Being forewarned is being forearmed. And it's usually good to retain experienced legal counsel to help you navigate the treacherous terrain of insurance land.

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**End Notes**

<sup>1</sup> Mark M. Hager, Civil Compensation and its Discontents: A Response to Huber, 42 STAN. L. REV. 539, 566 (1990).

<sup>2</sup> NCSC study and a 1995 U.S. Dept. of Justice study of civil cases.

<sup>3</sup> Daniel J. Capra, *An Accident and a Dream: Misinformation, Misstatement, and Misunderstandings about the Civil Justice System*, [www-1.nysba2.org](http://www-1.nysba2.org); Marc Galanter, *Real World Torts: an Antidote to Anecdote*, 55 MD. L. REV. 1093 (1996).

<sup>4</sup> Study by Michael Rustad of Suffolk University.

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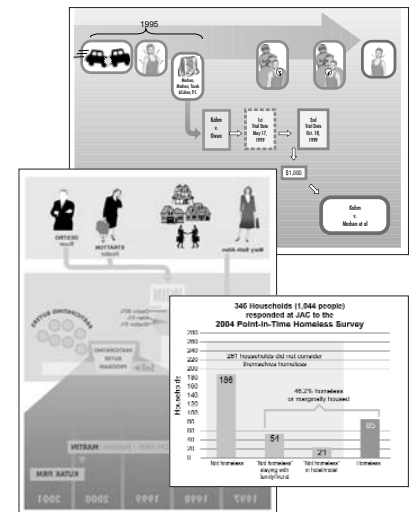
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