

A Little-Known Powerful Tool To Fight Calif. Insurance Fraud

Law360, New York (November 18, 2015, 1:08 PM ET) -- Insurance fraud imposes significant costs on the public and insurers, even if an insurer ultimately discovers the fraud and denies the fraudulent claim. Most states limit a defrauded insurer's remedies to breach of contract and fraud actions, which typically allow an insurer to recover its damages and rescind the policy. But California provides another option. The California Insurance Frauds Prevention Act (IFPA), located at California Insurance Code section 1871 et seq, is a little known but powerful tool for insurers to combat insurance fraud. Designed to prevent and punish insurance fraud through the imposition of significant penalties, it provides for the recovery of not only damages, but attorney fees, costs and expenses and a share of the penalties imposed.

California enacted the IFPA in 1989 after finding that rampant insurance fraud contributed substantially to rising premium costs, and the government needed assistance to prosecute insurance fraud. Unlike most state insurance fraud statutes — which authorize only the government to prosecute insurance fraud — the IFPA authorizes “interested persons, including an insurer, [to] bring a civil action for [insurance fraud] for the person and for the State of California.”[1] The action must be brought in the name of the state and filed under seal to provide the government the opportunity to investigate and determine whether to intervene. Generally, if the government does not intervene, the court unseals the complaint and the person who brought the action — often referred to as the relator — proceeds with the action. If the government intervenes, the relator remains involved, but the government has the primary responsibility for prosecuting the action.

To achieve its objectives, the IFPA imposes significant monetary penalties on persons who violate the IFPA or Penal Code sections 549-551 by, among other things, submitting fraudulent insurance claims. The IFPA prescribes penalties between \$5,000 and \$10,000 plus an assessment of not more than three times the amount of the claim.[2] The prescribed penalty is assessed for each fraudulent claim submitted to an insurer. Significantly, because the violation occurs upon completion of the proscribed act, the IFPA does not require proof that the insurer paid the fraudulent claim to justify the assessment of penalties. It only requires proof that the unlawful act led to the fraudulent claim.

The allocation of the proceeds from an IFPA action depends on whether the government intervenes. But under either scenario, the statutory framework creates significant financial incentives for insurers to bring an IFPA action — even if the insurer did not pay the fraudulent claim. If the government intervenes, the relator and the government may stipulate to the allocation of the judgment or settlement proceeds. Absent a stipulation, the IFPA provides for the following distribution. First, the relator recovers reasonable attorney’s fees, costs and expenses. Second, the government recovers reasonable attorney’s fees and costs. Third, if the relator paid money to the defendant, the relator receives the money paid to the defendant. Finally, between 30 percent and 40 percent of the remaining proceeds are allocated to the relator. If the government does not intervene, the relator receives an amount for reasonable attorney’s fees, costs and expenses and between 40 percent and 50 percent of the remaining proceeds. The relator also receives up to double any amounts paid to the defendant if the amount paid is greater than 50 percent of the proceeds. An insurer’s potential recovery in an IFPA action thus far exceeds that in a common law fraud action.

There is little case law interpreting the IFPA, but several rulings issued over the last 18 months confirmed the statute’s expansive reach and potential for significant recoveries.[3] These rulings demonstrate courts’ willingness to broadly interpret the IFPA consistent with its purpose to prevent and punish insurance fraud.

An Insurance Claim is Fraudulent if it is in Some Manner Deceitful

The IFPA does not define the term “fraudulent claim.” But, in an IFPA action pending against Bristol Myers Squibb (BMS), a California appellate court recently held that the term must be broadly interpreted to effectuate the statute’s purpose.[4] The relators and government allege that BMS violated the IFPA by paying kickbacks to doctors to induce them to prescribe its drugs. The parties asked the court to determine whether there could be an IFPA violation under a set of hypothetical facts. After finding that a person violates the IFPA by providing a good or service to induce a prescription, the court focused on what level of proof justifies the assessment of penalties under the IFPA. It concluded that the assessment of penalties requires proof of fraudulent claims resulting from the unlawful conduct, and then considered what constitutes a “fraudulent claim.”

The court recognized that the purpose of the IFPA’s penalty provision is to encourage whistleblowers and insurers to bring IFPA actions, and found that a broad interpretation of the term “fraudulent claim” is consistent with the statute’s objectives. It held that the “‘fraudulent claim’ requirement broadly refers to claims that are in some manner deceitful, and is not limited to claims that contain an express misstatement of fact.” The court explained that a “fraudulent claim” is one that is “characterized in any way by deceit” or “that result[s] from conduct that is done with an intention to gain unfair or dishonest advantage.” In other words, what starts off as a legitimate claim may become fraudulent if the insured inflates the claim, conceals material facts about it or misrepresents any portion of it to gain an unfair or dishonest advantage, such as a greater payout.

Proof that Unlawful Conduct Was a “Substantial Factor” Leading to the Claim Satisfies the IFPA’s Causation Requirement

In the same opinion discussed above, the California appellate court also considered what causal relationship between the unlawful conduct and the fraudulent claim justifies the assessment of penalties under the IFPA. The court held that “the unlawful conduct must be shown to have been a substantial factor resulting in the claims. ...”

The court rejected the more stringent “but-for” causation requirement, finding that it fails to take into account the possibility of concurrent independent causes for the claims. The court noted that it would be nearly impossible to establish the causation required by section 1871.7(b) if a doctor’s medically appropriate judgment justified a prescription, notwithstanding the alleged kickback. In short, the court concluded that the IFPA does not require proof of a quid pro quo causal relationship between a kickback and a claim.

The court also held that the plaintiffs need not establish causation on a prescription-by-prescription basis. Instead, causation may be inferred “from evidence that does not itself constitute direct evidence or reliance on an individual basis.” The court’s ruling opens the door for use of statistical sampling and other expert conclusions drawn from group behavior to establish causation.

Right to a Jury Trial

Last month, the trial court in the BMS case ruled that parties are entitled to a jury trial during the liability phase to determine whether penalties are appropriate under the IFPA.[5] The court held that the gist of an IFPA action is legal rather than equitable in nature even though damages are not specifically referenced in the IFPA’s penalty provisions. The court did not rule on who assesses the amount of the penalty, but signaled that the court rather than the jury should assess the amount.

Referral of a Claim to SIU Does Not Trigger the IFPA’s Statute of Limitations

In *People of the State of California ex rel. Fireman’s Fund Ins. Co. v. Front Gate Plaza LLC*, a Los Angeles Superior Court confirmed that an insurer’s mere referral of a claim to its special investigative unit (SIU) does not trigger the IFPA’s statute of limitations.

An IFPA action “may not be filed more than three years after the discovery of the facts constituting the grounds for commencing the action.”[6] The court held that this provision must, however, be read in the context of the insurance regulatory scheme, which requires insurers to establish and maintain an SIU to investigate possible fraudulent claims. The SIU must refer acts of suspected insurance fraud to the Department of Insurance (DOI). Referrals must be made where the facts and circumstances create a reasonable belief that a person or entity may have committed or is committing insurance fraud. The SIU must refer a claim to the DOI within 60 days after determining that the claim appears fraudulent.

The *Fireman’s Fund* case involved two claims for property damage that the insurer submitted to its SIU to assist with the claims investigation over three years before it filed an IFPA complaint. The defendants moved for summary judgment, claiming that the IFPA’s three-year statute of limitations barred the action. The defendants argued that an SIU referral automatically triggers the IFPA’s statute of limitations. The court disagreed. Consistent with the IFPA’s purpose and objective, the court held that the “mere reporting by an insurer to its SIU of suspected fraud would not, by itself, commence the running of the statute. Instead, it is the referral by the insurance company’s SIU to the Insurance Commissioner of the suspected fraud, which is the relevant date. ... If the mere referral to the SIU from

the claims department triggered the limitations period, the insurer would have to immediately report every possible suspected fraudulent claim to the DOI to prevent the limitations period from running before the DOI had any knowledge of the claim or the opportunity to investigate.” The court found that this result “would discount the reporting requirement of the SIU to the Department of Insurance, and would strike at the very nature of a qui tam action (where the state is the real party in interest).”

IFPA Penalties Are Based on the Amount of the Claim Submitted, Not the Amount Paid or Proven Fraudulent

In the Fireman’s Fund case discussed above, the defendants sought an in limine order stating that any penalties assessed against them should be calculated based solely on the amount the insurer paid on fraudulent portions the claims. They argued that penalties should not be assessed on any legitimate amounts paid or on unpaid amounts. The defendants’ motion, if granted, would have significantly reduced their exposure because the insurer had paid less than \$500,000 on the \$2.6 million claim, and approximately \$1.2 million on the \$33 million claim.

The court found that the IFPA’s plain language mandates a penalty of three times the amount of each claim and issued a tentative ruling denying the motion.[7] The court noted that nothing in the IFPA, Penal Code section 550, or the legislative history of either statute bases the imposition of the penalty on the amount an insurer paid on the claim. Nor do the statutes permit a court to parse penalties on fraudulent portions of claims. The court acknowledged that “[w]hile a violation of the statute could lead to a harsh result, the purpose of the statute to prevent all fraudulent claims (including those ‘paired’ with non-fraudulent claims) could be undermined if there were such apportionment.” The court also found that, consistent with the policy of deterring fraud, an insurer need not have paid a claim in order for the court to find that an IFPA violation occurred.

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[1] Cal. Ins. Code § 1871.7(e)(1).

[2] Cal. Ins. Code § 1871.7(b).

[3] The rulings were issued in two cases – State of California ex rel. Wilson v. Bristol Myers Squibb, Case No. BC367873 and People of the State of California ex rel. Fireman’s Fund Ins. Co. v. Front Gate Plaza, LLC, Case No. LC093216.

[4] State ex rel. Wilson v. Sup. Ct., 227 Cal. App. 4th 579 (2014).

[5] State of California ex rel. Wilson v. Bristol Myers Squibb, Case No. BC367873 (Court's Ruling and Order Re: Defendant Bristol Myers Squibb's Motion to Strike Jury Demand).

[6] Cal. Ins. Code § 1871.7(l)(1).

[7] The case settled before the scheduled hearing on the motion. Accordingly, the court's tentative ruling did not become a final order.

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