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Civil RICO and Antitrust Law: The Uneven Playing Field of the Workers' Compensation Fraud Game

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Civil RICO and Antitrust Law: The Uneven Playing Field of the Workers' Compensation Fraud Game

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The high cost of workers' compensation¹ premiums is devastating California's economy by driving many in-state employers out of business or to other states in search of greener pastures.² The net effect is a reduction in the number of out-of-state employers who are willing to relocate to California.³ Workers' compensation premiums, which are the prices employers must pay for workers' compensation insurance, have increased so rapidly that some employers have been forced into bankruptcy.⁴ Businesses which must scale down because of economic factors other than high workers' compensation premiums likewise find their problems compounded when many laid off employees file workers' compensation claims following termination, usually claiming stress as the

1. See CAL. LAB. CODE §§ 3201-5278 (West 1989 & Supp. 1993) (setting forth the scope, operation, proceedings, and coverage of California's workers' compensation and insurance laws).

2. LITTLE HOOVER COMMISSION, WORKERS' COMPENSATION—CONTAINING THE COSTS, at 24-26 (Feb. 1993) [hereinafter CONTAINING THE COSTS] (citing numerous successful businesses which are either shutting down or considering leaving California because of the high cost of workers' compensation).

3. *Id.* In the past five years, 669 manufacturing plants left the state, resulting in a loss of 100,000 jobs. *Id.* at 26. The main reason for this departure was said to be California's workers' compensation system. *Id.*; see LITTLE HOOVER COMMISSION, A REVIEW OF THE CURRENT PROBLEMS IN CALIFORNIA'S WORKERS' COMPENSATION SYSTEM, at 13-14 (Mar. 1988) [hereinafter CURRENT PROBLEMS] (stating that the high cost of premiums has had a negative impact on the perception of California's business climate, and may reduce the number of companies willing to relocate to California); see also Dan Weikel, *Companies Lured From Tarnished Golden State; Economy: Recruiters Target Businesses In O.C. And Elsewhere In California Frustrated By Increasing Costs And Regulations*, L.A. TIMES, Aug. 9, 1992, Orange County Edition, at A1, available in LEXIS, Nexis Library, LAT File (reporting that California's liberal stress claim laws are part of the reason for insurance premiums that are three to four times higher than in other areas of the country). A study by the Economic Development Corporation of Los Angeles County found that approximately 260 Southern California companies had expanded into other states or relocated outside California since 1989. *Id.* A statewide survey of 1,462 firms conducted by the California Business Roundtable indicated that one-third of those polled had plans to either move or expand operations out of state. *Id.* But see Stuart Silverstein, *Fraud Disables State's Workers' Comp Program*, L.A. TIMES, Aug. 23, 1992, at D1, available in LEXIS, Nexis Library, LAT File [hereinafter *Fraud Disables*] (reporting that organized labor and some economists feel that the recession, and not rampant workers' compensation costs, are the reason that many employers are leaving the state or going out of business).

4. CONTAINING THE COSTS, *supra* note 2, at 8; see *id.* at 25 (citing the closure of a popular restaurant in Newhall, California on May 12, 1992 as an example of the deleterious effects of rampant increases in workers' compensation costs). The owner of the 27-year-old restaurant stated that 14 other restaurants in the same chain had shut down since 1989 as a result of rising workers' compensation costs. *Id.*; see also *infra* note 6 and accompanying text (discussing the role of post-termination stress claims in the rising cost of workers' compensation insurance premiums).

compensable work-related injury.⁵ In fact, the number of stress injuries reported by employers to the Department of Industrial Relations has increased seventy percent in just five years.⁶ When an employer cuts back on employees, the logical assumption is that the reduction in payroll will yield a refund on the required workers' compensation premium.⁷ Instead, an inordinate amount of post-termination stress claims act to raise the cost to the insurance carrier, who then simply passes this increase on to the employer through higher premiums.⁸ Therefore, an employer attempting to *conserve* capital by terminating employees may actually incur an *increase* in capital outlay to cover the higher insurance premium resulting from the additional workers' compensation claims.⁹ Rather than staying in California to fight the rising workers' compensation costs, many companies are simply taking their businesses elsewhere.¹⁰

While California's \$11 billion workers' compensation system is one of the largest and most expensive in the United States, the benefits actually

5. See, e.g., CONTAINING THE COSTS, *supra* note 2, at 80 (recounting the experience of a Southern California plant which laid off 119 employees, 115 of whom subsequently filed mental and other workers' compensation claims); *Fraud Disables*, *supra* note 3, at D1 (discussing a common scenario for workers' compensation fraud cited by insurance industry investigators in which: (1) Workers who have been recently laid-off, or who need money for other reasons, see an advertisement for a workers' compensation "hot line," or are recruited by a pitchman for a doctor or lawyer (known as a "capper"); (2) the hot line or capper refers these workers to a lawyer to help them file a workers' compensation claim; (3) the lawyer then sends the workers to a doctor or psychologist who performs costly medical-legal evaluations to justify the claim, whether or not it is legitimate; (4) the doctor or psychologist refers the workers to other doctors and health care specialists, including chiropractors and physical therapists, to further run up the medical bills; (5) the bills are submitted to workers' compensation insurance companies, which decide whether to pay or challenge the claims; and (6) the resultant cost to insurers for either paying for or fighting fraudulent claims causes the imposition of higher charges on employers who buy their workers' compensation policies).

6. Howard Fine, *Workers' Comp Means Trouble For Anaheim Firm*, 15 ORANGE COUNTY BUS. J. 3, § 1 at 1 (Jan. 20, 1992) [hereinafter *Anaheim Firm*] (citing a recent study which found that the number of employer-reported stress injuries had increased from 6,800 in 1986 to over 11,000 in 1991). Workers' compensation experts estimate that the actual number of stress claims is almost 40,000 per year, since many stress claims are litigated by the employer, and are therefore unreported to the Department of Industrial Relations. *Id.*; see *Mental Stress Claims in California Workers' Compensation--Incidence, Costs and Trends*, CWC I RESEARCH NOTES, CALIFORNIA WORKERS' COMPENSATION INSTITUTE, June 1990 at 2 (finding that one of the reasons that 73% of mental stress claims filed under 1985 policies were not reported to the Department of Industrial Relations was the practice of not reporting claims which the employer is litigating).

7. See CAL. INS. CODE §§ 11730-41 (West 1989 & Supp. 1993) (including payroll as a factor in determining the premium rate for Workers' Compensation insurance).

8. See, e.g., *Anaheim Firm*, *supra* note 6, at 1 (reporting that, while Century Laminators had expected a \$175,000 refund in their workers' compensation premiums due to the 30% reduction in personnel, the company was instead required to pay an additional \$25,000 in reserves to cover the inordinate amount of post-termination stress claims).

9. *Id.*

10. *California Business Climate Survey*, CALIFORNIA BUSINESS ROUNDTABLE (Nov. 1991); CONTAINING THE COSTS, *supra* note 2, at 24-26.

received by injured workers are among the lowest in the nation.¹¹ This disparity is attributed to the pervasive amount of fraud which is allegedly being committed in virtually every sector of the system.¹² In fact, it is estimated that twenty percent of all claims are fraudulent.¹³

This Comment discusses a potentially effective anti-fraud technique currently being used by some insurance companies: the civil cause of action available under the Racketeer Influenced and Corrupt Organization Act (RICO).¹⁴ This Comment also contrasts the policy behind civil RICO with that of antitrust law,¹⁵ and posits the theory that the antitrust exemption currently enjoyed by workers' compensation insurance providers, combined with immunity from liability under civil RICO,

11. Grant Thornton, *Grant Thornton, Manufacturing Climates Study* (Aug. 1990) (stating that California ranks 47th out of 50 states in the level of benefits actually paid to injured workers); *Fremont Anti-Fraud Campaign Leads to First Criminal Indictments*, BUS. WIRE, Apr. 22, 1992, available in LEXIS, Nexis Library, BWIRE File (stating that California ranks third nationwide in per capita workers' compensation premiums paid by employers, and that fraudulent workers' compensation claims are a significant factor in California's low ranking for benefits actually paid to injured employees); see CALIFORNIA WORKERS' COMPENSATION INSTITUTE, BULLETIN (June 3, 1987), in CURRENT PROBLEMS, *supra* note 3, at 19 (reporting that during the period between 1977 and 1986, litigation costs for workers' compensation claims increased 304%, forensic medical costs increased 224%, and the cost in direct overhead to deliver one dollar of benefits rose from 32 cents to 52 cents). Between 1986 and 1991, the cost of medical care under California's workers' compensation system averaged an annual increase of 11.4% per worker compared to an average annual increase of 7.7% for U.S. consumer medical care expenses. *Fraud Disables*, *supra* note 3, at D1. The U.S. rate of inflation averaged 4.5% annually, rising only one-half as fast as the average annual increase in California workers' compensation medical costs per worker. *Id.*

12. COUNCIL ON CALIFORNIA COMPETITIVENESS, CALIFORNIA'S JOBS AND FUTURE (Apr. 1992) at 22, in CONTAINING THE COSTS, *supra* note 2, at 85 (stating that system-wide fraud deprives deserving workers of benefits, and deprives employers of the lower premiums that could be possible if money were not illegally siphoned away from the system). According to some estimates, between 20% and 30% of employee claims are fraudulent. *Id.* at 78-79.

13. CONTAINING THE COSTS, *supra* note 2, at 78; *Los Angeles Times Rejects Ad Warning Against Worker's Comp Fraud*, BUS. WIRE, Jan. 21, 1992, available in LEXIS, Nexis Library, BWIRE File; see Assemblyman Bill Jones (R-Fresno), *Untie This Noose On Our Economy: Until Workers' Compensation Is Reformed, Businesses Will Avoid California In Droves*, L.A. TIMES, Oct. 7, 1992, at B7, available in LEXIS, Nexis Library, LAT File (comparing California's workers' compensation system, which has tripled in cost over the last decade, with that of Oregon, which has reduced its rates by 10%, and noting that California is at a clear disadvantage in both keeping jobs in the state, and attracting new businesses to the state, partially because of the corrupt and unfair workers' compensation system); Peter Kerr, *The Price of Health: Employee Fraud - A Special Report: Vast Amount of Fraud Discovered In Workers' Compensation System*, N.Y. TIMES, Dec. 29, 1991, LATE Edition, at 1 available in LEXIS, Nexis Library, NYT File [hereinafter *Employee Fraud*] (stating that nationwide workers' compensation insurance costs are being driven up by billions of dollars a year due to fraud and exaggerated claims); *Fraud Disables*, *supra* note 3, at D1 (reporting that some insurance company investigators estimate that fraud and bill-padding by doctors, psychologists and chiropractors are so common that they account for more than 25% of the money paid on claims in California).

14. 18 U.S.C.S. §§ 1961-68 (1991 & Supp. 1993); see *infra* notes 304-328 and accompanying text (discussing the civil RICO suits brought by Zenith Insurance Company against various medical care providers for fraudulent and exaggerated claims).

15. Sherman Antitrust Act, 15 U.S.C.S. § 1 (1985 & Supp. 1993); 15 U.S.C.S. § 15 (1985) (§ 4 of the Clayton Act); 15 U.S.C.S. § 26 (1991) (§ 16 of the Clayton Act).

creates a gap in the law which opens the door for workers' compensation insurers to abuse the system with little or no risk of significant legal repercussions.¹⁶

Part I describes how California's workers' compensation system engenders fraudulent practices in every sector of the system and discusses the anti-fraud measures currently in place, including certain aspects of the workers' compensation reform legislation signed by Governor Pete Wilson on July 16, 1993.¹⁷ Part II compares the divergent policies of civil RICO and antitrust laws, and discusses the disparity in their current application within the workers' compensation system.¹⁸ Part III recounts the recent controversial lawsuits between Zenith Insurance Company and certain claimants, medical care providers, and attorneys in which allegations of RICO¹⁹ and antitrust²⁰ violations were traded.²¹ Finally, Part IV presents the legal ramifications of the use of civil RICO in California's workers' compensation system, and suggests that workers' compensation insurers currently enjoy a distinct legal advantage that presents dangers which warrant a closer look by both the judiciary and the California Legislature.²²

I. CALIFORNIA'S WORKERS' COMPENSATION SYSTEM: A BREEDING GROUND FOR FRAUD

In the early part of the twentieth century, the enactment of workers' compensation laws drastically changed the method by which job-related personal injuries were compensated.²³ The age-old axiom that people were responsible for injuries due to their own fault was abandoned in favor of limited compensation to an injured employee, or the employee's dependents in the case of death, without regard to who was at fault.²⁴ The underlying rationale for this change was the necessity of assuring prompt

16. See *infra* notes 361-379 and accompanying text.

17. See *infra* notes 23-179 and accompanying text.

18. See *infra* notes 189-303 and accompanying text.

19. See *Zenith Ins. Co. v. American Psychometric Consultants, Inc.*, No. 91-6308, at 7-29 (C.D. Cal. filed Nov. 18, 1991) [hereinafter *Zenith Complaint*] (alleging RICO violations by the defendants).

20. See *Princeton Medical Corp., et al., v. Zenith Ins. Co.*, No. 91-6866, at 7-11 (C.D. Cal. filed Dec. 17, 1991) [hereinafter *Princeton Complaint*] (alleging antitrust violations by the defendants).

21. See *infra* notes 304-360 and accompanying text (discussing the allegations set forth in these two suits).

22. See *infra* notes 361-379 and accompanying text.

23. CURRENT PROBLEMS, *supra* note 3, at 3.

24. *Id.*

payment of benefits to a person who was injured during the course of employment without the need to litigate every claim.²⁵ Concurrently, the liability of the employer was limited to a specified amount of compensation.²⁶

California law now mandates that every employer provide workers' compensation insurance for all employees.²⁷ California's workers' compensation system is largely administered by employers or their insurance carriers, with the State assuming only a supervisory role in settling disputes.²⁸ There are various conventional methods by which an employer can meet the requirement of ensuring that employees receive payment of workers' compensation benefits.²⁹ The most common source of workers' compensation insurance is through the non-profit State Compensation Insurance Fund (SCIF).³⁰ Others assure that their employees will receive payment of workers' compensation benefits by either purchasing insurance from a private insurer authorized by the SCIF, or by self-insuring.³¹ Since California's system is designed to assure that benefits are provided to all workers who are injured on the job, an employer wishing to self-insure must obtain formal consent by the Director

25. *Id.* The main purpose of industrial compensation is to ensure that an injured employee and dependents of the employee have adequate means of subsistence while the employee is unable to work. *Id.* Another purpose of industrial compensation is to bring about the employee's recovery as soon as possible in order to hasten return to the ranks of productive labor. *San Diego Transit Corp. v. Workers' Compensation Appeals Bd.*, 95 Cal. App. 3d 693, 701, 157 Cal. Rptr. 216, 220 (1979) (quoting *Moyer v. Workmen's Comp. Appeals Bd.*, 10 Cal. 3d 222, 233 (1973)).

26. STANFORD D. HERLICK, CALIFORNIA WORKERS' COMPENSATION HANDBOOK at 11 (1988).

27. CAL. INS. CODE § 3700(a)-(d) (West Supp. 1993) (requiring every employer, except the State, to secure payment of compensation benefits for employees by one or more specified means).

28. Herlick, *supra* note 26, at 1-2.

29. *See* CAL. INS. CODE § 3700(a)-(d) (West Supp. 1993) (requiring every employer, except the State, to secure payment of compensation benefits for employees by one or more specified means).

30. CONTAINING THE COSTS, *supra* note 2, at 11 (stating that the SCIF is the largest workers' compensation insurer in the State, covering approximately 21 percent of California's policyholders in 1990). The SCIF is an independent state agency required to offer workers' compensation coverage to any employer in California who meets specified minimum safety standards. *Id.*; *see* CAL. INS. CODE §§ 11770-11881 (West 1988 & Supp. 1993) (providing for the powers and duties of the State Compensation Insurance Fund); *id.* § 11870 (West 1988) (providing that the State, and various state agencies, may insure against liability with the State Compensation Insurance Fund).

31. *See* CAL. INS. CODE § 3700(b)-(c) (West 1989) (setting forth methods by which employers may secure a certificate of consent to self-insure, and excluding the State from this requirement); *see also id.* § 3300(a)-(d) (West 1989) (defining an employer as: (a) The State and every State agency; (b) each county, city, district, and all public and quasi public corporations and public agencies therein; (c) every person including any public service corporation, which has any natural person in service; and (d) the legal representative of any deceased employer); *id.* § 3301 (West 1989) (excluding from the definition of employer: (a) Any person while acting solely as the sponsor of a bowling team; and (b) any private, nonprofit organization while acting solely as the sponsor of a person who, as a condition of sentencing by a superior or municipal court, is performing services for the organization).

of Industrial Relations.³² Self-insurance is only practical for public agencies and large private employers because the self-insurance option requires a minimum deposit of \$220,000.³³

Recently enacted legislation provides an alternative to the conventional methods of providing workers' compensation insurance. California Labor Code section 3201.5 now allows building industry employers and construction workers to sidestep the state workers' compensation system altogether.³⁴ Through collective bargaining, large construction industry employers, or groups of smaller construction industry employers, are allowed to negotiate an alternative workers' compensation system with labor organizations.³⁵ While this concept has been both praised and criticized,³⁶ it is too early to tell whether section 3201.5 signals the advent of a more efficient system or a coup for the construction industry.

Until recently, California's workers' compensation system was one of the few systems in which insurance companies were guaranteed a profit, thereby ensuring the solvency of all workers' compensation insurers.³⁷ This guarantee of profitability was accomplished by establishing minimum premium rates which could be charged to employers by various workers'

32. See *id.* § 3700(b) (West Supp. 1993) (granting an employer the right to self-insure, so long as the employer has secured from the Director of Industrial Relations a certificate of consent to self-insure, which is given to an employer who has proven to the Director that he has the ability to self-insure, and to pay any compensation that may become due to his employees); *id.* § 3701(a)-(g)(2) (West 1989) (establishing the bonding and self-administration requirements for qualifying as a private self-insured employer). The minimum deposit to secure the liabilities of a private self-insured employer is 125% of the estimated future liability for compensation, plus 10% of the estimated future liability for payment of all administrative and legal costs relating to the employer's self-insuring, so long as it is at least \$220,000. *Id.* § 3701(a)-(b) (West 1989).

33. CONTAINING THE COSTS, *supra* note 2, at 8 (noting that private employers would have to expend a minimum of \$500,000 a year on workers' compensation in order for self-insurance to be a cost-effective option). California has approximately 600,000 employers, 75% of whom buy private insurance or pay into the nonprofit SCIF for insurance. *Id.* The remaining 25% are able to self-insure. *Id.*

34. See 1993 Cal. Legis. Serv. ch. 117, sec. 1, at 1038-39 (enacting CAL. LAB. CODE § 3201.5).

35. See *id.* (enacting CAL. LAB. CODE § 3201.5(a)(1)).

36. See Halle Jordan, *Workers' Comp Law Allows Private System*, THE RECORDER, July 28, 1993, at 1 (noting that proponents of Chapter 117 claim that it will reduce the cost of workers' compensation because collective bargaining units would be able to shut out attorneys, doctors and vocational rehabilitation counselors, all of whom drive up the costs of the workers' compensation system). *But see id.* (reporting that critics of the new law are concerned that the collective bargaining system may result in the bargaining away of workers' rights in order to secure a union contract). In a depressed construction market, workers will have little leverage in negotiating agreements with potential employers, thus enabling employers to stack panels of medical-legal evaluators and medical treatment providers with doctors more sympathetic to the employer than the worker. *Id.* at 1, 6.

37. CONTAINING THE COSTS, *supra* note 2, at 8; see *infra* note 113 and accompanying text (noting that California Insurance Code § 11732, which becomes effective January 1, 1995, eliminates this built-in profit system in favor of a competitive system).

compensation carriers.³⁸ The Workers' Compensation Insurance Rating Bureau (WCIRB)³⁹ set these minimum premium rates, which included a built-in profit and overhead percentage, by using a merit system.⁴⁰ The mandatory workers' compensation premium ultimately charged to a particular employer was based on the amount of the employer's payroll for employees⁴¹ covered by workers' compensation, the character of the business or employment, and the casualty history or experience of the individual employer.⁴² A higher premium was charged to those employers who sustained a higher frequency of claims.⁴³

In theory, this system was a viable method of expediting the compensation of injured workers without the need for litigation.⁴⁴ In practice, however, the infestation of fraud stopped the flow of benefits by creating an adversarial climate in what was originally intended to be a

38. CAL. INS. CODE §§ 11730-41 (West 1988 & Supp. 1993) (setting forth the regulations governing the determination and application of the merit system, under which workers' compensation premium rates are determined). Once established, these minimum premium rates are then forwarded to the Department of Insurance for approval; *see id.* §§ 11732-11732.1 (West 1988) (authorizing the Insurance Commissioner to approve a classification of risks and premium rates, and a merit rating system relating to California workers' compensation insurance).

39. The Workers' Compensation Insurance Rating Bureau is funded and operated by the workers' compensation carriers, and is licensed by the Insurance Commissioner to periodically develop and recommend rates for each of the more than 400 employment classifications, based on prior benefits and administrative costs. Herlick, *supra* note 26, at 32.

40. CAL. INS. CODE §§ 11730-41 (West 1988 & Supp. 1993); *see id.* § 11730 (West 1988) (defining merit rating as synonymous with schedule rating, which varies according to physical conditions). Merit rating also means experience rating, in which the insured employer's previous experience in the California workers' compensation system is used as a factor in raising or lowering the premium rate). *Id.*

41. *See* CAL. LAB. CODE § 3351(a)-(f) (West 1989) (defining employee, for the purposes of workers' compensation, as every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed); *id.* § 3352(a)-(m) (West Supp. 1993) (excluding from the definition of employee, for the purposes of workers' compensation coverage, various people who provide specified voluntary services, who participate in amateur sporting events without receiving remuneration, or various law enforcement officers who are regularly employed by an adjoining state but are deputized to work under the supervision of a California peace officer pursuant to specified subdivisions of the California Penal Code). The existence of an employment relationship for workers' compensation purposes depends on the factual nature of the relationship, and not on the public or private status of the employer, or on any considerations of deterrence. *Hoppmann v. Workers' Compensation Appeals Bd.*, 226 Cal. App. 3d 1119, 1126, 277 Cal. Rptr. 116, 120-21 (1991).

42. *See* CAL. INS. CODE §§ 11730-41 (West 1988 & Supp. 1993) (setting forth the regulations governing the determination and application of the merit system, under which workers' compensation premium rates are determined).

43. *Id.*

44. *See, e.g.,* *Portillo v. G.T. Price Products, Inc.*, 131 Cal. App. 3d 285, 287, 182 Cal. Rptr. 291, 293 (1982) (declaring that the Workers' Compensation Act is designed to afford workers quick determination of their claims for injury without regard to common-law questions of liability, negligence or fault).

non-confrontational system.⁴⁵ Neither prompt payment of benefits, nor reduction in litigation are currently being achieved.⁴⁶ The many reasons for the current system's failure to achieve the goal of adequately and fairly redressing workers for injuries are subject to much debate.⁴⁷ Nonetheless, there seems to be universal agreement that a high incidence of fraud exists within all sectors of California's workers' compensation system, which drains an already inefficient system.⁴⁸

A. Common Types of Fraud

Despite reforms,⁴⁹ unscrupulous employers, employees, medical clinics, and attorneys are still making fortunes by defrauding California's workers' compensation system.⁵⁰ Employers sometimes simply fail to provide workers' compensation insurance for employees.⁵¹ Those that do

45. See Mark D. Fefer & Sandra L. Kirsch, *What To Do About Workers' Comp*, FORTUNE MAG., June 29, 1992, at 80 (reporting that, in 1990, California workers collected \$7 billion in compensation claims, but \$1.5 billion was spent litigating disagreements); *Fraud Disables*, *supra* note 3, at D1 (quoting Rene Thomas Folse, a workers' compensation lawyer who represents insurers, as estimating that two sides in a dispute in California can run up \$15,000 to \$20,000 in medical-legal expenses just to dispense \$2,000 worth of benefits to the injured worker); *infra* notes 49-105 and accompanying text (discussing the pervasive fraud currently existing in the workers' compensation system and how it is slowing the payment of benefits for legitimate claims).

46. See CURRENT PROBLEMS, *supra* note 3, at 3, 12-21 (discussing the persistent delays in payment of benefits, as well as the increasing costs of litigation which continue to enervate the workers' compensation system); Bertram Cohen, *Workers' Compensation Psychiatric Claims In California*, ADDRESS TO THE SENATE INDUSTRIAL RELATIONS COMMITTEE, (Dec. 2, 1987), in CURRENT PROBLEMS, *supra* note 3, at 32 (noting that the majority of psychiatric injury claims are tacitly denied by employers or insurance carriers based on little more than the fact that the claim is psychiatric in nature). This habitual denial of psychiatric claims precludes the usual informal adjustment of claims and instead necessitates formal litigation. *Id.* Because psychiatric claims commonly arise out of failed interpersonal relationships, and are therefore more complex and people-intensive than other types of claims, the proceedings tend to take longer, resulting in a heavy drain on a system operating with very limited resources. *Id.* at 40; see also CONTAINING THE COSTS, *supra* note 2, at 94 (citing a 1985 study by the California Workers' Compensation Institute which found that 98% of stress claims were litigated, which is more than twice the rate of litigation for other types of workers' compensation claims).

47. See generally CONTAINING THE COSTS, *supra* note 2 (discussing the many problems currently plaguing the state's workers' compensation system, and urging immediate and widespread reforms).

48. *Id.*

49. See CAL. INS. CODE §§ 1877-1877.5 (West 1993) (creating the Workers' Compensation Insurance Fraud Reporting Act and establishing requirements for when insurers are required to report workers' compensation insurance fraud); *Review of Selected 1991 California Legislation*, 23 PAC. L.J. 709, 712 (1992) (discussing the changes in the handling of fraudulent workers' compensation claims brought about by the enactment of the Workers' Compensation Insurance Fraud Reporting Act).

50. Ron Gillmeister, *Cracking Down: New Powers to Fight Comp Fraud Arming Insurers in California*, CALIF. WORKERS' COMPENSATION INST., at 58 (Apr. 1992) [hereinafter *Cracking Down*].

51. CONTAINING THE COSTS, *supra* note 2, at 80. When an employer fails to provide workers' compensation insurance, injured workers can turn to the California Uninsured Employers Fund (CUEF), a fund which is administered by the Director of Industrial Relations. See CAL. LAB CODE § 3716(a)-(d)(4) (West Supp. 1993) (creating the Uninsured Employers Fund and establishing its obligations of ensuring that injured workers of illegally uninsured employers are not deprived of workers' compensation benefits). In a ten year period, the

insure often understate their payroll, or conceal high risk jobs by inappropriately classifying employees in lower risk categories, thus reducing their insurance premiums.⁵² All participants in the widely-used SCIF are negatively impacted by this type of employer fraud because this fund operates as a general fund from which all claims are paid.⁵³ By understating the payroll for employees covered by workers' compensation, an employer is able to pay less into the system.⁵⁴ While saving the dishonest employer money, these underpayments debilitate the SCIF because the amount of claims submitted by the employees is disproportionately high in relation to the premium paid by the employer.⁵⁵ The cost of paying these claims is passed on to all participants in the SCIF through higher premiums, effectively increasing the premiums paid by honest employers.⁵⁶

Employees also defraud the system in numerous ways, such as filing work-related claims for off-the-job injuries or collecting both unemployment and workers' compensation payments.⁵⁷ Employees might

amount of claims paid through this fund has increased more than 300 %, thus demonstrating the prevalence of this type of employer fraud. CONTAINING THE COSTS, *supra* note 2, at 80-81.

52. *Injured on the Job: Returning the Workers' Compensation System to Injured Workers and Their Employers*, STATE COMPENSATION INS. FUND, (Feb. 1992), cited in CONTAINING THE COSTS, *supra* note 2, at 80 [hereinafter *Injured Workers*]; see *Fraud Disables*, *supra* note 3, at D1 (discussing the increases in workers' compensation premiums for honest employers due to the oft-used practices of violating state law by simply not buying workers' compensation insurance, or lying to insurers about the number of employees working in hazardous jobs, thereby holding their rates down).

53. CONTAINING THE COSTS, *supra* note 2, at 80-82; CURRENT PROBLEMS, *supra* note 3, at 6, 21-22.

54. See CAL. INS. CODE §§ 11730-41 (West 1989 & Supp. 1993) (setting forth the regulations governing the determination and application of the merit system, under which workers' compensation premium rates are determined, and including the amount of the employer's payroll for covered employees as one of the factors which determine the premium charged for workers' compensation coverage).

55. *Injured Workers*, *supra* note 52; see *Construction Company Owners Arrested in \$300,000 Workers' Compensation Insurance Fraud; Charges Are First Ever Filed Against An Employer*, BUS. WIRE, May 19, 1993, available in LEXIS, Nexis Library, BWIRE File (reporting on the first criminal enforcement actions by the Workers' Compensation Insurance Fraud Unit against Evian Construction, an employer charged with under-reporting annual payroll and the number of employees). An audit by SCIF stated that Evian's annual payroll was only slightly more than \$356,000, however the construction firm had reported to the state Employment Development Department that their payroll was over \$1.1 million. *Id.*; *State Compensation Insurance Files RICO Suit Against Former Policyholders*, BUS. WIRE, July 20, 1992, available in LEXIS, Nexis Library, BWIRE File (reporting on a \$6 million suit filed against a group of individuals and corporations who had allegedly misrepresented the number of workers under their employment, the amount of annual payroll earned by the workers, the nature and type of work performed, prior workers' compensation premiums, and employee claims for work-related injuries); *RICO Suit Judgement in Workers' Comp Fraud Case; State Fund Prevails in Federal Suit Against Fraud Ring*, BUS. WIRE, June 25, 1992, available in LEXIS, Nexis Library, BWIRE File (reporting on the \$2.3 million judgement awarded the SCIF in its suit against a fraudulent employee leasing enterprise which had failed to report full payroll and had taken other steps to avoid paying workers' compensation premiums).

56. *Id.*

57. *Cracking Down*, *supra* note 50.

also perform similar work on one job while collecting workers' compensation payments from another employer.⁵⁸ Some employees may falsely complain to doctors of an inability to do certain activities in order to collect workers' compensation payments.⁵⁹ Termination is often a catalyst for fraudulent stress claims, although recent legislation which places limitations on post-termination claims will likely reduce the number of these bogus claims in the future.⁶⁰ Perhaps the most blatant example of a fraudulently filed claim on record is the case of a worker who claimed to have been blinded in a work-related accident.⁶¹ After recovering workers' compensation funds, this allegedly blind man was filmed loading a truck with building materials, climbing behind the wheel, and driving away.⁶²

In addition to employer and employee fraud, many medical clinics also defraud the workers' compensation system in various ways. Double billing is commonplace, whereby two insurers (such as an employer's medical care insurer and the employer's workers' compensation carrier) are billed for the same care.⁶³ Doctors often join forces with lawyers, using

58. *Id.*

59. *See, e.g., Employee Fraud, supra* note 13, at 1 (quoting Eugene Tish, chief operating officer of the Schuler Corporation of Salem, Oregon and inferring that, when 30 disability claims appear in the first 15 minutes of Monday morning, it is likely that most of the claims result from off-the-job injuries). The City of Pittsburgh reported a 15% drop in workers' compensation claims in 1991 after it televised videos taken by hidden cameras of supposedly injured police officers and firefighters working at second jobs, playing basketball and fixing roofs.
Id.

60. Stuart Silverstein, *Pitching Workers' Comp; Insurance: 'Cappers' Work The Streets, Trying To Get Passersby To Pursue Workers' Compensation Claims--Authorities Say The Practice Increases Fraudulent Filings*, L.A. TIMES, Apr. 19, 1992, at D1 [hereinafter *Pitching Workers' Comp*] (reporting on the practice of workers' compensation pitchmen to try to convince unemployed people to file stress claims against their previous employer); *see Anaheim Firm, supra* note 6, at 1 (noting that the incentive for insurance companies to reform the system is low because each stress claim results in between \$18,000 and \$25,000 of a company's workers' compensation insurance premium being kept by the insurance carrier as reserve for anticipated expenses); *see also* CAL. LAB. CODE § 3208.3(b) (West Supp. 1993) (requiring an employee to establish by a preponderance of the evidence that actual events of employment were responsible for at least 10 percent of the total causation from all sources contributing to the psychiatric injury under which compensation is being claimed); 1993 Cal. Legis. Serv. ch. 118, sec. 1, at 1040 (amending CAL. LAB. CODE § 3208.3(b) (instituting a higher threshold of compensability for psychiatric injuries by deleting the 10 percent requirement and instead requiring the plaintiff to show that the actual events of employment were predominant as to all combined causes of the psychiatric injury).

61. *See* CURRENT PROBLEMS, *supra* note 3, at 15 (discussing this incident, and stating that it was discovered during a review of closed files of the Fraud Bureau).

62. *Id.* After the Fraud Bureau reviewed the film, the Fraud Bureau declined to prosecute because they found that a significant investment of time would be needed to determine the worthiness of the prosecution. *Id.*; *see infra* notes 125-127 and accompanying text (discussing the mediocre record of the Fraud Bureau).

63. *Cracking Down, supra* note 50, at 1.

solicitation systems which employ runners⁶⁴ or cappers⁶⁵ to promote medical clinics by telling people outside unemployment, disability, and welfare offices that they can receive workers' compensation benefits regardless of whether their claim is legitimate.⁶⁶ Many medical clinics have even started using referral services to procure patients.⁶⁷ Unethical clinics are skillful at presenting inherently subjective "soft tissue" damage diagnoses such as back injuries, which can be extremely difficult for insurers to disprove.⁶⁸ Even when a legitimate work-related injury is completely absent, unethical doctors will still diagnose the patient as having such an injury.⁶⁹ The hardest types of fraud to detect include receiving payment for medical services never rendered, ordering tests that are not needed, and having lay people conduct tests which are billed as if the tests were done by professionals.⁷⁰ The detection of these types of fraudulent schemes can be extremely difficult since all of the participants are satisfied with the outcome, thereby diminishing the chances that a

64. See CAL. BUS. & PROF. CODE § 6151(a) (West Supp. 1993) (defining runner as any person, firm, association or corporation acting for consideration as an agent for an attorney at law or law firm in the solicitation or procurement of business for the attorney at law or law firm).

65. See *id.* (defining capper in identical terms as a runner).

66. *Cracking Down*, *supra* note 50, at 1; see CAL. BUS. & PROF. CODE § 2273 (West Supp. 1993) (stating that the practice of employing runners and cappers to procure patients constitutes unprofessional conduct); *Employee Fraud*, *supra* note 13, at 1 (discussing the various types of workers' compensation fraud commonly found in California, Oregon, Colorado, and New Jersey). One Los Angeles clinic, Boulevard Health Services, offered free trips for two to Las Vegas as incentives to patients who attended 30 therapy sessions. *Id.*; *Pitching Workers' Comp*, *supra* note 60, at D1 (reporting on the futility and impracticality of prosecuting individual cappers because they play only minor roles in a sophisticated scheme of fraud). Linking the capper to a doctor or lawyer is extremely difficult because of the complex surveillance required, and the fact that many cappers never actually meet the doctors and lawyers for whom they work. *Id.*; see also *California Workers' Compensation: Twitching Millionaires*, THE ECONOMIST (Oct. 3, 1992), American Survey at 29, available in LEXIS, Nexis Library, ECON File (reporting on an investigation by the Los Angeles district-attorney's office of several "medical-legal clinics" which churn out claims by allegedly using cappers to get people to pose as injured or stressful workers and using stolen claims-sheets from genuine employers to back up the claims). A set of books recently seized from such a clinic is reported to show that claims worth \$100 million per year were generated by 20 cappers. *Id.*

67. Sharon Bernstein, *Arrests Fuel Debate Over Patient-Referral Services*, L.A. TIMES, Apr. 5, 1993, B3, available in LEXIS, Nexis Library, LAT File. While there are stringent regulations governing this practice in California, the line between a lawful practice and a fraudulent practice is quite hazy. *Id.* (quoting Michael Dundon Roth, a Los Angeles attorney who is past chairman of the medicine and law committee of the American Bar Association and a director of the National Health Lawyers Association); see CAL. BUS. & PROF. CODE § 650 (West Supp. 1993) (specifying the guidelines for compensating people for the referral of patients).

68. CONTAINING THE COSTS, *supra* note 2 at 79.

69. *Pitching Workers' Comp*, *supra* note 60, at D1. Recent legislation has mandated that the Industrial Medical Council conduct a study assessing the feasibility of requiring objective medical findings for soft tissue injuries. See 1993 Cal. Legis. Serv. ch. 121, sec. 17, at 1065 (enacting CAL. LAB. CODE § 139.05).

70. *Cracking Down*, *supra* note 50.

fraudulent scheme will be reported to the authorities.⁷¹ Patients are happy because they are getting assistance in submitting a fraudulent claim, doctors are happy because they are getting patients, and attorneys are happy because they are getting compensated for representing these claimants, or getting kick-backs for referrals.⁷² New legislation sharply curtails the common practice of physicians referring their patients to other medical facilities in which the referring physician has a financial interest,⁷³ however the ban is full of exceptions.⁷⁴ Since this legislation did not take effect until July 16, 1993,⁷⁵ its effect on the high cost of workers' compensation is unascertainable.

Unscrupulous lawyers often combine with medical clinics in what are known as "workers' comp mills," where runners and cappers are hired to recruit workers outside of factories or state employment offices and refer them to the lawyers, who assist the workers in filing claims for compensation.⁷⁶ The lawyer then sends these workers to doctors or psychologists who perpetuate the scheme by performing costly evaluations to justify the claims.⁷⁷ A typical example is the experience of Kemper Insurance Company.⁷⁸ When a Southern California plant for which Kemper provided workers' compensation insurance laid-off 119 employees, 115 of the employees filed claims for stress and various soft tissue injuries.⁷⁹ Since the plant's closure, Kemper has received a total of 211 separate claims from the employees, and over seventy-five percent of those claims are being handled by one law firm.⁸⁰ It is likely that this is more than mere coincidence.

71. See, e.g., Sharon Bernstein, *6 Arrested in Patient Referral Scheme*, L.A. TIMES, Mar. 19, 1993, B1, available in LEXIS, Nexis Library, LAT File (describing the arrest of five doctors and a businesswoman for engaging in a fraudulent scheme whereby the doctors paid the businesswoman a fee for referring clients of personal injury and workers' compensation lawyers to these doctors as patients).

72. *Id.*

73. See 1993 Cal. Legis. Serv. ch. 121, sec. 20, at 1069 (enacting CAL. LAB. CODE § 139.3).

74. *Id.*, sec. 20, at 1070-72 (enacting CAL. LAB. CODE § 139.31) (setting forth numerous exceptions to the new prohibition on referrals).

75. *Id.*, sec. 80, at 1122 (declaring that the changes set forth in this act are needed to provide immediate relief to California businesses and workers, and shall take effect immediately).

76. *Id.*

77. *Id.*

78. *Workers' Compensation System Is Out Of Control*, SAN MARINO TRIB. and SAN MARINO NEWS, July 30, 1992, in CONTAINING THE COSTS, *supra* note 2 at 80 (reporting on the Kemper Insurance Companies).

79. *Id.*

80. *Id.*

Some physicians have been able to generate huge profits by simply writing medical-legal reports⁸¹ on claimants, regardless of the validity of the claimant's injury.⁸² Prior to recently enacted legislation,⁸³ employers were required to pay for these medical-legal evaluations irrespective of whether the claim itself was ever paid, and employees whose claims were being contested by the employer were not limited in the number of evaluations they could obtain.⁸⁴ The employee would often procure numerous medical-legal evaluations in order to find the most favorable diagnosis to substantiate the claim, all at the expense of the employer.⁸⁵ One needs only to be reminded that the workers' compensation system was designed to avoid costly litigation to see the absurdity of the following scenario: (1) Lawyers representing either the claimant or the employer/insurance company shop for a doctor willing to provide a medical-legal evaluation favorable to their respective positions; (2) based on the competing evaluations procured by each side, extreme postures are taken which discourage settlement and necessitate litigation; (3) the doctors provide expensive expert testimony at trial on the extent of the alleged

81. See CAL. CODE REGS. tit. 8, § 9793 (1986) (defining medical-legal report, for the purpose of determining the medical-legal range of charges, as meaning all initial comprehensive medical-legal reports submitted for the purpose of proving or disproving a contested claim); CAL. LAB. CODE § 4620 (West 1989) (defining medical-legal expenses as any costs and expenses for X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and, as needed interpreter's fees, for the purpose of proving or disproving a contested claim). These expenses can be incurred by or on behalf of any party, the administrative director, the board, or a referee. *Id.*

82. *Employee Fraud*, *supra* note 13, at 1 (reporting on the practice of some California physicians of placing misleading advertisements as to what kind of injuries are compensable, then using ghostwriters to produce the necessary medical histories for workers' compensation claims). In practice, these types of reports are paid even if the claim is ultimately denied, thereby enabling some physicians to generate huge profits by report writing, regardless of whether the injuries are valid. *Id.*; see CAL. LAB. CODE § 4624(c) (West 1989) (establishing that charges of all physicians providing initial comprehensive industrial medical-legal reports are rebuttably presumed reasonable, so long as the charges do not exceed the fee schedule in the Physician Fee Index published by the California Medical Association); *id.* § 4625 (West 1989) (establishing that all rebuttably presumed reasonable charges shall be paid promptly); *id.* § 4622(a)-(c) (West 1989) (setting forth the requirements for prompt payment for all medical-legal expenses within 60 days after receipt by the employer of the medical-legal report and itemized billing, and the method by which the employer may contest the reasonableness of the expenses); *id.* § 4626 (West 1989) (establishing that all charges for X-rays, laboratory services, and other diagnostic tests provided in connection with an industrial medical-legal evaluation shall be billed according to the fee schedule adopted by the administrative director pursuant to California Labor Code § 5307.1).

83. See 1993 Cal. Legis. Serv. ch. 121, sec. 34, at 1081 (amending CAL. LAB. CODE § 4064); *id.* sec. 80, at 1122 (declaring that Chapter 121 is an urgency statute which takes effect immediately); *infra* notes 90-94 and accompanying text (discussing Chapter 121).

84. See 1993 Cal. Legis. Serv. ch. 121, sec. 34, at 1081 (amending CAL. LAB. CODE § 4064) (stating that the employer is liable for the cost of each reasonable and necessary comprehensive medical-legal evaluation obtained by the employee).

85. CONTAINING THE COSTS, *supra* note 2, at 85.

injury; and (4) the lawyers accrue expensive legal fees for litigating the claim.⁸⁶ The doctors and lawyers are essentially middlemen profiting from the friction within the workers' compensation system, so, unlike the insurers and employers who must pay for this expensive medical and legal assistance, they have no incentive to avoid litigation.⁸⁷ In fact, the close correlation between the amount of medical/legal fees and the degree of employer/employee antagonism provides significant motivation to create and prolong the friction between employees and employers.⁸⁸ The end result of these exorbitant litigation expenses has been higher workers' compensation insurance premiums.⁸⁹

Certain sections of the California Labor Code which govern reimbursements for medical-legal evaluations have recently undergone significant change in order to reduce the number of medical-legal evaluations obtained by employees.⁹⁰ First, section 4621 bars medical-legal evaluations from being done prior to 60 days after the employer is notified of the claim.⁹¹ Second, section 4060 places a cap on the number of medical-legal evaluations which the employer and employee may obtain.⁹² Third, while prior law mandated only that medical-legal expenses be necessary and reasonable, without specifying which physicians were eligible to perform the initial medical-legal evaluation,⁹³ section 4060 now requires that the initial medical-legal evaluation be performed by the treating physician.⁹⁴ While it is too early to know whether these new laws will live up to the expectations of its supporters, it appears

86. COUNCIL ON CALIFORNIA COMPETITIVENESS, CALIFORNIA'S JOBS AND FUTURE (Apr. 1992) at 22, cited in CONTAINING THE COSTS, *supra* note 2, at 85.

87. *Id.*

88. *Id.*

89. SENATE INDUSTRIAL RELATIONS COMMITTEE, TASK FORCE ON MEDICAL-LEGAL ISSUES: BACKGROUND PAPER, in CONTAINING THE COSTS, *supra* note 2, at 85. Medical-legal evaluations account for almost half the amount spent on litigating workers' compensation cases, costing the workers' compensation system \$700 million in 1990, while litigation cost \$1.5 billion during the same period. *Id.* The California Workers' Compensation Institute found that the number of reports per litigated case increased an average of 2.8 to 3.6 % between 1984 and 1990. *Id.* A telling indicator of the pervasive abuse in the workers' compensation system is the fact that California's medical-legal reports often cost \$1,200 and up, while in other states the reports tend to cost from \$200 to \$400. *Fraud Disables*, *supra* note 3, at 1 (quoting Richard Victor, executive director of the Workers' Compensation Research Institute, a nonprofit think-tank in Cambridge, Massachusetts).

90. See 1993 Cal. Legis. Serv. ch. 121, sec. 43, at 1089 (amending CAL. LAB. CODE § 4621(a)-(d)).

91. See *id.* (amending CAL. LAB. CODE § 4621(b)).

92. See 1993 Cal. Legis. Serv. ch. 121, sec. 29, at 1076 (enacting CAL. LAB. CODE § 4060(d)) (providing that, in disputed claims, the employee may obtain one additional medical-legal report). The employer may only obtain another medical-legal evaluation if the employee is represented by an attorney. *Id.*

93. See 1984 Cal. Stat. ch. 596, sec. 4, at 2283-85 (setting forth the requirements that reimbursable medical-legal expenses must be both necessary and reasonable).

94. See 1993 Cal. Legis. Serv. ch. 121, sec. 29, at 1076 (enacting CAL. LAB. CODE § 4060(b)).

certain that the California Legislature is finally serious about reducing the amount of fraud in the workers' compensation system of this state.

Until recently, investigation and prosecution of fraud in the workers' compensation system was actively encouraged by only a few private insurers, or the state-run Department of Insurance.⁹⁵ The most important determination to be made by an insurer in processing a claim was whether the claim justified payment and, if so, the amount that was due.⁹⁶ Suspicious claims for a few thousand dollars were often simply paid by insurers because it was cheaper than pursuing litigation.⁹⁷ The result of this passive practice of payment was an inordinate number of small claims which added up to backbreaking losses for the workers' compensation system.⁹⁸

This system-wide indifference to fraud came to an abrupt halt largely as the result of a news report broadcast on May 19, 1991 by KCBS-TV in Los Angeles.⁹⁹ Harvey Levin, a KCBS reporter, stood outside an unemployment office posing as an unemployed data processor and was referred by a recruiter to the offices of lawyers and doctors who specialized in workers' compensation cases.¹⁰⁰ In a client interview at a Los Angeles law firm known as the Office of Administrative Law, Mr. Levin told interviewers that he was *not* sick or injured, while videotaping the interview by hidden video camera.¹⁰¹ Despite his declaration of good health, the firm filed forms describing him as suffering from severe abdominal pain, stiff and sore neck, lower-back pain, nervousness, dizziness, blurred vision, and too much stress on the job.¹⁰² He was then

95. CURRENT PROBLEMS, *supra* note 3, at 15; see *Employee Fraud*, *supra* note 13, at 1 (quoting Lori Kammerer, managing director of Californians for Compensation Reform, as saying that when businesses complained to their insurance companies about workers lying or inflating claims, they were often told that it would cost more to fight such claims than to pay them). Of the 2,500 cases investigated by the State Department of Insurance's fraud unit over its 12 year history, only 49 cases involved workers' compensation and only five were prosecuted. *Id.*

96. CURRENT PROBLEMS, *supra* note 3, at 15.

97. *Fraud Disables*, *supra* note 3, at 1 (quoting Rene Thomas Folse, a workers' compensation lawyer who represents insurers, as estimating that two sides in a dispute in California can run up \$15,000 to \$20,000 in medical-legal expenses just to dispense \$2,000 worth of benefits to the injured worker); *Employee Fraud*, *supra* note 15, at 1; CONTAINING THE COSTS, *supra* note 2, at 84.

98. *Employee Fraud*, *supra* note 13, at 1; CURRENT PROBLEMS, *supra* note 3, at 14-15.

99. *Employee Fraud*, *supra* note 13, at 1 (stating that the broadcast resulted in an increased number of investigations into workers' compensation fraud by the State Department of Insurance and the Los Angeles District Attorney).

100. *Id.*

101. *Id.*

102. *Id.*

referred to a medical clinic that performed an evaluation costing \$1,195.¹⁰³

New research regarding the relative costs of litigation versus out-of-court settlements lends encouragement to the current anti-fraud climate. While litigating fraudulent claims costs an average of \$7,000, settlement of these claims averages \$17,000.¹⁰⁴ With an average net savings of \$10,000 per claim at stake, many insurance companies are now taking a stand against suspicious claims through a variety of methods.¹⁰⁵ Over the past few years, many changes have been made to California's troubled workers' compensation system.

B. Reforming a Fraudulent System

Until recently, methods of detecting fraudulent claims practices were minimal, and denial of a claim often did not lead to further investigation.¹⁰⁶ Insurance companies usually kept only the data pertinent to processing approved claims, and information about prior claims such as the type of claim filed, the examining doctor, or the attorney representing the claimant was usually discarded.¹⁰⁷ Further, many insurance companies feared that reporting a potentially fraudulent claim would result in a bad faith lawsuit.¹⁰⁸ This passive approach to claims processing was a serious impediment to the detection of fraud.¹⁰⁹

Those familiar with the workers' compensation system have argued that insurers lack the incentive to reform fraud, since California's workers'

103. *Id.*

104. CONTAINING THE COSTS, *supra* note 2, at 84.

105. *Id.*; *see infra* notes 154-175 and accompanying text (discussing various techniques currently used by workers' compensation insurers to combat suspicious claims).

106. *Employee Fraud*, *supra* note 13, at 1; *see supra* notes 95-98 and accompanying text (discussing the indifference to fraud formerly exhibited by the workers' compensation system).

107. CURRENT PROBLEMS, *supra* note 3, at 15.

108. *Id.* The agency to which suspected fraud is reported is the Bureau of Fraudulent Claims of the Department of Insurance. CAL. INS. CODE § 1872 (West Supp. 1993) (creating the Bureau of Fraudulent Claims); *id.* § 1872.4(a) (West Supp. 1993) (empowering the Bureau of Fraudulent Claims to review and investigate each report as it deems necessary); *see infra* notes 125-153 and accompanying text (discussing the law pertinent to the Fraud Bureau of the Department of Insurance). *But see* CAL. INS. CODE § 1877.5 (West 1993) (providing civil protection to any insurer who furnishes information or assists in the investigation of acts related to workers' compensation insurance fraud as prohibited under sections 1871.1 or 1871.4 of the California Insurance Code, so long as it acts in good faith and reasonably believes the action taken was warranted by the facts known at that time); *Review of Selected 1991 California Legislation*, 23 PAC. L.J. 704-06, 709-14 (1992) (analyzing Chapters 116, 934, and 1222, which provide for increased scrutiny of suspicious insurance and workers' compensation claims, heightened penalties for insurance and workers' compensation fraud, as well as relief from civil liability for participating in the investigation of possible fraudulent claims).

109. CURRENT PROBLEMS, *supra* note 3, at 15.

compensation system has guaranteed a profit to workers' compensation insurers by allowing them to keep almost thirty-three percent of the premium dollars collected, thus ensuring that their profit and overhead costs would be covered.¹¹⁰ Claims that were paid out one year simply became the basis for higher premiums paid by employers the next year.¹¹¹ Insurance companies would benefit from any increase in premium rates, since the total pool of money from which the one-third share of guaranteed profit comes is larger.¹¹² Recent legislation has mandated that, as of January 1, 1995, this guaranteed profit system must be replaced by a competitive system.¹¹³ While there is no doubt that this will change the status quo dramatically, its consideration is largely beyond the scope of this Comment.¹¹⁴

In sum, while early settlement may appear to be the most painless way to handle a specific workers' compensation claim, the long term effect of settling the vast majority of fraudulent claims is disastrous to California's workers' compensation system because it simply encourages the filing of more fraudulent claims in order to receive settlement awards, thereby increasing premiums to employers.¹¹⁵ Various remedies have been advanced for curing California's ailing workers' compensation system, but the proposed solutions have often reflected the interests of the group offering the plan.¹¹⁶ Insurers ask for limits on the practices of unscrupulous attorneys and physicians who work together to recruit more claims, as well as for more stringent review of claims.¹¹⁷ Conversely, attorneys who represent injured workers argue for more participation in the

110. CONTAINING THE COSTS, *supra* note 2, at 13, 82 (observing that claims paid out by insurance companies become the basis for higher premium rates the next year); *see supra* notes 38-44 and accompanying text (discussing the procedure for setting the minimum premium rates which may be charged by workers' compensation insurers).

111. CONTAINING THE COSTS, *supra* note 2, at 82. *But see* Mary Lynn Vellinga, *Garamendi Says 'No' to 12.6% Hike*, SACRAMENTO BEE, Dec. 1, 1992 (denying the latest workers' compensation insurers' latest request for a rate hike because the request was based on wildly inconsistent expense ratios).

112. CONTAINING THE COSTS, *supra* note 2, at 82.

113. 1993 Cal. Legis. Serv. ch. 228, sec 2, at 1482 (enacting CAL. INS. CODE § 11735(a)).

114. *See infra* note 369 and accompanying text (positing the theory that this new competitive system increases the incentive for workers' compensation insurers to arbitrarily withhold payment of all but the most routine claims as a method of increasing profits while lowering insurance rates charged employers).

115. *See* E. Scott Reckard, *A New Policy For Insurance Fraud; The Search Is On To Catch The Fakes*, THE WASH. TIMES, Apr. 19, 1992, at A15, available in LEXIS, Nexis Library, WTIMES File (quoting Allen D. Field, head of major fraud prosecutions in Los Angeles County as saying that insurance companies are now realizing that the current practice of not contesting a \$10,000 fraudulent claim encourages five more fraudulent claims for the same thing).

116. Bradley J. Fikes, *Workers' Comp Update; Costs, Reform and Garamendi*, SAN DIEGO BUS. J., Mar. 9, 1992, § 1, at 13, available in LEXIS, Nexis Library, SDBJ File.

117. *Id.*

system, complaining that California's expensive workers' compensation system is being made a scapegoat for other economic problems, such as high unemployment, which are more appropriately attributed to the ongoing recession.¹¹⁸ Virtually every interest group admits that the workers' compensation system must be altered in order to reduce the high degree of fraud currently within the system.¹¹⁹ Yet any proposed legislation which threatens the interests of the various participants in the workers' compensation system is usually diluted by sophisticated lobbyists representing these well-financed special interest groups.¹²⁰ Despite these special interests, legislation which took effect on January 1, 1992¹²¹ is having a positive effect on the number of reports of fraud.¹²² Since investigation and prosecution of these *reports* of fraudulent practices is painstakingly slow, the question of whether the 1991 anti-fraud laws will translate into actual cost savings to the workers' compensation system through a reduction in *incidents* of fraud is likely to remain unanswered for several years.¹²³ Further, recent legislation which took effect on July 16, 1993, adds additional bite to the current anti-fraud climate.¹²⁴

118. *Id.*

119. *Fraud Disables*, *supra* note 3, at 1.

120. *Id.* (quoting Casey L. Young, administrative director of the California Division of Workers' Compensation, discussing the practice of various interest groups of hiring very effective lobbyists who fight reform legislation so that its usefulness is compromised); *see, e.g.*, WORKERS' COMPENSATION PRACTICE: USING THE NEW SYSTEM, 67 (Cal. Continuing Educ. Bar Sept./Oct. 1991) [hereinafter *New System*] (noting that heavy insurance industry lobbying was responsible for the defeat of Assembly Bill 1560 (Margolin) which would have increased the life of the Workers' Compensation Rate Study Commission, whose goal was to present a report on ways to reduce costs of the workers' compensation system); *id.* at 68 (reporting that the attorneys' lobby was able to achieve a last minute addition to the statute of amendments to CAL. LAB. CODE §§ 4903(a), 5710(b)(4), which mandated that only licensed attorneys were entitled to legal fees earned from representing clients, and predicting that hearing representatives will likely be proposing new legislation to undo these last minute changes); *supra* notes 110-112 and accompanying text (discussing the absence of incentive to reduce costs of the workers' compensation system). *But see New System*, *supra*, at 67 (noting that employer interests tried unsuccessfully to make the following changes to recent legislation changing CAL. LAB. CODE § 3208.3: (1) The requirement of clear and convincing evidence to establish a stress claim; (2) limiting recovery to stress following a sudden and extraordinary event; (3) exclusion of recovery for stress following routine personnel actions; and (4) substitution of 50% or 30% for the present requirement that 10% of the total causation from all sources which were responsible for the stress injury of a claimant were derived from events of employment).

121. *See* 1991 Cal. Stat. chs. 934, 116, 1222 (enacting and amending various sections of the CAL. INS. CODE and the CAL. LABOR CODE).

122. *Insurers Come on Strong in Probing Worker Comp Cases*, L.A. BUS. J., Aug. 31, 1992, at 1, available in LEXIS, Nexis Library, LABJ File [hereinafter *Probing Worker Comp*].

123. *Id.*

124. *See infra* notes 154-163 and accompanying text (discussing the recent changes to the California Business and Professions Code).

1. The 1991 Anti-Fraud Legislation

Prior to the enactment of the 1991 anti-fraud laws,¹²⁵ very little was being done to deter fraud in the workers' compensation system.¹²⁶ Although the Bureau of Fraudulent Claims had been created for the purpose of reviewing and investigating fraudulent insurance claims,¹²⁷ only 160 suspected cases of fraud were reported to the Fraud Bureau between 1979 and 1986.¹²⁸ By 1988, just seventeen of those cases had been investigated, and only one had been prosecuted.¹²⁹ Widespread awareness of the significant deleterious effects of fraud on California's workers' compensation system led to new legislation.¹³⁰ The 1991 anti-fraud laws take a two-pronged attack aimed at reducing fraudulent claims by requiring mandatory investigation units to ferret out violators and imposing stiffer criminal penalties for punishing the guilty culprits.¹³¹

Investigation of false claims is enhanced by the 1991 laws requiring insurers to maintain a special investigative unit whose purpose is to detect possible fraudulent claims.¹³² Also, insurers are now required to give various authorized government agencies¹³³ all relevant information that they possess regarding an investigation of possible workers' compensation

125. See 1991 Cal. Stat. chs. 934, 116, 1222 (providing stiffer penalties for those convicted of defrauding the workers' compensation system, and requiring all insurers to maintain a unit to investigate possible fraudulent claims).

126. CONTAINING THE COSTS, *supra* note 2, at 82.

127. See CAL. INS. CODE § 1872 (West 1993) (creating the Bureau of Fraudulent Claims); § 1872.4(a) (West 1993) (empowering the Bureau of Fraudulent Claims to review and investigate each report as it deems necessary).

128. CONTAINING THE COSTS, *supra* note 2, at 82.

129. CURRENT PROBLEMS, *supra* note 3, at 14.

130. See *supra* notes 99-103 and accompanying text (providing an example of the growing public awareness of fraud which has led to the enactment of Chapters 934, 116 and 1222).

131. See *infra* notes 132-146 and accompanying text (discussing the laws which require the formation of investigative units by insurers, and provide for more severe penalties for fraud and misrepresentation in the workers' compensation system; *New System*, *supra* note 120, at 68 (noting that provisions to discourage overreaching by attorneys, doctors, and others were already in effect prior to the new legislation, but that, in some instances, what had formerly been accepted as normal competitive business practices to obtain clients or to achieve an adequate award for a client may now be grounds for investigation and prosecution).

132. CAL. INS. CODE § 1875.20 (West 1993). All insurers were required to establish the investigative unit by July 1, 1992. *Id.* § 1875.22 (West Supp. 1992); see Kathy M. Kristof, *Workers' Comp Reform Unveiled By Garamendi*, L.A. TIMES, Jan. 25, 1992, § D at 1, available in LEXIS, Nexis Library, LAT File (quoting Insurance Commissioner John Garamendi as saying that the new law is designed to target doctors, attorneys, and medical care workers who encourage the filing of fraudulent workers' compensation claims).

133. See CAL. INS. CODE § 1877.1(a) (West 1993) (defining authorized governmental agency as the district attorney of any county, the office of the Attorney General, the Department of Insurance, the Department of Industrial Relations, and any licensing agency governed by the Business and Professions Code).

insurance fraud.¹³⁴ Employers are assessed a fee to pay for the investigation and prosecution of violators.¹³⁵ This augmented program for rooting out violators of the workers' compensation system is accompanied by heightened penalties for those convicted of defrauding the workers' compensation system.¹³⁶

Criminal penalties for defrauding the workers' compensation system have been increased in an effort to discourage fraudulent and abusive practices.¹³⁷ The act of intentionally misrepresenting a fact for the purpose of obtaining workers' compensation insurance at an improperly low rate was formerly a misdemeanor, however section 11760 of the California Insurance Code now allows for a felony conviction for this type of misrepresentation, providing for up to five years imprisonment or a fine of up to \$50,000, or double the value of the fraud, whichever is greater.¹³⁸ Advertisements which pertain to industrial injuries or illnesses that are false or misleading with respect to workers' compensation are now prohibited.¹³⁹ While cappers and runners who procure claimants for

134. See *id.* § 1877.3(a)-(b) (West 1993) (mandating that the governmental agency provide the insurer with a written request for the desired information, and absent such a request, imposing the duty on insurers to notify the Bureau of Fraudulent Claims of the Department of Insurance if they have any knowledge or reasonable belief that a fraudulent act has been committed). Any information given to an authorized governmental agency must be kept confidential by that agency, may only be confidentially released to other authorized governmental agencies for the purposes of investigation, prosecution, or prevention of insurance fraud, and may not be made part of the public record. *Id.* §§ 1877.3(c), 1877.4(a) (West 1993); see also *id.* § 1877.1(b) (West 1993) (defining relevant as having a tendency to make the existence of any fact that is of consequence to the investigation or determination of an issue more probable or less probable than it would be without the information).

135. See CAL. LAB. CODE § 62.6 (West Supp. 1993) (authorizing the establishment of the State Fraud Investigation and Prosecution Surcharge, from which revenues are deposited in the Workers' Compensation Fraud Account in the Insurance Fund to be used for the investigation and prosecution of workers' compensation fraud as prescribed by California Insurance Code § 1872.83); CAL. INS. CODE §§ 1877-1877.5 (West 1993) (creating the Workers' Compensation Insurance Fraud Reporting Act and establishing criteria by which insurers are required to report workers' compensation insurance fraud). The justification for this mandatory assessment is the explicit legislative finding that workers' compensation fraud contributes to the increasing costs of workers' compensation, and that prevention of this fraud may reduce the number of workers' compensation claims and payments, ultimately reducing the costs of the entire system. *Id.* § 1871(d)-(f) (West 1993); see also *Review of Selected 1991 California Legislation*, 23 PAC. L.J. 709, 712 (1992) (contrasting pre-1992 law with the current law relating to the handling of fraudulent workers' compensation claims brought about by the enactment of the Workers' Compensation Insurance Fraud Reporting Act); *infra* notes 145-153 and accompanying text (discussing Chapters 116, 934, and 1222, and their effectiveness in reducing workers' compensation fraud).

136. See CAL. INS. CODE §§ 11760(a), 11880(a) (West Supp. 1993); *infra* notes 135-140 and accompanying text.

137. See *Review of Selected 1991 California Legislation*, 23 PAC. L.J. 704-06, 709-14 (1992) (reviewing the changes brought about by 1991 California Statute Chapters 116, 934, and 1222).

138. CAL. INS. CODE §§ 11760(a), 11880(a) (West Supp. 1993). A person who violates sections 11760(a) or 11880(a), and has a prior felony conviction under the same subdivision is subject to a two-year enhanced sentence for each prior conviction. *Id.* §§ 11760(b), 11880(b). Extreme violations can result in both imprisonment and a fine. *Id.* § 11760(a) (West Supp. 1993).

139. CAL. LAB. CODE § 139.45 (West Supp. 1993).

doctors or attorneys, as well as those employing them, are only subject to misdemeanor penalties,¹⁴⁰ the stakes escalate dramatically with a subsequent conviction.¹⁴¹ Repeat offenses are felonies, and can be punished by up to three years in prison as well as a fine of up to \$10,000.¹⁴²

Section 1871.4 of the California Insurance Code imposes severe penalties for making false or fraudulent written or oral statements to either obtain or deny compensation.¹⁴³ However, section 1871.4 acts as a double-edged sword because it applies to both sides of the system: to those who make fraudulent statements for the purpose of *obtaining* compensation from insurers,¹⁴⁴ and to employers and insurers who make fraudulent statements in an effort to *deny* compensation to claimants.¹⁴⁵ While these heightened criminal penalties, along with the new mandatory reporting of suspicious claims, indicate a significant alteration in California's approach to workers' compensation fraud, the initial effectiveness of these penalties in reducing the amount of fraud in the workers' compensation system has been questionable.¹⁴⁶

Although it is still somewhat premature to judge the long-term effectiveness of the 1991 anti-fraud laws because of their relative newness,

140. CAL. BUS. & PROF. CODE § 2315(a) (West Supp. 1993) (setting forth the punishment for those found guilty of employing persons to procure patients); *id.* § 6152(a)(1)-(2) (West 1990) (making it unlawful for a person to either work as a runner or capper, or to solicit others to work as a runner or capper); *id.* § 6153 (West Supp. 1993) (providing the penalty for conviction under California Business and Professions Code § 6152).

141. See *infra* note 142 and accompanying text.

142. CAL. BUS. & PROF. CODE § 2315(b) (West Supp. 1993) (providing for a maximum penalty of 3 years in prison and a \$10,000 fine upon a second or subsequent conviction of employment of runners and cappers, in violation of California Business and Professions Code § 2273); *id.* § 6153 (West Supp. 1993) (providing the same penalty for conviction of working as a runner or capper, in violation of California Business and Professions Code § 6152).

143. CAL. INS. CODE § 1871.4(a)-(c) (West Supp. 1993). Violators of this section can be imprisoned for up to five years, and be fined up to \$50,000, or double the value of the fraud, whichever is greater. *Id.* § 1871.4(b) (West Supp. 1993).

144. Examples of such claimants are patients, medical clinics, and attorneys.

145. CAL. INS. CODE § 1871.4(a)(4) (West 1992). Violations are punishable by imprisonment in county jail for one year, or in state prison for up to five years. *Id.* § 1871.4(b) (West 1992). In lieu of a prison sentence, a fine may be imposed for up to \$50,000 or double the value of the fraud, whichever is greater. *Id.* Extreme violations can result in both imprisonment and fine. *Id.* Any person who has a prior felony conviction under California Insurance Code § 1871.4(a), or of former § 1871.1 of the California Insurance Code, or of sections 548 or 550 of the California Penal Code, will receive a two year enhancement for each prior conviction. *Id.* § 1871.4(c) (West 1992); see *infra* notes 370-373 and accompanying text (suggesting that the Legislature enact a statutory treble damages penalty which is imposed on insurance companies who fraudulently withhold payment of claims).

146. See Hallye Jordan, *Funds Sought to Fight Comp Fraud*, LOS ANGELES DAILY J., June 17, 1992, at 3 [hereinafter *Funds Sought*]; *infra* notes 145-153 and accompanying text (discussing the marginal effectiveness of the 1991 anti-fraud laws).

one trend has become evident: The number of reported instances of suspected fraud has increased dramatically.¹⁴⁷ The dismal number of reported instances of fraud prior to 1992¹⁴⁸ was eclipsed within the first three months of 1992, when 977 cases of suspected fraud were reported.¹⁴⁹ This number grew to almost 4,000 reported instances of suspected fraud by mid-year.¹⁵⁰ Critics of the new anti-fraud program were not impressed by this rise in the number of reports of suspected fraud, and complained that these reports did not translate into an actual reduction in the amount of fraud plaguing the workers' compensation system.¹⁵¹ In fact, state investigators and local prosecutors claimed that the new program was almost totally ineffective.¹⁵² Even the State Insurance Commissioner has admitted that fraud has only been reduced by two percent since the new anti-fraud laws went into effect.¹⁵³ Perhaps the biggest obstacle facing the new anti-fraud program has been insufficient funding.¹⁵⁴ The tremendous number of fraud reports received by the Fraud Bureau averaged 100 calls per day by mid-1992, creating a tidal wave of paperwork which virtually swamped investigators and hampered their effectiveness.¹⁵⁵ New legislation has expanded the sources of available funds with which to prosecute those who are abusing the workers' compensation system.

2. *Using Dirty Money to Clean Up the Workers' Compensation System*

Legislation which took effect on July 16, 1993 attempts to address prosecutors' complaints of insufficient funding to fight fraud within the workers' compensation system.¹⁵⁶ Section 6154 of the California

147. CONTAINING THE COSTS, *supra* note 2, at 83-84.

148. Only 160 suspected cases of fraud were reported between 1979 and 1986. CONTAINING THE COSTS, *supra* note 2, at 82.

149. *Funds Sought*, *supra* note 146, at 1.

150. *Id.*

151. *Funds Sought*, *supra* note 146, at 1.

152. *See id.* (stating that common complaints of investigators and prosecutors are that the system was poorly conceived and badly underfunded).

153. CONTAINING THE COSTS, *supra* note 2, at 83.

154. *See id.* at 84 (reporting that the program's original \$3,000,000 appropriation was insufficient and needed an additional \$10,000,000). The legislature responded by adding an additional \$7,000,000 to the program. *Id.*

155. *Id.*

156. *See supra* note 152 and accompanying text (noting the lack of financial resources available to prosecutors).

Business and Professions Code expands the sources of funds available to district attorneys' offices.¹⁵⁷ The income of an attorney which was earned through the use of runners or cappers can now be seized and used by the prosecuting district attorney to investigate and prosecute fraud.¹⁵⁸ Further, section 6154 expressly voids any contracts for professional services which were obtained under fraudulent circumstances, provides for the recovery of any fees collected under such a contract, and mandates that these fees go to the prosecuting district attorney's office.¹⁵⁹ It is still too early to tell whether these changes will yield funds sufficient to bring the number of prosecutions to a level which corresponds with the number of reports of fraud.

California now allows any interested party to bring a civil action, in the name of the State, for the crime of employing runners or cappers to procure workers' compensation applicants.¹⁶⁰ The Attorney General or district attorney can intervene in this type of action, and take responsibility for prosecution of the suit.¹⁶¹ Because the action is brought in the name of the state, it can only be dismissed if the court and the Attorney General acquiesce in the dismissal.¹⁶² While this ability to bring a civil suit for employing runners or cappers will assist in reducing this fraudulent practice, its narrowness does not address the entire spectrum of means by which fraud impacts the workers' compensation system.¹⁶³ Many insurance companies have been resorting to various methods of combatting the types of fraud which are not addressed by these recent changes in the law.¹⁶⁴

157. 1993 Cal. Legis. Serv. ch. 120, sec. 2, at 1046 (enacting CAL. BUS. & PROF. CODE § 6154(b)) (providing that one-half of any penalty collected by a district attorney for the unlawful employment of a runner or capper is paid to the county treasurer of the county in which the judgment was entered, and one-half of the penalty is paid to the Workers' Compensation Fraud Account in the Insurance Fund).

158. *Id.*

159. *See id.* (enacting CAL. BUS. & PROF. CODE § 6154(a)).

160. *See* Cal. Legis. Serv. ch. 120, sec. 3.2, at 1048 (enacting CAL. INS. CODE § 1871.7(d)-(e)).

161. *See id.*, sec. 3.3, at 1048 (enacting CAL. INS. CODE § 1871.7(e)(2)).

162. *See id.* (enacting § 1871.7(e)(1)). If the Attorney General or the district attorney choose to intervene in the action, they may elect to dismiss the suit notwithstanding the objections of the person initiating the action. *See id.* (enacting § 1871.7(f)(2)(A)).

163. *See supra* notes 50-89 and accompanying text (discussing the various types of fraud, other than employing runners, cappers, and steerers, employed by medical clinics and attorneys).

164. *See infra* notes 165-173 and accompanying text.

C. A New Trend in Fighting Workers' Compensation Fraud

Several major insurance companies have assumed aggressive stances towards workers' compensation fraud, adopting various tactics to defeat the large number of fraudulent claims submitted by so called workers' compensation mills.¹⁶⁵ For instance, Transamerica Insurance Group's special fraud investigation unit has been saving the company approximately \$1 million per month by identifying suspicious claims and simply refusing to pay them.¹⁶⁶ Such a refusal to pay forces the fraudulent mills into the public eye by filing suit, or appealing to the State Workers' Compensation Appeals Board.¹⁶⁷ The Kemper Insurance Company has begun subpoenaing records from suspected fraudulent medical clinics.¹⁶⁸ In one case alone, this tactic forced a medical clinic to dismiss \$56,000 in suspicious medical liens.¹⁶⁹

A novel anti-fraud tactic with potentially far-reaching implications has been adopted by Zenith Insurance Company ("Zenith"): Use of the Racketeer Influenced and Corrupt Organization Act (RICO).¹⁷⁰ This tactic circumvents the prohibitive cost of litigating each suspicious claim in a separate action.¹⁷¹ Instead, Zenith was able to consolidate all of the claims submitted by a suspected workers' compensation mill into one civil

165. See, e.g., *Fremont Comp Launches Aggressive Anti-Fraud Campaign*, BUS. WIRE, Jan. 21, 1992, available in LEXIS, Nexis Library, BWIRE File (discussing Fremont Compensation Insurance Company's aggressive anti-fraud campaign based on deterrence and support of aggressive prosecution); *Fremont Anti-Fraud Campaign Leads To First Criminal Indictments*, BUS. WIRE, Apr. 22, 1992, available in LEXIS, Nexis Library, BWIRE File (reporting on an indictment of a medical clinic and workers' compensation claimant for insurance fraud under the new anti-fraud legislation). Fremont Comp has reported dozens of cases for review to several district attorneys and has been working intimately with the State Bureau of Fraudulent Claims as well as district attorneys' offices in investigating fraud. *Id.*; see also *Garamendi Announces Insurance Fraud Bust; Key Suspect In Major Workers Compensation Fraud Case Arrested*, BUS. WIRE, Apr. 19, 1992, available in LEXIS, Nexis Library, BWIRE File (reporting on the indictment of Jorge Coronado, owner of a business called Spanish Marketing, which is estimated to have cost California businesses over \$100 million in just 18 months through the processing of fraudulent workers compensation insurance claims). Coronado's arrest was the result of an investigation that produced nine arrests in April under the new anti-fraud laws. *Briefly: Insurance*, L.A. TIMES, Aug. 20, 1992, at D2, available in LEXIS, Nexis Library, LAT File.

166. *Probing Worker Comp*, *supra* note 122, at 1 (reporting that Transamerica found that 10 medical clinics using 120 different names had accounted for 40 percent of the company's total gross workers' comp billings in 1991).

167. *Id.*

168. *Id.*

169. *Id.*

170. 18 U.S.C. §§ 1961-1868.

171. See *supra* notes 104-105 and accompanying text (noting that the litigation of fraudulent claims costs an average of \$7,000).

RICO action.¹⁷² In late 1991, Zenith filed a civil RICO suit in United States District Court, Central District of California¹⁷³ against Wellington Medical Corporation and other medical care providers, attorneys, and workers' compensation claimants ("Wellington").¹⁷⁴ Wellington subsequently filed a countersuit against Zenith and other insurance companies alleging antitrust violations.¹⁷⁵ These suits were ultimately settled out-of-court, with Wellington agreeing to dismiss the antitrust suit, and to drop more than \$1.6 million in workers' compensation claims.¹⁷⁶ While these suits were still pending, Zenith brought several more civil RICO suits against other workers' compensation mills.¹⁷⁷ This method of consolidating fraudulent claims into one civil RICO suit has proven to be a cost-effective means for insurers to fight fraud in the workers' compensation system.¹⁷⁸ Nevertheless, this powerful weapon which tips the balance of power in favor of the insurance companies may be

172. See *infra* notes 245-254 and accompanying text (discussing the concept of a pattern of racketeering activity, which is an essential element of a civil RICO suit).

173. In order to bring a RICO suit, Zenith had to sue in federal court because California's state law equivalent of federal RICO, known as a "little RICO" statute, does not provide for a private cause of action. CAL. PENAL CODE §§ 186-186.7 (West 1988 & Supp. 1993); see *infra* notes 368-371 and accompanying text (suggesting that California enact a "little RICO" statute that provides for a private cause of action).

174. *Zenith Complaint*, *supra* note 19, at 7-29 (alleging that various medical care providers have engaged in RICO violations through fraudulent and/or excessive billing practices). In the interest of clarity, the defendants in the Zenith suit will be referred to collectively as "Wellington," however the full list of defendants is as follows: American Psychometric Consultants, Inc.; Robert S. Ransom, David Leonelli; Wellington Medical Corporation; Timothy Fishback; Hoseyn Safai; Glen A. Lintner (individual); Glen A. Lintner (law firm); Yolanda N. Arriola; A&W Interpreting Services; Jesus Ayala; Bulmaro Cabrera; Jose Cabrera; Manuel Cabrera; and Santos Cabrera. *Id.*, at 1.

175. See *Princeton Complaint*, *supra* note 20, at 7-12 (alleging illegal agreements between various insurance companies and employers to avoid paying workers' compensation obligations). In the interest of clarity, the plaintiffs in the *Princeton v. Zenith* antitrust suit will be referred to collectively as "Wellington," which is also the referenced defendant in the *Zenith Insurance Company v. American Psychometric Consultants, Inc.* suit. The complete list of plaintiffs is as follows: Princeton Medical Corporation; Wellington Medical Corporation; American Assessment Medical Corporation; California Comp Care Medical Corporation; and Professional Consultation Services, Inc. *Id.*, at 1. See also 15 U.S.C.S. § 1 (1985 & Supp. 1993) (§ 1 of the Sherman Act); 15 U.S.C.S. § 15 (1985) (§ 4 of the Clayton Act); 15 U.S.C.S. § 26 (1991) (§ 16 of the Clayton Act) (setting forth the various antitrust laws which Zenith is alleged to have violated).

176. See *infra* notes 352-360 and accompanying text (discussing the settlement terms of the *Zenith* suit).

177. See *Zenith Insurance Files Its Fourth RICO Action Against Alleged Abusers of The Workers' Compensation System*, BUS. WIRE, Oct. 20, 1992, available in LEXIS, Nexis Library, BWIRE File.

178. The use of civil RICO has also been used to effectively fight employer fraud within the workers' compensation system. Last year, the State Compensation Insurance Fund won a civil RICO suit against a fraudulent employee leasing company who had misrepresented the ownership of several businesses and failed to report full payroll in an effort to avoid paying their fair share of workers' compensation premiums. See *RICO Suit Judgement in Workers' Comp Fraud Case; State Fund Prevails in Federal Suit Against Fraud Ring*, BUS. WIRE, June 25, 1992, available in LEXIS, Nexis Library, BWIRE File.

introducing new dangers into the workers' compensation system.¹⁷⁹ A close look at the policies behind RICO and related antitrust laws reveals vast differences in their application to California's workers' compensation system.

II. THE CONFLICTING POLICIES OF CIVIL RICO AND ANTITRUST LAWS

The Racketeer Influenced and Corrupt Organizations Act¹⁸⁰ is relatively new, and has been constantly expanding since its inception in 1970.¹⁸¹ A summary of RICO's background shows that the use of RICO in fighting workers' compensation fraud is a logical and significant expansion of this civil cause of action.¹⁸² Conversely, antitrust law has borne an extensive body of case law, extending back more than five centuries.¹⁸³ An examination of the background of these two civil causes of action highlights the effectiveness of the civil RICO suit in combatting workers' compensation mills, and underscores the relative difficulty that a medical care provider would have in attempting to prove violations of antitrust laws by workers' compensation insurance companies.¹⁸⁴

179. See *infra* notes 365-366 and accompanying text (discussing the relatively minimal risk of liability to treble damage suits which workers' compensation insurers enjoy in relation to medical care providers).

180. 18 U.S.C.S. §§ 1961-68 (1991 & Supp. 1993).

181. GREGORY P. JOSEPH, CIVIL RICO: A DEFINITIVE GUIDE at 3 (1992).

182. See *infra* notes 185-256 and accompanying text (providing a very brief summary of the RICO Act).

183. *Dyer's Case*, Y.B. Pasch. 2 Hen. V, f. 5, pl. 5 (1414) (voiding an agreement between a master and his indentured servant, in which the servant, upon completing his term of apprenticeship, has promised not to use his art for half a year).

184. See *infra* notes 257-304 and accompanying text (discussing the complexities of proving antitrust violations by an insurer). A medical care provider seeking treble damages against an insurer who is defrauding the workers' compensation system would be relegated to an antitrust claim, since, under California law, insurers are exempt from liability for violations of the federal RICO statute. *American International Group, Inc. v. Superior Court*, 234 Cal. App. 3d 749, 767, 285 Cal. Rptr. 765, 776 (1991). See *infra* notes 207-215 and accompanying text (discussing the *American Int'l. Group, Inc. v. Superior Court* decision, finding that extensive state regulations of the insurance industry precluded liability under federal RICO laws).

A. The Expansive Policy of the Racketeer Influenced and Corrupt Organizations Act

The Racketeer Influenced and Corrupt Organizations Act (RICO)¹⁸⁵ was included within the Organized Crime Control Act of 1970 (OCCA).¹⁸⁶ The OCCA was part of the government's war against the infiltration of organized crime into America's legitimate business community.¹⁸⁷ Therefore, the original RICO bill before the United States Senate was based primarily on criminal law, limiting civil remedies to injunctive actions brought by the federal government.¹⁸⁸ The RICO statute's statement of findings expressly called for broad and liberal interpretation of RICO in order to more effectively fight the serious threat posed by organized crime.¹⁸⁹ Shortly before the House of Representatives approved the RICO bill, they added a treble damages remedy patterned after Section Four of the Clayton Act,¹⁹⁰ an antitrust statute.¹⁹¹ This treble damages remedy was intended to be a civil remedy for those who

185. 18 U.S.C. §§ 1961-68 (1991 & Supp. 1993). RICO was enacted as Title IX of the Organized Crime Control Act of 1970. Pub. L. No. 91-452, 84 Stat. 922, 941 (1970). *See generally* JOSEPH, *supra* note 181 (providing a comprehensive guide to civil actions under RICO, and reporting on opinions of the United States Supreme Court and federal courts of appeals dealing with civil RICO litigation); DOUGLAS E. ABRAMS, *THE LAW OF CIVIL RICO* (1991 & 1992 Supp.) [hereinafter ABRAMS]; Douglas E. Abrams, *Civil RICO's Cause of Action: The Landscape After Sedima*, 12 TUL. MAR. L.J. 19 (1987) [hereinafter *Landscape*]; Douglas E. Abrams, *The Place of Procedural Control in Determining Who May Sue or Be Sued: Lessons in Statutory Interpretation from Civil RICO and Sedima*, 38 VAND. L. REV. 1477 (1985); PAUL A. BATISTA & MARK S. RHODES, *CIVIL RICO PRACTICE MANUAL: 1992 CUMULATIVE SUPPLEMENT NO. 2* (1992)).

186. Organized Crime Control Act of 1970, Pub. L. No. 91-452, § 904, 84 Stat. 922 (codified as amended in §§ 18, 28 U.S.C. (1982 & Supp. IV 1986)).

187. JOSEPH, *supra* note 181, at 2-3; Pub. L. No. 91-452, 84 Stat. at 943 (1970).

188. *Id.* at 2-3.

189. Pub. L. No. 91-452, § 904, 84 Stat. 947 (1970); *see* JOSEPH, *supra* note 181, at 3 (citing various cases which differ in their interpretation as to how far to expand the limits of civil litigation under RICO); 1970 U.S. Code Cong. & Admin. News 1073 (setting forth in the statement of findings that the purpose of RICO is to eradicate organized crime). *See generally* Note, *RICO and the Liberal Construction Clause*, 66 CORNELL L. REV. 167 (1980).

190. 15 U.S.C.S. § 15 (1985) (codifying § 4 of the Clayton Act, which provides the remedy of treble damages, the cost of the suit, and reasonable attorney's fees to any person who has been injured in his business or property by any action forbidden in the antitrust laws).

191. JOSEPH, *supra* note 181, at 2-3; *see* 18 U.S.C. § 1964(c) (stating that any person injured in his business or property by reason of a violation of section 1962 of this chapter may sue therefor in any appropriate United States district court and shall recover threefold the damages he sustains and the cost of the suit, including a reasonable attorney's fee); H.R. 1549, 91st Cong., 2d Sess., 116 Cong. Rec. 35,363-64 (1970) (amending the bill to include a treble damages remedy similar to section 4 of the Clayton Act); 116 Cong. Rec. 36,296 (1970) (approving the amendment adding a treble damages remedy).

had been injured by reason of criminal activity prohibited by the bill.¹⁹² Because of the legislative intent underlying the inclusion of the civil RICO remedy, early court decisions of civil RICO suits required a criminal conviction under RICO as a prerequisite for bringing a civil suit. Such a requirement is no longer the case.¹⁹³ Despite the statute's explicit mandate for broad interpretation of RICO, some scholars have theorized that the lateness of this addition of a civil remedy to the RICO Act precluded Congress from fully contemplating the extent to which the plaintiff pool would be expanded.¹⁹⁴ Nevertheless, the reach of civil RICO is continually expanding, and has been used against such diverse defendants as Big Eight accounting firms,¹⁹⁵ banks,¹⁹⁶ colleges,¹⁹⁷ insurance companies,¹⁹⁸ law firms,¹⁹⁹ and securities investment firms,²⁰⁰ as well as controversial organizations such as the Church of Scientology²⁰¹ and the Ku Klux Klan.²⁰²

192. JOSEPH, *supra* note 181, at 2-3; Sweeney, *An Introduction To RICO*, 12 TUL. MAR. L.J. 7, 9-10 (1987) (noting that civil RICO was intended to help reform corrupt organizations, and the civil remedy was meant to be used *after* successful criminal prosecution). In 1977, the United States Supreme Court held that plaintiffs must prove injury of the type the antitrust laws were designed to prevent in order to have civil RICO standing. *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 489 (1977). While more recent decisions have not adhered to this narrow view, RICO's resemblance to the Clayton Act still prompts many courts to consider antitrust caselaw under the Clayton Act in deciding RICO lawsuits. See *Agency Holding Corp. v. Malley-Duff & Assoc., Inc.*, 483 U.S. 143, 156 (1987); *Shearson/American Express, Inc. v. McMahon*, 482 U.S. 220, 241 (1987) (relying on the Clayton Act for guidance in interpreting the RICO statute).

193. *Sedima v. Imrex*, 473 U.S. 479, 491 (1985) (noting that the burden of proof necessary for criminal conviction is proof beyond a reasonable doubt, while the lesser preponderance standard is all that is needed for civil sanctions). There is no evidence that Congress intended to impose a higher burden of proof on civil RICO actions, therefore, absence of a criminal conviction does not preclude a civil cause of action under the less onerous burden of proof. *Id.* at 491; see Sweeney, *supra* note 192, at 9-10 (noting that civil RICO was intended to help reform corrupt organizations, and the civil remedy was meant to be used only after successful criminal prosecution).

194. JOSEPH, *supra* note 181, at 3. This lack of opportunity for complete forethought is the most likely explanation for the dramatic and unexpected variety of civil RICO defendants who are not typically associated with professional criminals. *Id.*; *Landscape*, *supra* note 185, at 22-23; see *Abrams*, *supra* note 185, at 25-37 (discussing the legislative history of Civil RICO). Note that many states have enacted "little RICO" statutes patterned on federal RICO. See RICO CASES COMMITTEE, A COMPREHENSIVE PERSPECTIVE ON CIVIL AND CRIMINAL RICO LEGISLATION AND LITIGATION App. C (ABA Crim. Just. Syst., Apr. 18, 1985) (providing the text of the Federal RICO statute and comparing it with the following state RICO statutes: Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Nevada, New Jersey, New Mexico, North Dakota, Oregon, Pennsylvania, Rhode Island, Utah and Wisconsin). Unlike most states, California has no private cause of action. CAL. PEN. CODE § 186-186.7 (West 1988 & Supp. 1993).

195. See, e.g., *Bank of Am. Nat'l Trust & Savs. Ass'n v. Touche Ross & Co.*, 782 F.2d 966 (11th Cir. 1986).

196. See, e.g., *Wilcox v. First Interstate Bank*, 815 F.2d 522 (9th Cir. 1987).

197. See, e.g., *Robinson v. City Colleges of Chicago*, 656 F. Supp. 555 (N.D. Ill. 1987).

198. See, e.g., *Agency Holding Corp. v. Malley-Duff & Assocs.*, 107 S. Ct. 2759 (1987).

199. See, e.g., *Penturelli v. Spector, Cohen, Gadon & Rosen*, 640 F. Supp. 868 (E.D. Pa. 1986).

200. See, e.g., *Shearson/Am. Express, Inc. v. McMahon*, 107 S. Ct. 2332 (1987).

201. See, e.g., *Van Schaick v. Church of Scientology, Inc.*, 535 F. Supp. 1125 (D. Mass. 1982).

The criminal law origin of the civil RICO cause of action has induced a judicial reluctance to limit the types of conduct giving rise to civil RICO actions due to concern that any limitation on RICO for civil actions might create a similar limiting precedent for criminal RICO prosecutions of organized crime.²⁰³ Such a limiting precedent could compromise RICO's ability to do the very job for which it was intended.²⁰⁴ The result has been a judicial trend of giving very wide berth to civil RICO actions devoid of organized crime implications.²⁰⁵ Contrary to the expansive trend of civil RICO, a recent California Court of Appeal decision places a limitation on the civil RICO cause of action which directly impacts California's workers' compensation system.²⁰⁶

In 1991, the California Court of Appeal for the Second District affirmed a lower court decision that federal antitrust laws precluded insurance companies from being sued under the federal RICO Act.²⁰⁷ In *American International Group, Inc. v. Superior Court*,²⁰⁸ it was alleged that a defendant insurer, American International Group, violated the RICO Act by perpetrating a fraudulent scheme to avoid paying premium refunds to its clients.²⁰⁹ The appellate court held that, under the McCarran-Ferguson Act,²¹⁰ the insurance industry is to be regulated primarily by the states, and not the federal government.²¹¹ Because California already

202. See, e.g., *Vietnamese Fishermen's Ass'n v. Knights of the Ku Klux Klan*, 543 F. Supp. 198 (S.D. Tex. 1982); see generally *Landscape*, *supra* note 185, at 22-23 (discussing the expansion of civil RICO litigation to maritime actions and citing additional examples of civil RICO suits against a variety of defendants not normally associated with organized crime).

203. JOSEPH, *supra* note 181, at 3-4.

204. *Id.*

205. See *Landscape*, *supra* note 185, at 22-23 (noting that, as of 1985, only nine percent of the 270 district court civil RICO decisions involved allegations of criminal activity of a type generally associated with professional criminals). Although case law largely supports expansive application of RICO, there are still inconsistencies in judicial interpretation of the proper breadth of RICO. See, e.g., JOSEPH, *supra* note 181, at 3 (comparing *Grider v. Texas Oil & Gas Corp.*, 868 F.2d 1147 (10th Cir. 1989), and *Quaknine v. McFarlane*, 897 F.2d 75 (2d Cir. 1990) (rejecting the argument that a liberal interpretation of RICO mandates an expansion of section 1962(a) beyond the "investment use" requirement for standing) with *Busby v. Crown Supply, Inc.*, 896 F.2d 833 (4th Cir. 1990) (accepting the argument that a liberal interpretation of RICO mandates expansion of RICO beyond the "investment use" requirement for standing).

206. See *infra* notes 367-368 and accompanying text (discussing the ramifications of this limitation of the civil RICO cause of action).

207. *American Int'l Group, Inc. v. Superior Court*, 234 Cal. App. 3d 749, 768, 285 Cal. Rptr. 765, 777 (1991).

208. 234 Cal. App. 3d 749, 285 Cal. Rptr. 765 (1991).

209. *Id.*

210. 15 U.S.C.S. §§ 1011-1015 (1984).

211. 234 Cal. App. 3d at 768, 285 Cal. Rptr. at 777 (holding that RICO does not specifically relate to the business of insurance, and therefore does not come within the exception set out in 15 U.S.C. § 1012(b)). This exception states that no Act of Congress may invalidate, impair, or supersede any State law which regulates the

had an extensive statutory scheme of regulating the insurance industry,²¹² including a section which expressly prohibited the conduct which was asserted by the plaintiff,²¹³ the court refused to allow the federal RICO Act to supersede state law.²¹⁴ The court cited section 1012(b) of the McCarran-Ferguson Act, which states that no act of Congress may supersede any state law for the purpose of regulating the business of insurance (unless the Act specifically relates to the business of insurance).²¹⁵ The federal RICO Act does not specifically relate to the business of insurance, so the only remedies available to the plaintiff were either administrative proceedings authorized by state law, or common law actions.²¹⁶ The result of this decision is a legal one-way street: workers' compensation insurers can use civil RICO to their advantage in fighting fraudulent workers' compensation claims, yet are themselves immune from civil RICO liability if they fraudulently withhold payment of workers' compensation claims.

Bringing a Civil Action Under RICO

Section 1964(c) of Title 18 of the United States Code creates the civil RICO cause of action and gives federal courts jurisdiction to hear civil RICO cases.²¹⁷ Any person²¹⁸ who is injured in the person's business

business of insurance unless the Act specifically relates to the business of insurance. 15 U.S.C. § 1012(b).

212. See generally CAL. INS. CODE. (setting forth the regulations which govern California's insurance industry).

213. See CAL. INS. CODE § 790.03 (West Supp. 1993).

214. American Int'l Group, Inc. v. Superior Court, 234 Cal. App. 3d 749, 768, 285 Cal. Rptr. 765, 777 (1991). The Court employed a four-step analysis to determine if McCarran-Ferguson barred the application of a federal statute: (1) Does RICO specifically relate to the business of insurance? (2) Do defendant's activities constitute the business of insurance for purposes of McCarran-Ferguson? (3) If so, then has California enacted any laws for the purpose of regulating such activities? (4) If so, would the application of RICO invalidate, impair or supersede such laws? *Id.* at 758, 771. See *infra* notes 267-272 and accompanying text (discussing the McCarran-Ferguson Act).

215. *American Int'l Group, Inc.*, 234 Cal. App. 3d at 768, 285 Cal. Rptr. at 777; 15 U.S.C.S. § 1012(b) (1984).

216. *Id.* at 768, 285 Cal. Rptr. at 777. The American International Group Court did not specifically mention an antitrust suit as an available cause of action, however, an antitrust suit such as the Wellington Complaint is possible because the antitrust exemption enjoyed by the insurance industry is only partial. See *infra* notes 266-272 and accompanying text (discussing the partial exemption of the insurance industry to antitrust laws).

217. 18 U.S.C. § 1964(c) (1991). See generally JOSEPH, *supra* note 181, at 5-22 (providing a complete analysis of jurisdiction and venue for both state and federal civil RICO actions). Consistent with the underlying liberal construction given RICO, the United States Supreme Court has recently ruled that state courts have concurrent jurisdiction over civil RICO claims, reasoning that giving state courts the power to hear RICO claims promotes the legislature's intent that RICO be broadly used to fight organized crime. *Id.* at 9 (citing *Tafflin v. Levitt*, 493 U.S. 455, 464 (1990)); see *id.* at 9-18, 149-150 (discussing various issues raised by concurrent state

or property by conduct prohibited under the RICO Act can sue in federal district court for treble damages and the cost of the suit, including a reasonable attorney's fee.²¹⁹ There are three required elements for stating a civil RICO claim.²²⁰ The plaintiff must have suffered: (1) *Injury in its business or property* because the defendant, (2) while involved in one or more enumerated relationships with an *enterprise*,²²¹ (3) engaged in a *pattern of racketeering activity*.²²² These three elements of a civil RICO suit are comprised of identifiable components which, in order to properly plead a civil RICO suit, must be distinguishable.²²³ Aside from pleading an injury, the plaintiff must also distinguish as *separate* entities the person who is the defendant, the unlawful enterprise, and the pattern of racketeering activity. Simply put, the defendant is not the unlawful enterprise, but is a distinct entity who has merely associated with the enterprise.²²⁴ Similarly, the enterprise is not the pattern of racketeering activity, even though the enterprise and the pattern are often established by the same evidence.²²⁵ The interrelationships between these three

and federal jurisdiction, such as removal, remand, abstention, arbitration and collateral estoppel).

218. See 18 U.S.C. 1961(3) (1991) (defining person as including any individual or entity capable of holding a legal or beneficial interest in a property). This definition creates an extremely broad class of potential plaintiffs, and civil RICO claims have been asserted by individuals, corporations, partnerships, labor unions, churches, universities, estates, and governmental agencies. *Landscape*, *supra* note 185, at 27.

219. 18 U.S.C.S. § 1962(c) (1991). The full text of § 1962(c) states that:

It shall be unlawful for any person employed by or associated with any enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity or collection of unlawful debt.

Id.

220. *Id.*

221. See *id.* § 1961(4) (1991) (defining enterprise as including any individual, partnership, corporation, association, or other legal entity, and any union or group of individuals associated in fact although not a legal entity); *infra* notes 240-244 and accompanying text (discussing the issue of whether the enterprise must be an entity separate from the defendant, with the requisite *relationship* between the enterprise and the defendant, or whether the defendant and the enterprise can be the same entity).

222. 18 U.S.C.S. § 1962(c) (1991); see *id.* § 1961(1) (Supp. 1993) (defining racketeering activity); *Landscape*, *supra* note 185, at 30 n.54 (summarizing § 1961(1)'s definition of racketeering activity as any act engaged in by a person which is "chargeable" under several generically described state criminal laws, any act "indictable" under several specific federal criminal provisions including the mail and wire fraud statutes, or any "offense" involving bankruptcy or securities fraud or drug-related activities that is "punishable" under federal law).

223. See JOSEPH, *supra* note 181 at 57.

224. *Id.* at 42.

225. *United States v. Turkette*, 452 U.S. 576, 583 (1981); JOSEPH, *supra* note 181, at 62; see *infra* notes 236-254 and accompanying text (discussing the distinctions between the enterprise and the pattern of racketeering activity).

components have been a fruitful source of confusion in civil RICO litigation.²²⁶

The first requirement for a civil RICO suit is injury to the plaintiff's business or property. Courts have been consistent in recognizing that recovery for personal injuries is not compensable under RICO.²²⁷ Prior to 1985, RICO's close relationship to section Four of the Clayton Act²²⁸ prompted some courts to require civil RICO plaintiffs to allege illegal antitrust activity that placed them at a competitive disadvantage in the marketplace.²²⁹ This impediment was removed in the landmark case of *Sedima, S.P.R.L. v. Imrex Co.*²³⁰ In *Sedima*, the United States Supreme Court eliminated the antitrust injury requirement, stating that a claim may be brought under section 1964(c) so long as the defendant has engaged in a pattern of racketeering activities²³¹ which injured the plaintiff in the plaintiff's business or property.²³² The *Sedima* Court held that recovery under section 1964(c) was not limited to injuries that are competitive in nature because the statute expressly granted recovery to any person injured in the person's business or property.²³³ While the dissent in *Sedima* cautioned that too broad a reading of the civil RICO statute would validate uses of the statute that were never intended by Congress, the majority opened the door for a wide variety of plaintiffs in finding that the competitive-injury and racketeering-injury requirements imposed by earlier courts were inconsistent with RICO's language and legislative history.²³⁴ The burgeoning use of civil RICO in the area of workers' compensation

226. See JOSEPH, *supra* note 181, at 41.

227. *Landscape*, *supra* note 185, at 27-28 n.43 (citing numerous cases which have held that the business or property requirement of the RICO Act excludes redress for personal injuries suffered).

228. 15 U.S.C. § 15 (1985) (codifying section 4 of the Clayton Act, which provides the remedy of treble damages, the cost of the suit, and reasonable attorney's fees to any person who has been injured in his business or property by any action forbidden in the antitrust laws); see *supra* note 190-192 and accompanying text (noting that the Clayton Act was the basis for the civil RICO treble damages remedy).

229. *Landscape*, *supra* note 185, at 27-28.

230. 473 U.S. 479 (1985).

231. See 18 U.S.C.S. § 1961(1) (Supp. 1993) (defining racketeering activity).

232. *Sedima, S.P.R.L. v. Imrex Co.*, 473 U.S., at 495.

233. *Id.* at 497 n.15. The Court reasoned that, had Congress intended to limit recovery to competitive injuries, they would not have granted recovery for injuries to property. *Id.* But see *id.* at 523-530 (Powell, J., dissenting) (taking exception to this distinction and stating that Congress did intend to limit recovery to competitive injuries).

234. *Sedima*, 473 U.S. at 497 n.15 (holding that civil RICO damages are not limited to competitive injury); *id.* at 493-500, (holding that civil RICO damages are likewise not limited to racketeering injury); see *supra* notes 185-192 and accompanying text (discussing the legislative history of RICO).

fraud illustrates the continued strength of the expansive *Sedima* precedent of redressing non-antitrust injuries.²³⁵

The second step for pleading a civil RICO complaint is to allege the existence of an enterprise.²³⁶ The definition of a RICO enterprise is extremely broad, thereby assuring the application of RICO to a wide range of conduct.²³⁷ Section 1961(4) of the RICO Act defines enterprise as including any individual, partnership, corporation, association, or other legal entity, as well as any union or group of individuals associated in fact although not a legal entity.²³⁸ This absence of a requirement that the enterprise be based on a legally recognized relationship allows a civil RICO plaintiff to use circumstantial evidence to establish the existence of an enterprise, significantly enhancing the scope of civil RICO.²³⁹

The plaintiff must then allege that the defendant was involved in one or more enumerated *relationships* with this enterprise which affects interstate or foreign commerce.²⁴⁰ The relationship requirement of section 1962(c) raises a troublesome issue. In order to establish a relationship there must, by definition, be two distinct parties.²⁴¹ This relationship requirement brings up the question of whether a civil RICO *defendant* may also be the *enterprise*, or whether the enterprise must be an entity distinct from the defendant.²⁴² If a civil RICO defendant and enterprise are one in the same, then a paradoxical situation arises whereby the requisite *relationship* element exists between a single entity.²⁴³ Almost all courts confronted by the separate entity issue have concluded that the section 1962(c) enterprise requirement assumes that the defendant and the enterprise are two distinct entities.²⁴⁴

235. See *infra* notes 366-367 and accompanying text (discussing the use of civil RICO suits as a cost-effective method of litigating fraudulent workers' compensation claims).

236. 18 U.S.C.S. § 1962(c) (1991).

237. *Landscape*, *supra* note 185, at 32.

238. 18 U.S.C.S. § 1961(4) (1991). Even entirely illegitimate enterprises may be RICO enterprises. *United States v. Turkette*, 452 U.S. 576, 580-81 (1981).

239. See, e.g., *Zenith Complaint*, *supra* note 19; see also *infra* notes 317-328 and accompanying text (discussing *Zenith's* use of circumstantial evidence to allege the existence of an enterprise).

240. 18 U.S.C.S. § 1962(c) (1991).

241. See BLACK'S LAW DICTIONARY 1288 (6th ed. 1990) (defining relation as the connection of two persons, or their situation with respect to each other).

242. *Landscape*, *supra* note 185 at 32-36 (discussing the distinct entity issue in terms of §§ 1962(a), 1962(b), and 1962(c)).

243. See *supra* note 241 and accompanying text (defining relation as involving two or more entities).

244. *Landscape*, *supra* note 185, at 36; see *id.* 36-37 n.85-86 (citing numerous district court and United States Supreme Court opinions which have concluded, as a matter of law, that the enterprise and the defendant remain distinct entities, and citing *United States v. Hartley*, 678 F.2d 961, 988 (11th Cir.) as an example of the minority of cases which has held that a corporation may be simultaneously both a defendant and the § 1962(c)

Once the plaintiff has established an injury in its business or property, and the defendant's relationship with an enterprise, the third step for pleading a civil RICO complaint is to allege that the defendant was engaged in a pattern of racketeering activity.²⁴⁵ While the definition of "enterprise" in section 1961(4) is meant to be purely illustrative,²⁴⁶ the laundry list of predicate acts enumerated in the definition of racketeering activity in section 1961(1) is meant to be exhaustive.²⁴⁷ Therefore, the plaintiff must allege conduct specifically enumerated in the definition of 1961(1).²⁴⁸ Common examples of prohibited non-violent racketeering activity include mail fraud,²⁴⁹ wire fraud,²⁵⁰ and embezzlement from pension and welfare funds.²⁵¹

RICO requires more than proof of the existence of an enterprise which has engaged in racketeering activity: the plaintiff must prove multiple acts of racketeering activity sufficient to constitute a *pattern*.²⁵² The *Sedima* Court stated that two acts were necessary to establish a pattern, but that two *isolated* acts may not be sufficient.²⁵³ Thus, under *Sedima* a combination of *continuity plus relationship* is required to produce a pattern.²⁵⁴

In the event that a group of workers' compensation insurance companies form an enterprise which engages in a pattern of racketeering activity for the purpose of fraudulently withholding payment of valid

enterprise).

245. 18 U.S.C.S. § 1962(c) (1991). See 18 U.S.C.S. § 1961(1) (Supp. 1993) (including within the definition of racketeering activity such things as: threats involving murder or kidnapping; dealing dangerous drugs; bribery; counterfeiting; embezzlement; mail and wire fraud; tampering with, or retaliating against, a witness; money laundering; sexual exploitation of children; and embezzlement from union funds).

246. See JOSEPH, *supra* note 181, at 63 (noting that § 1961(4) provides that the term enterprise "includes" the list that follows, and is thus only illustrative of the types of entities which may constitute an enterprise).

247. 18 U.S.C.S. § 1961(1) (Supp. 1993) (defining racketeering activity); JOSEPH, *supra* note 181, at 62-63. The *Sedima* court held that racketeering activity consists of no more and no less than the commission of a predicate act. *Sedima, S.P.R.L. v. Imrex Co., Inc.*, 473 U.S. 479, 495 (1985). See *Miranda v. Ponce Fed. Bank*, 948 F.2d 41, 48 (1st Cir. 1991) (stating that the list of predicate acts in 18 U.S.C. § 1961(1) was intended by Congress to be complete).

248. See JOSEPH, *supra* note 181, at 63.

249. See 18 U.S.C.S. § 1341 (1991) (defining mail fraud and making it a federal crime); see *Zenith Complaint*, *supra* note 19, at 21-22 (alleging mail fraud as a basis for establishing racketeering activity).

250. See 18 U.S.C.S. § 1343 (1991) (defining wire fraud and making it a federal crime).

251. See *id.* § 1961(1) (Supp. 1993) (including mail fraud, wire fraud, and embezzlement from pension and welfare funds within the definition of racketeering activity); *id.* § 664 (1991) (defining embezzlement from pension and welfare funds and making it a federal crime).

252. *Id.* § 1961(5) (1991) (defining pattern of racketeering activity as requiring at least two acts of racketeering activity).

253. *Sedima*, 473 U.S. at 496 n.14.

254. *Id.*; *Landscape*, *supra* note 185, at 46.

workers' compensation claims, a plaintiff may not bring a civil RICO suit against the fraudulent workers' compensation insurers. This is due to the *American International Group* precedent barring the civil RICO suit from application against insurance companies due to pre-emption by state laws regulating the insurance industry.²⁵⁵ Under current law, a plaintiff in this situation must instead resort to administrative remedies available under California's Insurance Code, or to the remedies provided by common law. The common law equivalent to the treble damages civil RICO remedy is an antitrust suit. A brief consideration of the extensive body of antitrust law highlights a significant disparity in the common law as it pertains to workers' compensation fraud: the high likelihood that an insurer will be successful in bringing a civil RICO suit against fraudulent claimants, and the remote likelihood that a claimant will be successful in bringing an antitrust suit against fraudulent insurers.

B. The Narrow Policy of Antitrust Law

In contrast to the relative youth of civil RICO, the common law origin of antitrust law goes back more than 500 years to an action which upheld an apprentice's right to compete with his master.²⁵⁶ Although the roots of antitrust law are embedded in the common law, contemporary treatment of antitrust law is largely statutory.²⁵⁷ This Comment considers the application of antitrust law to the workers' compensation insurance industry. As such, only those aspects of antitrust law which touch upon workers' compensation insurance are examined.²⁵⁸

255. See *supra* notes 207-216 and accompanying text (discussing the *American Int'l Group, Inc. v. Superior Court* decision).

256. *Dyer's Case*, *supra* note 183.

257. 1 B.E. WITKIN, *SUMMARY OF CALIFORNIA LAW, Contracts* § 544 (9th ed. 1987).

258. The reader is encouraged to review the large body of literature for a more in-depth treatment of this fascinating area of law. See, e.g., ABA ANTITRUST SECTION, *ANTITRUST LAW DEVELOPMENTS* (3d ed. 1992); PHILLIP AREEDA AND LOUIS KAPLOW, *ANTITRUST ANALYSIS PROBLEMS, TEXT, CASES-1991 SUPPLEMENT* (4th ed. 1988); TERRY CALVANI AND JOHN SIEGFRIED, *ECONOMIC ANALYSIS AND ANTITRUST LAW* (2d ed. 1988); CARLA A. HILLS, *ANTITRUST ADVISER* (1971); ERNEST GELLHORN, *ANTITRUST LAW AND ECONOMICS IN A NUTSHELL* (3d ed. 1986); PHILIP C. JONES, *LITIGATING PRIVATE ANTITRUST ACTIONS* (1984); MARIA P. RIVERA, *ANTITRUST PRIMER: BASICS OF ANTITRUST LAW AND INVESTIGATION*, NATIONAL DISTRICT ATTORNEYS ASSOC., (1980); STEPHEN F. ROSS, *PRINCIPLES OF ANTITRUST LAW* (1993); LAWRENCE ANTHONY SULLIVAN, *HANDBOOK OF THE LAW OF ANTITRUST* (1977); 54 AM. JUR. 2D, *Monopolies, Restraints of Trade, and Unfair Trade Practices* § 3, at 669 (1971).

The underlying foundation of antitrust law is the tenet that competition reigns supreme.²⁵⁹ While RICO reaches an ever-expanding variety of business conduct wholly unrelated to competition,²⁶⁰ antitrust policy dictates that it be applied only to specific business conduct which adversely impacts competition.²⁶¹ This procompetition policy behind antitrust law is based on the belief that protection of competition ultimately protects the public welfare through efficient use of economic resources.²⁶² The Sherman Act²⁶³ is the principal federal antitrust statute, and proscribes all agreements among competitors that *unreasonably* restrict competition.²⁶⁴ Conduct is deemed unreasonable when it eliminates or reduces competition without yielding economic benefits (*i.e.*, an *unreasonable* restraint of trade).²⁶⁵

259. Turner, *The Durability, Relevance, and Future of American Antitrust Policy*, 75 CAL. L. REV. 797, 798 (1987).

260. See Pub. L. No. 91-452, § 904, 84 Stat. 947 (1970) (calling for broad and liberal interpretation of RICO in order to more effectively fight the serious threat posed by organized crime); JOSEPH, *supra* note 181, at 62-81 (discussing the wide variety of non-competitive conduct to which RICO applies).

261. *Columbia v. Omni Outdoor Advertising, Inc.*, 499 U.S. 365, 400 (1991) (noting that a conspiracy which involves an element of unlawfulness other than anticompetitive motivation has nothing to do with the policies of antitrust law); SULLIVAN, *supra* note 258, at 20 (stating that antitrust law is limited to anticompetitive business conduct); Turner, *supra* note 259 (making the same assertion); see *supra* notes 185-205 and accompanying text (discussing the expansionist policy behind the RICO Act).

262. *Northern Pac. R. Co. v. United States*, 356 U.S. 1, 4 (1958); Turner, *supra* note 259, at 798 (noting that the protection of competition is necessary to protect consumer welfare). To apply antitrust law in non-competitive situations, even for the attainment of the most worthy societal goals, would inject vagueness into the antitrust arena and risk dampening legitimate business conduct. *Id.* See generally 1 PHILIP AREEDA & D. TURNER, ANTITRUST LAW ¶¶ 103-112 (1978) and 4 PHILIP AREEDA & D. TURNER, ANTITRUST LAW ¶¶ 903-904 (1980) (discussing the issues concerning antitrust goals).

263. 15 U.S.C.S. § 1 (Supp. 1993).

264. See *NCAA v. Board of Regents*, 468 U.S. 85, 98 (1984); *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 687-91 (1978); *Continental T.V., Inc., v. GTE Sylvania, Inc.*, 433 U.S. 36, 49 (1977); *Chicago Bd. of Trade v. United States*, 246 U.S. 231, 238 (1918); *Standard Oil Co. v. United States*, 221 U.S. 1, 58 (1911) (consistently holding that only *unreasonable* restraints on competition violate § 1 of the Sherman Act, since every trade agreement or regulation restrains trade in some way); ABA Antitrust Section, *supra* note 258, at 1-2 (noting that the Sherman Act states that *every* contract, combination, or conspiracy to restrain trade is illegal, and therefore, a literal reading of the Act would prohibit *all* concerted activity to restrain trade); 15 U.S.C.S. § 1 (1988).

265. 15 U.S.C.S. § 1 (1988); see *Apex Hosiery Co. v. Leader*, 310 U.S. 469, 493 (1940) (stating that the Sherman Act was enacted to prevent restraints to free competition which tended to restrict production, raise prices or otherwise control the market to the detriment of purchasers of goods and services). The Sherman Act and its progeny were not aimed at protecting *individual* competitors, but rather the promotion of procompetitive *conduct* as a whole. *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977); Turner, *supra* note 259, at 798; Note, *Antitrust Standing, Antitrust Injury, and the Per Se Standing*, 93 YALE L.J. 1309, 1310 (1984).

Not all anti-competitive practices are subject to federal²⁶⁶ antitrust laws. The McCarran-Ferguson Act²⁶⁷ exempts from federal antitrust law those areas of the insurance industry which are subject to state regulation, including workers' compensation.²⁶⁸ Given the fact that the underlying policy of antitrust law is the protection of the public welfare, Congress chose to allow the States to authorize anti-competitive practices which they believed to be in the public interest.²⁶⁹ The McCarran-Ferguson Act specifically exempts the "business of insurance" from antitrust liability.²⁷⁰ Under this exemption, insurers may lawfully collect and exchange information pertaining to patterns of submission of falsified claims.²⁷¹ They may not, however, engage in price fixing, since this conduct would adversely impact competition.²⁷²

In addition to the proscription against a concerted agreement to fix prices, insurance companies may not band together in an agreement to refuse to deal with a particular market participant (*i.e.*, a group boycott),²⁷³ since even when the motivation behind the boycott is to drive fraudulent enterprises from business, an unlawful means is

266. California law does not apply here because Federal law expressly bars boycotts, coercion, and intimidation. As such, State law can not authorize something that Federal law expressly prohibits.

267. 15 U.S.C. §§ 1011-1015 (1984).

268. 15 U.S.C. § 1012(b) (1984) (exempting conduct which relates to the business of insurance to the extent that such business is regulated by State law).

269. *Saint Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 565 (1978) (Stewart, J., dissenting).

270. 15 U.S.C. § 1012(b) (1984) (exempting the business of insurance to the extent that such business is regulated by state law); *see Hartford Fire Ins. Co. v. California*, 113 S. Ct. 2891, 2901 (1993) (stating that the McCarran-Ferguson Act did not exempt the "business of insurance companies," but rather, the business of insurance) (emphasis added). The Court explained that the "business of insurance" singles out one *activity* from others, rather than distinguishing one *entity* from another. *Id.*

271. DEPARTMENT OF JUSTICE, STATE OF CALIFORNIA, ANTITRUST GUIDELINES FOR THE INSURANCE INDUSTRY 44 (Mar. 1990). This exchange of information is allowable because it is not seen as relating to price fixing. *Id.*

272. *United States v. Trenton Potteries Co.*, 273 U.S. 392, 397 (1926). *See ANTITRUST GUIDELINES, supra* note 271, at 16-18 (discussing various agreements which have been construed as price fixing).

273. ABA ANTITRUST SECTION, *supra* note 258, at 77; ANTITRUST GUIDELINES, *supra* note 271, at 18-19 (stating that group boycotts against customers or suppliers, as well as competitors are *per se* illegal). *See infra* notes 288-292 and accompanying text (discussing the *per se* doctrine). A concerted refusal to deal is the most common type of boycott described in antitrust litigation in the insurance industry. *See, e.g., Hartford Fire Ins. Co. v. California*, 113 S. Ct. 2891, 2895-2900 (1993) (alleging a group boycott by a group of primary insurers and reinsurers). When the economic harm of a group refusal to deal is not readily apparent, then federal antitrust law may not treat a group refusal to deal as a *per se* illegal boycott. ANTITRUST GUIDELINES, *supra* note 271, at 18-19. *See infra* notes 344-351 and accompanying text (discussing the minute order in the Wellington case, in which Judge Hupp stated that the alleged conduct of Zenith was not the type of conduct which the *per se* doctrine was designed to cover).

unjustified.²⁷⁴ Therefore, an alleged boycott by an insurer negates McCarran-Ferguson immunity from antitrust liability.²⁷⁵ Once outside this antitrust immunity, the activity is closely scrutinized to determine whether or not it rises to the level of a boycott.²⁷⁶ A pattern of uniform business conduct by competitors, known as conscious parallelism, is usually the basis for allegations of such a concerted action.²⁷⁷ But a strong case of parallelism, whereby various competitors are engaging in *unexplained* parallel conduct, is still not enough to create an inference of unlawful conspiracy.²⁷⁸ Instead, courts view parallelism as one of many factors to be weighed in supporting an inference of concerted action.²⁷⁹ Other circumstances, called "plus factors," are added to the mix, and the behavior of the defendants is then viewed as a whole.²⁸⁰ These plus factors include actions which evince similarity of language, terms, and conditions where such similarity is improbable, absent collusion.²⁸¹ An important plus factor is proof that the conduct would be contrary to the parties' self-interest if they acted alone.²⁸² If sound business reasons exist

274. See, e.g., *Paramount Famous Lasky Corp. v. United States*, 282 U.S. 30, 43 (1930) (stating that the interest of the public in the preservation of competition is the primary consideration of the Sherman Act, and that good motives do not exonerate unlawful activity under the statute). The Court noted that law is not to be compromised in accommodating good intentions of parties, or in obtaining some good results. *Id.* It is likewise unlawful to conspire to drive a party out of business by spreading the information that he is morally and financially unreliable, and has a criminal record. *McCann v. New York Stock Exchange*, 107 F.2d 908, 912 (2d Cir. 1939). While the withholding of payment for the sole purpose of driving a creditor out of business is not specifically prohibited by law, numerous Supreme Court holdings have easily jumped this hurdle. See, e.g., *Fashion Originators' Guild of Am. v. Federal Trade Comm'n*, 312 U.S. 457, 463 (1941) (stating that the Sherman and Clayton Acts did not define specific categories of prohibited conduct, but were instead prophylactic regulations designed to eliminate any type of activity which might lead to undesirable trade restraints and practices); *Saint Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 552 (1978) (holding that the Sherman Antitrust Act prohibited concerted refusals to do business with a particular person or business in order to obtain concessions or to express displeasure with certain acts or practices).

275. See, e.g., *Hartford Fire Ins. Co. v. California*, 113 S. Ct. 2891, 2913 (1993) (stating that a group boycott is not exempted from liability under the McCarran-Ferguson Act).

276. See *infra* notes 288-303 and accompanying text (discussing the per se and Rule of Reason doctrines, which are the two doctrines under which conduct is scrutinized to determine whether such conduct violates antitrust law).

277. ABA ANTITRUST SECTION, *supra* note 258, at 5.

278. *In re Workers Compensation Ins. Antitrust Litig.*, 867 F.2d 1552, 1563, 1566 (8th Cir. 1989), *cert. denied*, 492 U.S. 920 (1989).

279. ABA ANTITRUST SECTION, *supra* note 258, at 6.

280. *In re Workers Compensation Ins. Antitrust Litig.*, *supra* note 278, at 1563, 1566 (stating that the overall conduct of the defendants must be weighed).

281. ABA ANTITRUST SECTION, *supra* note 258, at 7-10 (discussing the various plus factors which have been employed by Courts in considering circumstantial evidence of unlawful conspiracies).

282. *Todorov v. DCH Healthcare Auth.*, 921 F.2d 1438, 1456 n.30 (11th Cir. 1991) (stating that the plaintiff must establish that, if there were no conspiracy, each defendant engaging in the parallel action would be acting contrary to its economic self-interest). See *infra* notes 368-371 and accompanying text (noting that there is ample reason for any individual insurance company to engage in a unilateral practice of withholding

by which defendants can justify the challenged conduct, then a finding of conspiracy is unlikely.²⁸³

Once a court finds that a conspiracy exists, the conduct is then scrutinized under one of two doctrines to determine whether or not the challenged conduct falls within the umbrella of antitrust law: the per se doctrine or the Rule of Reason.²⁸⁴ Each is distinct in its application, and is used exclusive of the other.²⁸⁵ The differences between these two doctrines amount to a decisive impact on the likelihood that an antitrust suit will be successful.²⁸⁶ As such, the judicial determination of whether conduct is examined under the per se doctrine or the Rule of Reason is crucial, and can sometimes be the determining factor in a plaintiff's decision to continue litigating or pursue an out-of-court settlement.²⁸⁷

The Per Se Doctrine and The Rule of Reason

Under the per se doctrine,²⁸⁸ a court makes a preliminary determination as to whether the challenged conduct is per se illegal.²⁸⁹ A finding of per se illegality means that the defendants' conduct is seen as so restrictive of competition (rather than one designed to increase economic efficiency and render markets more, rather than less, competitive) that it is conclusively unreasonable, making further examination of the reasons for the challenged practice and its effects irrelevant.²⁹⁰ A per se ruling ends the case in favor of the plaintiff, allowing the plaintiff to forego the expense of drawn out litigation which is usually required under the Rule of Reason.²⁹¹ Just as the civil RICO

payment for valid workers' compensation claims).

283. *Todorov*, 921 F.2d at 1456.

284. SULLIVAN, *supra* note 258, at 153.

285. *Id.*

286. *Id.*

287. See ANTITRUST GUIDELINES, *supra* note 271, at 16 (noting that the limitation of per se rules has resulted in more complex litigation and uncertainty among prosecutors); *infra* notes 288-303 and accompanying text (discussing the per se and Rule of Reason doctrines, and noting that the Rule of Reason involves much more complex inquiry into the nature of the conduct).

288. See *Broadcast Music, Inc., v. CBS*, 441 U.S. 1, 19-20 (1979) (stating that the per se doctrine renders per se illegal practice which facially appears to be one that would always or almost always tend to restrict competition and decrease output).

289. SULLIVAN, *supra* note 258, at 153.

290. *Broadcast Music*, 441 U.S. at 8, 19-20.

291. *United States v. Realty Multi-List, Inc.*, 629 F.2d 1351, 1362-63 (5th Cir. 1980) (calling the per se rule the "trump card" of antitrust law which allows an antitrust plaintiff who successfully plays it to simply tally his score); ABA ANTITRUST SECTION, *supra* note 258, at 33; see *infra* notes 293-298 and accompanying text (discussing the Rule of Reason doctrine).

cause of action provides insurance companies with a cost effective method of litigating numerous contested claims, a per se analysis would provide a plaintiff with a cost effective method of litigating an antitrust suit concerning the fraudulent withholding of numerous valid claims. The plaintiff would only need to prove that the defendant actually engaged in the alleged conduct.²⁹²

A plaintiff who is unsuccessful in a plea for per se scrutiny must then turn to the Rule of Reason.²⁹³ In contrast to a per se analysis, the Rule of Reason involves a complicated and prolonged economic investigation into the entire history of the industry involved, including the nature, purpose and effect of the challenged conduct.²⁹⁴ This complex inquiry is necessary to determine whether a particular restraint is unreasonable, since only unreasonable restraints on competition are unlawful.²⁹⁵ Due to the desirability of maintaining a free market without undue restraints on legitimate business practices, public policy often plays a large part in a court's consideration of the reasonableness of a defendant's conduct.²⁹⁶ This public policy orientation can significantly impact a plaintiff's chance of succeeding in an antitrust suit.²⁹⁷ In the workers' compensation insurance setting, a Rule of Reason analysis would most likely consider the expressed intent of Congress to defer to the states the regulation of insurance, as well as the great harm that fraudulent workers' compensation mills have on the public welfare, and thus face a costly uphill battle.²⁹⁸

In reviewing the case law surrounding both RICO and antitrust violations, the complexity of successfully pleading such a violation is

292. See *United States v. Realty Multi-List, Inc.*, 629 F.2d at 1362-63 (noting that further inquiry is unnecessary, once conduct deemed per se illegal is proven).

293. SULLIVAN, *supra* note 258, at 153. Where conduct does not obviously stifle competition, but may adversely affect it, the Rule of Reason is the appropriate analysis. *Id.* at 169-70.

294. *Northern Pac. R. Co. v. United States*, 356 U.S. 1, 4-5 (1958). A plaintiff bringing suit under the Rule of Reason must show not only that the challenged conduct was an unreasonable restraint on trade, but also that the plaintiff suffered direct injury as a result of the unreasonable conduct. JONES, *supra* note 258, § 19.05, at 351-52. This standing requirement allows courts to limit the parties which may sue for injuries sustained by reason of an antitrust violation. *Id.*, § 18.02, at 327 (emphasis in original). The determination is made based on the pleadings, and assumes that the allegations and damages are true. *Id.*

295. *Standard Oil Co. v. United States*, 221 U.S. 1, 103 (1911). *Standard Oil* was the case from which evolved the concept that contracts and conspiracies which inhibit competition are prohibited only if they are unreasonable, thus giving modern recognition to the 200 year old Rule of Reason. GELLHORN, *supra* note 258, at 3-5. The Rule of Reason was first applied in 1711 in *Mitchel v. Reynolds*, 1 P.Wms. 181, 24 Eng.Rep. 347 (1711). *Id.*

296. JONES, *supra* note 258, § 26.02, at 415.

297. *Id.*, § 26.02, at 415.

298. See, e.g., *infra* note 349-351 and accompanying text (noting that, once the Wellington plaintiffs were required to prove their case under a Rule of Reason analysis, they settled with the defendants because the case became prohibitively expensive).

apparent.²⁹⁹ While RICO has expanded beyond anticompetitive conduct, antitrust law is confined to anticompetitive actions.³⁰⁰ Given this limitation to anticompetitive conduct, it is highly unlikely that conduct which does not obviously impair competition will be scrutinized under the per se doctrine of antitrust law.³⁰¹ The complexity and expense of bringing suit under the rule of reason amounts to a significant burden on such an antitrust plaintiff.³⁰² This is most evident in the recent litigation between Zenith Insurance Company and various medical care providers.³⁰³

III. CIVIL LITIGATION BETWEEN ZENITH AND WELLINGTON

In November of 1991, Zenith Insurance Company ("Zenith") brought a civil RICO suit in United States District Court, Central District of California against Wellington Medical Corporation, American Psychometric Consultants, and five former workers of the La Serre restaurant in Sherman Oaks, California (collectively referred to as "Wellington").³⁰⁴ The suit alleged that the defendants filed fraudulent workers' compensation claims, submitted false medical-legal evaluations, and billed for unnecessary services.³⁰⁵ A countersuit was filed by

299. See *supra* notes 180-298 and accompanying text (discussing the background of the RICO Act and antitrust law).

300. *Columbia v. Omni Outdoor Advertising, Inc.*, 499 U.S. 365, 400 (1991) (noting that a conspiracy which involves an element of unlawfulness other than anticompetitive motivation has nothing to do with the policies of antitrust law); SULLIVAN, *supra* note 258, at 20 (stating that antitrust law is limited to anticompetitive business conduct); Turner, *supra* note 259 (making the same assertion).

301. SULLIVAN, *supra* note 258, at 169-70; see, e.g., *Princeton Medical Corp., et al. v. Zenith Ins. Co.*, et al., No. CV 91-6866-HLH (C.D. Cal. filed May 18, 1992) (in which the Wellington plaintiffs were told to drop their per se violation theory because the suit would be analyzed under the rule of reason).

302. See *supra* notes 293-301 and accompanying text (describing the difficulty and expense of proving antitrust violations under the Rule of Reason).

303. See *infra* notes 330-360 and accompanying text (discussing the Wellington antitrust suit and the eventual out-of-court settlement).

304. *Zenith Complaint*, *supra* note 19.

305. *Id.*; see Louise Kertesz, *Work Comp Fraud Allegations Boil Over; Insurer's Complaint Triggers Countersuit By Medical Clinics*, BUS. INS., Feb. 3, 1992, at 21, available in LEXIS, Nexis Library, Busins File (discussing the allegations of the suit and reporting that the owner of defendant Wellington Medical Corporation, Dr. Bryon Crawford, had previously agreed to pay the Workers Compensation Appeals Board \$20,000 in a case which alleged that he had employed unqualified personnel to ghostwrite medical-legal evaluations of workers compensation claimants). The type of behavior alleged by Zenith is not covered by newly enacted California Insurance Code § 1871.7, which provides the statutory right for any interested party to bring civil action for the crime of employing runners, cappers, or steerers to procure workers' compensation claimants. 1993 Cal. Legis. Serv. ch. 120, sec. 3.3, at 1048 (enacting CAL. INS. CODE § 1871.7(e)(1)). See *supra* notes 156-164 and accompanying text (discussing newly enacted legislation which addresses fraud within the workers' compensation).

Wellington, alleging that Zenith violated antitrust laws in a vigilante-style effort to fight what Wellington asserted were legitimate claims.³⁰⁶ The eventual out-of-court settlement of these suits, as well as several similar civil RICO actions brought by Zenith against other workers' compensation mills, indicates that the civil RICO cause of action will be a major factor in curbing fraud in California's workers' compensation system.³⁰⁷

A. Zenith Insurance Company v. American Psychometric Consultants, Inc.³⁰⁸

On November 18, 1991, Zenith Insurance Company filed a suit against various workers' compensation claimants, interpreters, doctors, psychologists, and an attorney in U.S. District Court in Los Angeles.³⁰⁹ In the suit, Zenith alleged that American Psychometric Consultants ("APC"), Wellington Medical Corporation, and the law firm of Glen A. Lintner, formed an enterprise³¹⁰ for submitting and prosecuting fraudulent and exaggerated workers' compensation claims in which extensive reciprocal referrals were used.³¹¹ In its complaint, Zenith alleged that an enterprise existed whereby the defendant law firm and medical clinics all solicited either healthy employees who were willing to submit fraudulent claims, or injured, ill, or disabled workers who would submit exaggerated or inflated claims for workers' compensation benefits.³¹² Claimants who first came to the Lintner firm were represented in all efforts to obtain payment of benefits or settlement, and were then allegedly referred to the defendant medical clinics for extensive medical-legal evaluations which included psychological examination and

306. *Princeton Complaint*, *supra* note 20, at 7-14; see *Kertesz*, *supra* note 305, at 21 (discussing the allegations of the countersuit). See *supra* notes 174-175 and accompanying text (setting forth the complete list of plaintiffs and defendants in the two suits, who have been simplified in this Comment to "Zenith" and "Wellington" for the sake of clarity).

307. See Stuart Silverstein, *Deal Reached In Workers' Comp Suit*, L.A. TIMES, Aug. 18, 1992, Part D at 1, available in LEXIS, Nexis Library, LAT File (reporting on the settlement terms between Wellington Medical Corporation and Zenith Insurance Company, and noting Zenith's intent to proceed to trial against American Psychometric Consultants, the medical group that referred the workers to Wellington Medical Clinic); *Zenith Insurance Co. Reaches Settlement*, BUS. WIRE, Oct. 1, 1992, available in LEXIS, Nexis Library, BWIRE File [hereinafter *Settlement*] (reporting that Zenith Insurance Company reached a settlement with American Psychometric Consultants and providing a description of the settlement terms).

308. *Zenith Complaint*, *supra* note 19.

309. *Id.*

310. See 18 U.S.C. § 1961(4) (1991) (defining enterprise for the purposes of RICO).

311. *Zenith Complaint*, *supra* note 19, at 7-8.

312. *Id.* at 7-9.

treatment in order to exaggerate and inflate the medical bills.³¹³ Claimants who first came to the defendant medical clinics were allegedly referred to Lintner for representation.³¹⁴ The Lintner firm would always retain the defendant medical clinics to provide medical-legal evaluations for all claims contested by Zenith.³¹⁵ Zenith further alleged that A&W Interpreting Services, a firm which assisted in medical-legal evaluations by interpreting for Spanish-speaking claimants, was used for English-speaking claimants in order to inflate and exaggerate the fraudulent claims.³¹⁶

Zenith's complaint was based on allegations stemming from the employment of five workers by La Serre Restaurant in Sherman Oaks, California.³¹⁷ In June of 1991, all five workers quit La Serre and went to work for Villas Garden, a nearby restaurant managed by Eduardo Sanchez, a former La Serre employee.³¹⁸ At the same time, Sanchez had a workers' compensation claim pending against La Serre, in which he had been diagnosed by APC as being disabled from psychological stress.³¹⁹ Despite this purported disability, Sanchez was working at Villas Garden at the time.³²⁰ APC had billed Zenith for the medical evaluation and treatment of Sanchez, had referred him to Wellington for additional evaluation and treatment, and referred him to A&W Interpreting Services for unnecessary interpretation, all of which was billed to Zenith.³²¹

On July 5th, 1991, the five claimants visited APC and were all identically diagnosed as being disabled due to psychological stress and trauma.³²² In billing Zenith for the examination and treatment of the five claimants, APC submitted five identical bills for evaluation and treatment performed by a single APC employee on July 5th. The bills showed that, on July 5th, each claimant received 18.10 hours of psychological testing and evaluation by David Leonelli, an assistant at APC.³²³ Aside from the fact that the total hours billed for treatment administered by the same employee to the same claimants on the same day was 90.5 hours, the itemization of the time spent for the various tests was grossly exaggerated

313. *Id.*

314. *Id.*

315. *Id.* at 9.

316. *Id.* at 7-9.

317. *Id.* at 10.

318. *Id.*

319. *Id.*

320. *Id.*

321. *Id.*

322. *Id.* at 11-12.

323. *Id.* at 12-13.

and broken down identically for each bill.³²⁴ The individual responses in the tests given to each claimant were conspicuously indistinguishable, even though the answers were typically responses to either incomplete sentences or single-words.³²⁵ The medical-legal evaluations of the five claimants contained identical diagnoses and lengths of disability, stating that the claimants (who were all working at Villas Garden at the time of their July 5th evaluations) would be unable to work until October 8, 1991 due to disabling conditions which all coincidentally began on May 20, 1991.³²⁶ Zenith also charged that APC referred the claimants to the Lintner firm after their July 5th evaluations in order to justify the medical-legal evaluations done by APC.³²⁷ Similar conduct of unnecessary examinations, fraudulent reports, and exaggerated medical bills was alleged against Wellington Medical Corporation.³²⁸

B. Princeton Medical Corp., et al., v. Zenith Insurance Company³²⁹

Wellington³³⁰ filed suit against Zenith and other insurance companies³³¹ on December 17, 1991, alleging violations of antitrust laws.³³² In this suit, Wellington alleged that the defendants had engaged in an illegal conspiracy and combination for the purpose of forming an unlawful group boycott or concerted refusal to deal with the plaintiff medical clinics, and to fix the terms of payments to be made to the plaintiffs.³³³ Wellington claimed that the ultimate goal of the conspiracy was to reduce the revenues of the medical care providers and drive them

324. *Id.* An example of the type of exaggerated time itemization used by APC is the allotment of 3.5 hours to administer the Minnesota Multiphasic Personality Inventory test, which is actually a self-administered test. *Id.* at 13. These five identically itemized bills were also identical to the itemized bill submitted to Zenith on behalf of Sanchez. *Id.* at 13.

325. *Id.* at 13-16.

326. *Id.* at 16.

327. *Id.* at 18. Medical-legal evaluations are needed only for proving or disproving *contested* claims, therefore this act of referring the claimants to Lintner *after* the medical-legal evaluations were already done was unlawful. CAL. CODE REGS. tit. 8, § 9793 (1993) (defining medical-legal report, for the purpose of determining the medical-legal range of charges, as meaning all initial comprehensive medical-legal reports submitted in order to prove or disprove a contested claim); CAL. LAB. CODE § 4620 (West 1989) (defining medical-legal expenses as any costs and expenses incurred by or on behalf of any party, the administrative director, the board, or a referee for X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and, as needed, interpreter's fees, for the purpose of proving or disproving a contested claim).

328. *Id.* at 18-23.

329. *Princeton Complaint, supra* note 20.

330. "Wellington" is collectively used for the entire group of plaintiffs. *See supra* note 175.

331. *See supra* note 175.

332. *Princeton Complaint, supra* note 20, at 7-12.

333. *Id.* at 7-8.

out of business, thereby reducing the number of workers' compensation claims against Zenith.³³⁴

Wellington contended that Zenith and the other defendants had engaged in an unlawful conspiracy to drive Wellington from business by various illegal practices.³³⁵ First, it was alleged that they had adopted uniform changes in payment policies by refusing to pay medical-legal evaluations and treatment expenses in a timely manner.³³⁶ Second, the defendants purportedly adopted uniform pretextual objections to stress claims, medical-legal evaluation charges, and treatment expenses submitted by Wellington by characterizing the claims as fraudulent or false.³³⁷ Third, virtually identical communication policies were supposedly adopted by the defendant insurance companies, which mandated that all communications with Wellington be in writing, resulting in increases in Wellington's cost of doing business and delayed negotiation and payment of claims.³³⁸ Fourth, Wellington accused the defendants of telling other insurers that Wellington was engaged in illegal business practices and of encouraging other insurers and employers to likewise refuse to deal with Wellington in the settlement of liens, and to instead litigate all liens.³³⁹ Lastly, the defendants were accused of communicating among themselves and with other insurers and employers through secret or public means.³⁴⁰

As with most antitrust suits, the basis of Wellington's antitrust suit was largely premised on circumstantial evidence such as conversations with the various defendant insurance companies.³⁴¹ For example, a Zenith attorney allegedly stated that Zenith was tired of the large size of Wellington's bills and was joining with other insurers to refuse to pay any bills for medical-legal evaluations and treatment submitted by Wellington and further

334. *Id.* at 7.

335. *Id.* at 8-9.

336. *Id.* at 8. It was alleged that Zenith declared their intent to continue this practice, even though it was a departure from general industry practice. *Id.*

337. *Id.* Wellington alleged that the defendants would tacitly contest the claims as being fraudulent or false, even though Zenith had no knowledge of the merits of the particular claims. *Id.*

338. *Id.* at 8-9. This practice was a severe handicap to Wellington, since the medical clinic had historically obtained most revenues from telephone negotiations with Zenith's claims personnel. *Id.* See *supra* notes 277-283 and accompanying text (discussing the concept of "conscious parallelism").

339. *Princeton Complaint*, *supra* note 20, at 9. Wellington alleged that this practice of "sham" litigation was an attempt to create publicity harmful to Wellington. *Id.*

340. *Id.* Wellington specifically mentioned a sponsored supplement in the October 28, 1991 Los Angeles Business Journal, written by a lawyer for Zenith which attacks forensic medical clinics and states that the insurance industry is contemplating taking action to eliminate the profit in evaluating and treating psychiatric injuries. *Id.*

341. *Princeton Complaint*, *supra* note 20, at 10-11.

intended to litigate all cases rather than agreeing on settlements.³⁴² Similar allegations were leveled at the other defendants, in which the insurance companies stated that they would not pay any medical-legal evaluations submitted by Wellington unless by judicial order.³⁴³

The turning point in the case came from a minute order issued by Judge Harry L. Hupp, in which the Wellington plaintiffs were told to drop their per se violation theory.³⁴⁴ Judge Hupp stated that, in his opinion, the per se violation would apply only if the defendants were in competition with the plaintiff.³⁴⁵ Since the plaintiffs were medical care providers, rather than insurers, the actions of the insurance company defendants did not impact competition.³⁴⁶ Further, he stated that the "boycott" alleged was also not intended to affect competition among psychiatrists and psychologists specializing in writing workers' compensation reports.³⁴⁷ It was not readily apparent how competition in the psychiatric report business would be harmed by a group decision requiring the report writer to establish the validity of reports.³⁴⁸ With the per se theory dropped, the case would be analyzed under the Rule of Reason.³⁴⁹ The great expense involved in litigating an antitrust suit under the Rule of Reason³⁵⁰ was instrumental in prompting Wellington to seek an out-of-court settlement with Zenith.³⁵¹

342. *Id.* at 10.

343. *Id.* at 10-11. Zenith allegedly stated that its new policy was to object to 99% of liens and maintain this objection until the workers' compensation case was settled, thereby refusing to pay for Wellington's medical-legal evaluation and treatment expenses prior to settlement of the workers' compensation case. *Id.* at 11. The complaint also stated that, since litigation of a claim can take several years, a delay in payment or settlement of Wellington's liens until after completion of litigation would put them out of business. *Id.*

344. *Princeton Medical Corp., et al. v. Zenith Ins. Co., et al.*, No. CV 91-6866-HLH (C.D. Cal. filed May 18, 1992) (order denying motion to dismiss amended complaint) (copy on file with the *Pacific Law Journal*).

345. *Id.*; see *supra* notes 288-292 and accompanying text (discussing the per se theory, and its general confinement to those types of conduct which obviously adversely affect competition).

346. *Princeton Medical Corp., et al. v. Zenith Ins. Co., et al.*, No. CV 91-6866-HLH (Cent. D. Cal. May 18, 1992).

347. *Id.*

348. *Id.*

349. *Id.*

350. See *supra* notes 293-298 and accompanying text (discussing the detailed analysis which a plaintiff must undergo in proving the unreasonableness of conduct analyzed under the Rule of Reason).

351. Telephone Interview with Donald G. Norris, Partner of Burton & Norris, attorneys for the Wellington plaintiffs (July 1, 1993) (stating that the lawsuit became prohibitively expensive after the plaintiffs were advised to drop their per se violation theory) (copy on file with the *Pacific Law Journal*); see *Zenith Insurance Co. Reaches Settlement*, *supra* note 307 (reporting on the settlement terms between Zenith and APC, and stating that Zenith had also settled with Dr. Byron Crawford and Wellington Medical Group).

C. Resolution of the Zenith and Wellington Suits

Prior to reaching a verdict in either the Zenith civil RICO suit or the Wellington antitrust suit, an out-of-court settlement between Zenith and Wellington was announced in which Zenith dismissed their RICO actions against all of the defendants in return for the dismissal of over \$1.6 million in suspected fraudulent lien claims.³⁵² In addition to dropping the antitrust suit against Zenith, Wellington agreed to pay Zenith an undisclosed amount of cash, and to substantially alter their business protocols in further dealings with Zenith.³⁵³

The business protocols to which Wellington agreed pertained to advertising format, medical-legal evaluations, disclosure of quarterly financial statements, and the ratio of comprehensive examinations performed in relation to more limited exams.³⁵⁴ Wellington agreed that all further advertising would state the penalties for defrauding the workers' compensation system, as well as the rights of employers to control treatment and investigate workers' compensation claims.³⁵⁵ Only one initial medical-legal evaluation per person would be paid, unless prior written consent had been obtained from Zenith.³⁵⁶ Time constraints were placed on when medical-legal evaluations or treatment could be performed.³⁵⁷ Wellington agreed that treatment and evaluation costs would strictly adhere to the established statutory medical fee schedules.³⁵⁸ Further, Wellington agreed to include on each bill the names of, and amount of time spent by, all employees who performed the

352. *Settlement, supra* note 307.

353. *Id.*; *see infra* notes 354-360 and accompanying text (discussing the business practices which Wellington agreed to alter in return for Zenith's moving for dismissal of the civil RICO complaint).

354. *Settlement, supra* note 307.

355. *Id.* The statement of penalties for making false claims must be in 12-point boldface type. *Id.* The advertisements must state that the employer has the right to control treatment in connection with workers' compensation claims for up to 30 days and to investigate such claims for up to 90 days. *Id.*

356. *Id.*

357. *Id.* Zenith would not have to pay for medical treatment if the treatment was provided prior to the earlier of 30 days from receipt by the employer of notice of a workers' compensation claim or notice that Zenith had denied the claim. *Id.* Further, Zenith would not pay for medical-legal evaluations performed prior to the earlier of 90 days from Zenith's receipt of the claim or Zenith's denial of the claim for benefits. *Id.* *See supra* note 90-94 and accompanying text (discussing recently enacted California Labor Code §§ 4060, 4621, which make significant changes in the laws pertaining to medical-legal evaluations arising from workers' compensation claims).

358. *See* CAL. LAB. CODE § 4628(a)-(j) (West Supp. 1993) (setting forth the requirements for preparation of medical report and payment schedules for doctors examining injured employees).

work being billed.³⁵⁹ Lastly, Wellington would provide Zenith with annual financial statements as well as quarterly statistics regarding the number of comprehensive examinations performed in relation to more limited levels of examination.³⁶⁰ The lopsided out-of-court settlement indicates the power of civil RICO in combatting fraudulent workers' compensation mills.

IV. RAMIFICATIONS AND SUGGESTIONS FOR FURTHER ACTION

There is no disputing the fact that workers' compensation mills pose a serious threat to the continued viability of California's workers' compensation system. Nor is there dispute surrounding the fact that a significant number of claims by workers are fraudulent--as high as thirty percent by some estimates.³⁶¹ The recent enactment of several workers' compensation reform bills³⁶² demonstrates the California Legislature's commitment to resolve the crisis which exists within the workers' compensation system. To be sure, this reform legislation will reduce the number of medical-legal evaluations and stress claims which currently engulf the system. Nevertheless, there are many sources of fraud within the workers' compensation system which this legislation does not address.³⁶³ It is not the purpose of this Comment to sympathize with the reprehensible conduct of fraudulent workers' compensation mills, or the workers who knowingly submit fraudulent claims. Rather, this Comment considers an inequity in the law which *may* be exploited by workers' compensation insurers as a low-risk means of prolonging or denying payment of legitimate claims. Assuming *arguendo* that twenty to thirty percent of all claims are indeed fraudulent,³⁶⁴ then seventy to eighty percent of all workers' compensation claims are legitimate. In order to assure the continued protection of the rights of this legitimate majority of claimants

359. *Settlement*, *supra* note 307. Each bill would also contain a statement under penalty of perjury regarding the accuracy of the amount of time spent by each person. *Id.*

360. *Id.*

361. CONTAINING THE COSTS, *supra* note 2, at 78-79 (reporting that the Council on California Competitiveness estimates that as much as 30% of employee claims are fraudulent, while major insurers estimate that 20% of such claims are fraudulent).

362. *See supra* notes 156-164 and accompanying text (discussing the new workers' compensation reform legislation).

363. *See supra* notes 50-105 and accompanying text (discussing the various sources of fraud which exist within the workers' compensation system).

364. *See* CONTAINING THE COSTS, *supra* note 2, at 78 (estimating that 20 to 30% of all workers' compensation claims are fraudulent).

to receive prompt payment of benefits, it is essential that the Legislature address every possible type of fraud which might occur. Given the fact that the workers' compensation system is largely self-regulating,³⁶⁵ the critical equilibrium may be upset by an imbalance in liability between various participants in the system.

A. Workers' Compensation Insurers Have Minimal Risk of Treble Damages Liability

The expansion of civil RICO to the workers' compensation system has proven itself as a cost-effective weapon for insurance companies to use against fraudulent claimants.³⁶⁶ By consolidating all of their claims into a single suit, less funds are spent on litigating, which ideally translates into more benefits for deserving injured workers. The treble damages remedy available to a successful civil RICO plaintiff serves as a powerful inducement for a defendant workers' compensation mill to settle out of court, thereby shortening the length of time the plaintiff must spend on the case and saving the workers' compensation system even more money.

In the event that a group of workers' compensation insurance companies engage in fraudulent non-payment of legitimate claims which would otherwise meet all the requirements of a RICO violation, they cannot be held liable for such conduct under the precedent set by *American International Group, Inc. v. Superior Court*.³⁶⁷ Instead, the only treble-damages remedy which would apply to these insurers would be a common law antitrust suit. As has been illustrated above, such a suit would be prohibitively expensive to bring due to the necessity of analyzing the complaint under the Rule of Reason.³⁶⁸ Since no other applicable cause of action exists which carries a treble damages remedy, workers' compensation insurers bear little risk of such liability.

365. HERLICK, *supra* note 26, at 1-2.

366. See *supra* note 352-360 and accompanying text (discussing the favorable settlement terms of the civil RICO suit brought by Zenith).

367. 234 Cal. App. 3d 749, 285 Cal. Rptr. 765 (1991). See *supra* notes 207-216 and accompanying text (discussing the *American Int'l Group* case).

368. See *supra* notes 294-298 and accompanying text (discussing the lengthy analysis required under the Rule of Reason doctrine).

B. *An Incentive For Fraudulent Nonpayment of Legitimate Claims Exists Among Workers' Compensation Insurers*

To those who believe that all workers' compensation insurers stringently adhere to the "prompt payment" policy of the workers' compensation system, the minimal risk of treble damages liability to workers' compensation insurers is a non-issue. Yet, while insurers characterize the medical clinics as being the main source of fraud within the workers' compensation system, they themselves are not above reproach. A recent investigation by the Los Angeles county district attorney's office concerns a suspected kickback scheme between a medical referral firm and insurance administrators who agreed to use their doctors.³⁶⁹ While this may simply be an isolated occurrence, it may also be the tip of the iceberg. When one considers the fact that the premiums which a workers' compensation insurer collects from employers are invested in various financial endeavors, it becomes evident that, like any investor, the workers' compensation insurance industry is subject to the cyclical nature of our economy.³⁷⁰ The impending change from a guaranteed profit system to a competitive system³⁷¹ will encourage insurers to lower their rates as much as possible in order to remain competitive. A logical method of balancing this reduction in rates is a reduction in the number of claims paid. Given the lower return on investments during a recession, the current economic climate in California engenders the practice of denying payment of legitimate claims.

It is assumed that the vast majority of workers' compensation insurers would be above allowing a sluggish economy, such as the one currently being experienced in California, to dictate their policy of claim payment.

369. Stuart Silverstein, *Unusual Fraud Probe Focuses on Insurers' Side of Workers' Comp*, L.A. TIMES, Aug. 4, 1993, Part D at 1, available in LEXIS, Nexis Library, LAT File. The referral firm, L.A. Management, acted as a middleman between doctors and administrators who handle workers' compensation claims for some employers and insurance companies. *Id.* Under the alleged scheme, doctors and medical clinics sent bills to the referral firm, whereupon L.A. Management would improperly inflate the medical charges, pass them on to the administrator, and these inflated bills would ultimately be paid by the employer. *Id.* The investigation concerns how L.A. Management secured its business from the insurance administrators, and whether they paid kickbacks to the administrators or the insurance companies the administrators serve. *Id.*

370. See generally Patricia K. Lundvall, *The Rise and Fall of the Antitrust Exemption for the Business of Insurance*, MCGEORGE SCHOOL OF LAW CENTER FOR RESEARCH (John Stauffer Charitable Trust Comment on the Law Series, June 1989) (discussing the intimate relationship between insurance industry practices and market fluctuations). While the Lundvall article refers specifically to property/casualty insurance, the economic principles described therein would apply to any investment portfolio.

371. See *supra* notes 113-114 and accompanying text (noting that recent legislation mandates enactment of a competitive system of workers' compensation insurance on January 1, 1995).

Nevertheless, the possibility exists for just such a practice. An insurer is obviously justified in refusing to pay fraudulent claims, however there is little risk involved to an insurance company which takes this practice a step further by adopting a policy of non-payment of all but the most routine claims. Aside from the much maligned "soft-tissue" injuries, there are many types of legitimate injuries which are routinely missed in cursory exams and could, therefore, be suspected as fraudulent. Detection of many injuries requires more extensive diagnostic exams, which are not ordinarily prescribed. While a practice of denying or delaying payment of these non-routine claims would likely reduce payment of fraudulent claims, it would also reduce payment of legitimate claims. Given the prompt payment policy of the workers' compensation system, such a practice goes too far. In the event that the Legislature decides to address this dangerous situation, there are various measures available: (1) Enactment of a "little RICO" statute, or a statutory treble damages penalty for fraudulent workers' compensation insurers; (2) a mandate that workers' compensation insurers adhere to a state-sponsored antitrust compliance program; and (3) a provision for proceedings before the Workers' Compensation Appeals Board to determine separate payment schedules for suspect claimants.

1. California Should Include a Civil Cause of Action In The State's "Little RICO" Statute

In declining to apply federal civil RICO liability to the insurance industry, the *American International Group*³⁷² court cited section 1012(b) of the McCarran-Ferguson Act, which states that no Act of Congress may supersede any State law for the purpose of regulating the business of insurance (unless the Act specifically relates to the business of insurance).³⁷³ This effectively places the regulation of the insurance industry on the shoulders of the state. In order to provide a treble damages remedy outside the confines of antitrust law, the California Legislature should adopt a civil RICO cause of action which specifically applies to the insurance industry. This type of statute would avoid the anticompetitive confines of antitrust law. A "little RICO" statute which provides a civil cause of action against those who form an enterprise for the purpose of engaging in a pattern of racketeering activity would enable a plaintiff to

372. 234 Cal. App. 3d 749, 285 Cal. Rptr. 765 (1991).

373. *Id.* at 768, 777; see 15 U.S.C. § 1012(b) (barring an Act of Congress from superseding any State law for the purpose of regulating the business of insurance).

sue in state court, rather than federal court. By including within the definition of racketeering activity the offense of fraudulent withholding of payment by an insurance company, the risk that workers' compensation insurers will engage in a pattern of conduct such as that alleged in the Wellington complaint would be reduced. Given California's dismal record in terms of the amount of benefits which actually reach injured workers,³⁷⁴ a state court would likely be more sympathetic to such a plaintiff.

In the event that the Legislature desires to remain consistent with federal law and preclude insurance companies from liability under the federal RICO Act,³⁷⁵ the Legislature can simply enact a statute which provides a treble damage remedy to a plaintiff who proves injury as a result of fraudulent payment practices by a workers' compensation insurer.

2. Mandatory State-Sponsored Antitrust Compliance Programs

Antitrust compliance programs are a fact of life in the modern business world. Simply put, they are internal guidelines established by a company which govern the conduct of the company's employees. By giving the employees firm parameters within which to perform, it is believed that productivity is enhanced because the employee no longer fears crossing the line between aggressive (but legal) business practices, and conduct which is illegal.³⁷⁶ While the traditional exemption of the workers' compensation insurance industry from antitrust law has never given rise to the need for an antitrust compliance program, the recent advent of fraud in the workers' compensation system has raised the stakes in the insurance industry significantly.

Since the workers' compensation industry is already subject to extensive regulation by the state, it is not unreasonable for the state Legislature to sponsor a detailed antitrust compliance program which applies to all workers' compensation insurers. Given the recent legislation which enables construction industry employers to provide workers' compensation altogether outside the state workers' compensation

374. See Thornton, *supra* note 11 (noting that California ranks 47th out of 50 states in terms of the amount of benefits paid to injured workers).

375. See *supra* notes 207-216 and accompanying text (discussing the *American Int'l Group* case, which refused to apply RICO to the insurance industry).

376. WALKER B. COMEGYS, ANTITRUST COMPLIANCE MANUAL—A GUIDE FOR COUNSEL AND EXECUTIVES OF BUSINESSES AND PROFESSIONS, 349 (2d ed. 1992).

system,³⁷⁷ the need for firm antitrust guidelines is certainly timely. By setting forth specific guidelines regarding communication between insurers, the risk of conduct such as that alleged in the Wellington complaint is minimized. A plaintiff who is able to prove conduct which falls outside of the established antitrust compliance program would be much more likely to be scrutinized under the *per se* doctrine, thereby enhancing the likelihood of a successful antitrust suit.

3. Administrative Hearings to Determine Payment Schedules for Suspicious Claims

While some medical care providers may actually be submitting universally fraudulent claims, the more likely scenario is that some claims are fraudulent, while others are legitimate. An insurer who arbitrarily withholds payment from a suspected workers' compensation mill may actually be denying valid claims along with fraudulent claims. In light of the strong possibility that most claims submitted by a specific workers' compensation mill are fraudulent, equity might say that just such a practice of arbitrary withholding of payment is exactly what the suspected workers' compensation mill deserves. Such reasoning misses the point, since this type of practice forces the legitimately injured worker to suffer for the sins of the medical care provider.

The California Insurance Commissioner could ensure the protection of legitimate claimants and diminish the rampant fraud currently infesting our workers' compensation system by establishing a "Registry of Suspicious Claimants." Medical care providers who are placed on this list would be required to justify the legitimacy of each claim to the insurer *prior* to payment by the insurance company. Placement in this registry could be done in an administrative hearing before the Workers' Compensation Appeals Board where the insurance company would be allowed to present evidence that, for example, thirty-five percent of a particular provider's claims were suspicious.³⁷⁸ The medical provider would be given the opportunity to dispute the allegations, and the decision of the Workers' Compensation Appeals Board would be final.³⁷⁹ Such a process would

377. See *supra* notes 34-37 (describing newly enacted Chapter 117).

378. In the event of an administrative finding of actual fraud, the appropriate licensing board should be notified so that a determination might be made as to whether there were adequate grounds to revoke the medical provider's license to practice medicine.

379. Once a provider has been deemed a Suspicious Claimant, provisions should be in place for a similar hearing whereby the suspect provider can petition to be removed from this registry.

serve to protect consumers from insurance company abuses while allowing for a more efficient method of reducing fraudulent claims. Because the suspicious claimants would have to prove the legitimacy of each claim before it was paid, rather than the insurer being required to prove the *illegitimacy* of the claim, the burden is shifted away from insurers, thereby reducing the costs to the workers' compensation system.

V. CONCLUSION

Given the fact that the workers' compensation system is largely self-regulating, the legal advantage currently enjoyed by the workers' compensation insurance industry is not necessarily a bad thing. In the event that insurance companies are only combatting fraudulent claimants, such an uneven playing field is only beneficial to the system so long as the insurers do not abuse their power. From a policy standpoint, there is nothing wrong with a group of insurers getting together and adopting *lawful* procedures to fight fraudulent claimants.³⁸⁰ Indeed, reducing the amount of fraudulent claims would benefit the entire workers' compensation industry, and boost California's sagging economy at the same time. The antitrust exemption of the business of insurance allows for the exchange of information relating to falsified claims,³⁸¹ even though this type of communication would be a violation of antitrust law in any other business. The concern is that the antitrust exemption, combined with an absence of RICO liability, makes it too easy for workers' compensation insurers to forget the distinction between profitable objectives and antifraud objectives.

Workers' compensation fraud is such a hot topic that a very obvious truth is easily overlooked: Most workers' compensation claims are legitimate. The risk created by the imbalance in treble damage liability is that workers' compensation insurers might engage in the type of conduct alleged in the Wellington complaint against large volume claimants, as well as fraudulent claimants. In this instance, legitimate consumers are injured. Given California's current position as forty-seventh in terms of

380. It has long been established that a desire to drive fraudulent people from business does not justify using unlawful means to accomplish this otherwise laudable objective. *See, e.g., Standard Sanitary Mfg. Co. v. United States*, 226 U.S. 20, 49 (1912) (stating that good intentions or good results do not justify deviation from the law); *Paramount Famous Lasky Corp. v. United States*, 282 U.S. 30, 43 (1930) (stating that otherwise laudable motives to put unscrupulous people out of business do not excuse unlawful means).

381. *See supra* notes 266-272 and accompanying text (discussing the antitrust exemption provided the business of insurance).

workers' compensation efficiency, we cannot afford to injure honest consumers any further. If the California Legislature is as committed to cleaning up the workers' compensation system as they would have voters believe, then they should adopt the types of reforms advocated in this Comment. Such reforms would only threaten insurers who engage in fraudulent payment practices. By adopting a more viable treble damage remedy than that which is currently available under antitrust law, the Legislature would be creating a level playing field for all sectors of the workers' compensation system, thus ensuring that injured workers receive the compensation that they rightfully deserve.

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