

Business Litigation

Marlene K. Heyser

This issue brings us three feature articles from the TIPS Business Litigation Committee. Each article provides insight into the challenging arena of business litigation. The importance of the federal Racketeer Influenced and Corrupt Organizations Act (RICO) in litigating no-fault insurance fraud is explained by Michael Sirignano and Frank Tiscione. Civil actions filed under RICO against health care providers address serious fraud that harms many. In her article on remote communications and specific jurisdiction, Amy Gross addresses the complex issue of establishing jurisdiction over defendants in actions involving electronic communication, including email, the Internet, and websites. Jonathan Dunitz and Melanie Stevens discuss strategies to preserve insurance coverage rights in litigation, from the procurement

of insurance and ensuring additional insured status, as appropriate, to guiding your client through the post-loss preservation of coverage.

Also in this edition, Jim Holmes provides "Quick Tips for Success in Becoming Insurance Panel Counsel." Holly Polglase and Michelle Byers highlight Massachusetts legislation altering the relationship between attorneys and self-represented parties and the jurors that will decide their cases. Briana Montminy reviews the just-published ABA/TIPS book *Misrepresentation in the Life, Health, and Disability Insurance Application Process, Second Edition*. Rick Morefield offers thoughts and reflections on his career in "When I Was a New Lawyer." Finally, Sierra Spitzer recaps the Midyear Meeting in Houston, while Jennifer Kilpatrick previews Chicago, national headquarters for the ABA and host city for the 2015 ABA Annual Meeting. ♦

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RICO Actions Fight No-Fault Insurance Fraud

Michael A. Sirignano and Frank P. Tiscione

State no-fault insurance laws help facilitate payment to individuals who have suffered bodily injury as a result of an automobile accident by requiring insurers to promptly pay benefits without regard to fault. Where no-fault benefits are assigned to a health care provider that submits claims directly to the assignee's insurance company, the injured party receives treatment, and the health care provider receives payment.

All works well—unless health care providers engage in fraud by submitting unwarranted bills. Because insurers generally are required to pay promptly and are under tight time deadlines, such bills are often paid before the fraud is detected.

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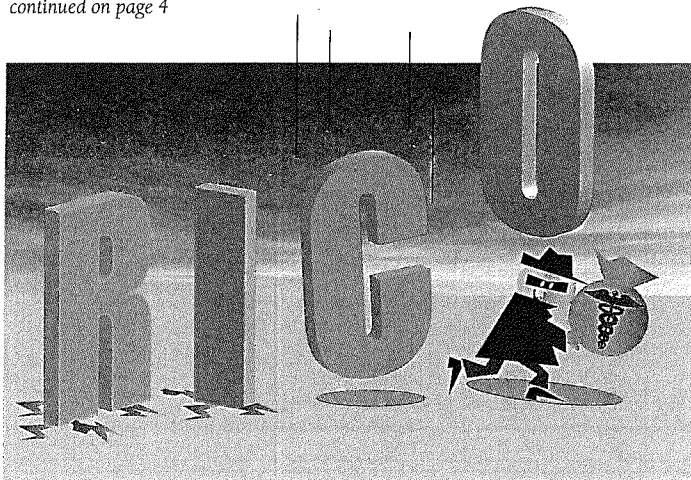


Illustration by Andrew O. Alcalá

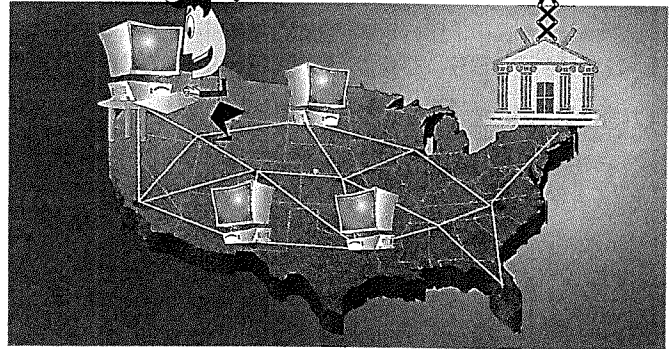
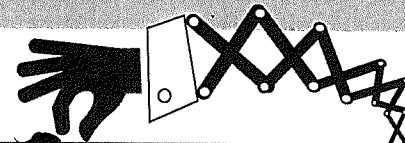


Illustration by Andrew O. Alcalá

Remote Communications and Specific Jurisdiction

Amy C. Gross

The U.S. Supreme Court recognized the reach of long-arm jurisdiction in a 1985 keystone case as follows:

[I]t is an inescapable fact of modern commercial life that a substantial amount of business is transacted solely by mail and wire communications across state lines, thus obviating the need for physical presence within a State in which business is conducted. *Burger King Corp. v. Rudzewicz*, 471 U.S. 463, 476 (1985).

Thirty years later, as remote communications continue to evolve and email and the Internet are established in everyday life, potential litigants must consider whether defendants' *continued on page 6*

RICO Actions Fight No-Fault Insurance Fraud

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The scourge of no-fault insurance fraud harms consumers, policyholders, insurance companies, and legitimate health care providers. In recent years, this illegal activity has been countered by increased federal and state criminal prosecutions against fraudsters, legislative and regulatory responses seeking to tackle the issue, and insurers' aggressive efforts to stamp out the problem by invoking the courts.

To stem the rise in fraudulent no-fault claims by health care providers—and to block or recoup payment of those claims—many insurance companies are choosing to file civil actions under the federal Racketeer Influenced and Corrupt Organizations Act (RICO). Despite the fact that the complex pleading requirements of RICO necessitate the employment of experienced counsel, insurers are bringing these lawsuits in multiple jurisdictions—from New York and New Jersey to Florida, Illinois, Michigan, and beyond—against a growing number of illegitimate health care providers and associated fraudsters.

In these cases, insurers allege that health care providers filed claims and received payment in violation of one or more of a variety of state or federal laws. Insurers seek compensatory damages as well as punitive and treble damages, in addition to the recovery of no-fault insurance payments they previously made to the providers. They also assert a right to be awarded their attorneys' fees and court costs, as authorized by RICO.

The Standard

Federal courts have long been predisposed to disallow civil RICO claims that are not aimed at eradicating organized, long-term "traditional" criminal activity. The courts also have been strict in requiring plaintiffs that bring civil RICO claims to sufficiently plead and prove the complex elements supporting that statute. More recently, however, federal courts have recognized that, if pled properly, RICO is an appropriate tool for insurers to use in the fight against systematic abuse of a state's no-fault insurance system.

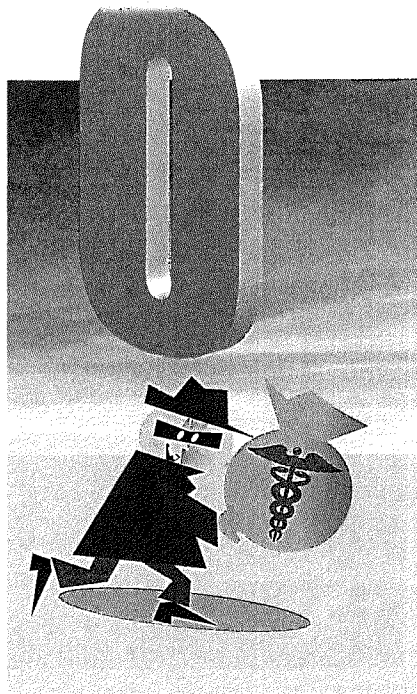
In their RICO actions, insurance companies generally allege that they have been injured by the defendant health care providers' "pattern of racketeering activity" as a result of the providers' direct or indirect participation in a RICO "enterprise" affecting interstate commerce. The essence of these actions is the insurers' allegations that the providers submitted fraudulent bills for services that were not provided, provided without a valid medical reason to do so, or billed at inflated rates. In other instances and depending on the governing state's particular licensing statutes, insurers allege that the providers were not entitled to payment of their claims because the providers violated licensing laws such as those prohibiting control by unlicensed individuals instead of medical professionals, illegal kickback arrangements, or illegal fee-splitting.

The racketeering activity alleged in these actions typically is supported by detailed allegations of mail fraud resulting from the providers' use of the U.S. mails to submit fraudulent bills to the plaintiff insurers. While there are myriad pleading requirements underlying assertion of a valid RICO claim, to satisfy the pattern requirement, a plaintiff can allege an open-ended pattern of racketeering activity (i.e., past criminal conduct coupled with a threat of future criminal conduct) or a closed-ended pattern of racketeering activity (i.e., past criminal conduct extending over a substantial period of time). In general, federal courts require that the pattern of racketeering activity be substantial in order to support a civil RICO claim.

Fraudulent Schemes and Available Remedies

A recent ruling by a federal district court in New York granting the motion of a number of insurers for default judgment, *Liberty Mutual Ins. Co. v. Matskina*, No. 1:14-cv-01330 (E.D.N.Y. Sept. 18, 2014), illustrates the nature of the fraudulent schemes that are often the subject of civil RICO actions and the remedies available to insurers.

In *Matskina*, the court noted that the plaintiff insurers' 193-page complaint adequately set forth each of the detailed elements of RICO (as well as fraud and unjust enrichment) and described the fraud scheme as the brainchild of an unlicensed layperson who owned and controlled various acupuncture clinics. As noted by the court, the clinics' owner paid licensed acupuncturists to form professional corporations



and represent to the state licensing agency that they owned and controlled them, when, in fact, it was the unlicensed layperson who "was pulling the strings and deriving the full benefit of ownership" in violation of state law. The insurers alleged that, in addition to the phony licensing of 10 professional corporations that were the subject of the motion, the unlicensed layperson established separate billing and collection companies to control the professional corporations and manage their submission of fraudulent or inflated acupuncture bills to the insurance companies.

Citing this fraudulent scheme, the plaintiff insurers sought a declaratory judgment that they had no obligation to pay pending claims from the defendants. Based on alleged violations of RICO, common law fraud, and unjust enrichment, the insurers also sought treble damages exceeding \$4 million based on claims already paid. The court granted the insurers' request for judgment in full, further finding that the liability of the defendants was joint and several.

Conclusion

The power of insurers' RICO actions against fraudulent health care providers can be seen in the extent of actions filed, as well as the awards the carriers have obtained.

For example, in *State Farm Mut. Automobile Ins. Co. v. Lincow*, 715 F. Supp. 2d 617 (E.D. Pa. 2010), a Pennsylvania jury determined that the defendant providers should pay over \$4 million, an amount that was trebled, leading to a \$12.1 million award in favor of the plaintiff insurers.

While federal courts deny attempts to transform claims for simple illegalities into RICO cases, the past few years have shown that courts are open to insurers pursuing civil RICO cases to help eradicate concerted fraudulent activity and elaborate ruses used to illegally profit from abuse of state no-fault insurance laws. ❖

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