CONTINUING EDUCATION COURSE

INSURANCE – FRAUD - LAW

Life & Health and Property & Casualty

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IRONICALLY IN THE UNITED STATE, MANY AMERICANS BELIEVE THAT INSURANCE FRAUD IS A “VICTIMLESS CRIME” AND DOES NOT COST CONSUMERS ANYTHING.

THE TRUTH IS THAT INSURANCE FRAUD HURTS EVERYONE – FROM THE LITTLE OLD LADY WHO IS WORKING IN HER GARDEN TO THE CEO WHO IS SITTING IN HIS OFFICE, HIGH-UP IN THE SEARS TOWER.

BECAUSE WE ALL PAY THE COSTS OF INSURANCE FRAUD BY HAVING TO PAY EXTRA AMOUNTS FOR GOODS, SERVICES, INSURANCE, AND TAXES, MANY PEOPLE UNFORTUNATELY SEE THIS COST AS SIMPLY BEING A **FRAUD TAX.**

Insurance Fraud law

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Table of Content

Insurance Fraud 1

Insurance fraud, whether it is padding a claim to cover the cost of an insurance deductible or the activities of organized crime rings, cost the average American household more than $5,000 a year in the form of higher insurance premiums and higher prices for goods and services. Studies have indicated that many Americans are unaware that insurance fraud causes their premiums to increase by 10% to 30% each year.

What is insurance Fraud?

Insurance fraud occurs when individuals knowingly and intentionally deceive an agent, insurance company or other person to try to obtain money to which they aren't entitled. A typical fraudulent scheme occurs when someone puts false information on an insurance application and when false or misleading information is given or important information is omitted in an insurance transaction or claim.

Insurance fraud is committed by all kinds of people. The FBI, State prosecutors and the Insurance fraud division have prosecuted lawyers, doctors, car salesmen, insurance agents and other persons in positions of trust. Insurance fraud also includes people who seek to benefit from insurance through making false claims of loss or injury.

Insurance fraud cost an estimated $96.2 billion in increased premiums for 1999, according to a report conducted by Conning & Company. This total, which was at the height of a strong economy, can be expected to rise during an economic slowdown.

According to Conning's study, the sharp drop in the stock market and record levels of personal debt are underlying conditions for a potential increase in insurance fraud.

Five of the Most Common Types of Insurance Fraud: **2**

(1) Person(s) exaggerating the amount and value of items stolen from a home or business.

(2) Person(s) staging automobile accidents which result in inflated injury claims.

(3) Person(s) under reporting the number of miles driven on his auto policy.

(4) Person(s) failing to accurately report medical history when applying for life or health insurance.

(5) Employees of a company who fake or exaggerate injuries to avoid work and draw workers' compensation payments.

Research indicates that public attitude about insurance fraud has grown increasingly tolerant in recent years. Studies show that one in three Americans believe it is "all right" to pad insurance claims to make up for premiums paid in previous years when they had no claims. Most people believe that insurance fraud is a victimless crime. They also think that this type of crime is acceptable because it is committed against insurance companies. To them, the insurance industry is the wealthiest industry in the world and can afford the loss. They fail to realize that they are the victims and that insurance fraud is costing them a lot of money each year in the form of increased insurance premiums. Insurance fraud directly affects the amount we pay for life, health, auto and

homeowner’s insurance. It also increases the prices we pay for goods and services.

Vanishing Premium Insurance Policies Fraud

Several years ago, the life insurance industry began marketing individual life insurance policies which they could sell using "vanishing premium" sales illustrations. These policies proved attractive to consumers looking for permanent life insurance without having to pay premiums for life. Many estate planners also recommended their clients purchase joint life or second-to-die policies using the "vanishing premium" method to fund estate taxes. With the use of computer-generated sales illustrations, life insurers and life insurance agents routinely represented that the "vanishing premium" life insurance policy only required premium payments for a few years and thereafter the policy "paid for itself" out of interest or dividend earnings.

In many cases, these sales illustrations were based upon unrealistic assumptions about future interest rates and the insurance company's earnings. What then happened is, in later years, while the policyholder was paying his scheduled premiums for the number of years illustrated, the insurance company quietly reduced its interest rates or dividends to lower but more realistic levels. About the time the policyholder was expecting to stop making premium payments and let the policy pay for itself as represented, the company or agent would come back to the policyholder with a "revised" illustration showing the need for many more years of premium payments. The policyholder having budgeted to stop making payments for the life insurance, was then presented with a shocking and financially threatening dilemma: 1) either continue making expensive premium payments for many more years, or 2) risk having the insurance policy lapse for non-payment.

Fortunately, the laws of Texas and many other states provide life insurance consumers with a cause of action for damages caused by deceptive and misleading insurance sales practices. Successful suits have been prosecuted against many of North America's largest life insurance companies and their agents.

Insurance Fraud
Causes
Your
Insurance Premiums
to rise
10% to 30%
Each Year!

In an attempt to stamp out insurance fraud and hold down premiums for its residents, South Carolina has passed a mandatory report act. It states "…any person, insurer or authorized agency having reason to believe that another has made a false statement or misrepresentation or has knowledge of a suspected false statement or misrepresentation shall, for purpose of reporting and investigation, notify the Insurance Fraud Division of the office of the Attorney General of the knowledge, or belief and provide any additional information within his possession relative thereto."

Florida has a Fraud Busters reward program that encourages its residents to report insurance fraud. Rewards are payable to persons providing information leading to the arrest and conviction of persons committing complex and organized insurance crimes.

Rewards up to:

- $25,000 for information of losses greater than $ 1 million
- $10,000 for information of losses between $100,000 and $1million
- $1,000 for information of losses less than $20,000

Soft Fraud vs. Hard Fraud 3

Soft Fraud

This kind of insurance fraud is committed by normally honest people who tell “little white lies” to their insurance company. It may involve overstating their losses or simply filing a judged claim. They think their actions are harmless. But, soft fraud is a crime and in many states it is a felony.

Hard Fraud

Someone deliberately fakes an accident, injury, theft, arson or other loss to collect money illegally from insurance companies. Crooks often act alone, but increasingly, organized crime rings stage large schemes that steal millions of dollars.

Hard fraud also includes illegal acts by insurance agents, claim handlers, underwriters, and insurance companies.

What is the cost? 4

Insurance fraud costs Americans a least $80 billion a year and perhaps a great deal more. This type of fraud is hard to measure because so much goes undetected. But there is enough evidence to exhibit that insurance fraud is widespread and expensive.

Here are several of the better known annual estimates?

- $96.2 billion (Conning & Company) all lines of insurance
- $18-20 billion (National Insurance Crime Bureau). Only property & casualty fraud.
- $100 billion (U.S. Government Accounting Office). Only fraud and abuse in Medicare and Medicaid

Who are targets for Insurance fraud schemes?

Insurers –Short list

1. Allstate
2. Geico
3. Liberty Mutual
4. Prudential
5. State Farm

Self—Insurers—Short list

1. Ford Motor Company
2. Lucent Technologies
3. Target Corporation
4. Kellog Company
5. United Airlines
6. Nabisco Inc.
7. International Paper
8. K-Mart

9. Emerson Electric Company

Governmental Health Programs

1. Medicare
2. Medicaid

Insurance premiums are increasing at such a rapid pace that many of America's prestigious companies have decided to become self insured. The insurance industry has to do something about insurance fraud otherwise the cost of insurance will be unaffordable for most Americans.

Insurance fraud is almost as widespread as income tax evasion!

One state survey found that 58 percent of its people, roughly 5.4 million, feel it would be strongly appropriate for someone to commit some form of insurance fraud under certain circumstances. Yet, while more than half of the population may be willing to rationalize insurance fraud, an ever higher percentage felt that steps can be taken to discourage it.

Other Key Facts 5

- More than one – third of people hurt in auto accidents exaggerate their injuries. This adds $ 13-18 billion to America's annual insurance bill.
  (Rand Institute for Civil Justice)

- Fraudulent property/casualty insurance claims cost insurers about $30 billion annually (Insurance Information Institute)

- Healthcare fraud alone costs Americans $54 billion a year (Coalition Against Insurance Fraud)
- Workers compensation fraud costs the insurance industry $5 billion each year (National Insurance Crime Bureau)

Workers' Compensation Fraud – California 6

Workers Compensation fraud is running so rampant in California that its state legislators passed a law that requires every insurer selling workers compensation insurance in California to have a special investigation unit to investigate suspicious claims.

In 2003, thousands of businesses in Los Angeles decided to let their worker's compensation insurance lapse. The reason, skyrocketing premium costs – Although employees are required to have workers' compensation insurance many businesses have decided to break the law rather than paying the high premiums. State regulators and law enforcement officials expect the problem to get worse as premiums continue to increase and violators risk breaking the law just to keep their establishment afloat.

A 2001 study by the California Department of Industrial Relations and Employment Development Department estimated that 25% of the state's million-plus employer's may not carry any insurance.

The state Uninsured Employer's Fund, which pays benefits to injured workers whose employees are uninsured, handled 1,669 cases in 2001, up from 1,575 cases in 2000.

Although it may not be as well known as employee fraud-such as when a worker fakes or exaggerates an injury- employers have committed workers compensation fraud for years.

Although state officials say that businesses of all sizes commit workers' compensation fraud, the problem is believed to be particularly prevalent among smaller business, many of which simply refuse to pay for insurance.

The state of California issued 1,201 civil citations to businesses for violating workers' compensation laws – 276 were issued to restaurant owners.

Other small businesses, such as contractors who must prove they have insurance to get a license, may engage in more sophisticated schemes simply to lower premiums, such as paying employees partly in cash or classifying workers who engage in dangerous jobs as low risk clerks.

Employer's workers' compensation premium is largely governed by total payroll size, the likelihood of injury given the nature of a job and an employer's specific history of losses.

California began cracking down on workers compensation fraud in the early 1990's when a change in the law made the fraud a felony. But, attention mainly focused on employees who fabricated bogus claims with the help of unscrupulous lawyers and doctors.

The crackdown led to 202 arrests for insurance fraud in the 1995-96 fiscal year and nearly 300 two years later. Now state investigators are shifting their focus to employer fraud since most of the aggressive fraud mills have been put out of business.

Tips for Preventing Worker's Compensation Fraud
Employers understandably worry about rising workers' compensation premiums and workers are concerned about employers being uninsured. Industry experts note that fraudulent

compensation claims are partly to blame for rate increases and that some of the fraud can be prevented.

Six tips for preventing Fraud: 7

1. Do a more thorough background check on people you want to hire. Check credentials and references, and go beyond those offered by the prospective employee.
2. Increase your risk management. Make a commitment of having a clean & safe environment for your employees.

3. If one of your employees is injured on the job, do not wait to call your insurer. Get as much information as possible, including statements from witnesses, and contact your insurance carrier within minutes. Many business owners worry that calling the insurer will cause premiums to go up. In fact, the longer companies delay calling, the more problems they are likely to have with the claim.

4. Maintain a positive relationship with the injured worker. Employers run into problems when they establish adversarial relationships with claimants.

5. Watch for potential fraud. Pay attention to any information you receive that indicates the injury might be bogus or non-work-related.

6. Provide claimant information. When investigating a claim, give the insurance company as much information as possible about the claimant. Investigators need a description of the claimant's physical appearance and an accurate residential address, but they also like to know as much as possible about

patterns, disciplinary problems, arguments with supervisors etc.

Automobile thefts in the United States 8

The National Crime Bureau is a not-for-profit organization that partners with law enforcement agencies and insurers to help identify, detect, and prosecute insurance criminals. It reported in early 2003 that nine of the top ten metropolitan areas for vehicle theft are in or near ports and Canadian and Mexican borders or within easy reach of them.

The ten metropolitan areas (MSA's) with the highest vehicle theft rates in 2002 are the following:

(1) Phoenix, Arizona
(2) Fresno, California
(3) Modesto, California
(4) Stockton –Lodi, California
(5) Las Vegas, Nevada
(6) Miami, Florida
(7) Sacramento, California
(8) Oakland, California
(9) Seattle, Washington
(10) Tacoma, Washington

The NICB indicated that nine of the top 25 MSA's with the highest vehicle theft rates are in California. In this state alone, car theft has grown from 182,000 in 2000 to 210,000 in 2001 and over 227,000 in 2002.

NICB also reported that 19 of those top 25 metropolitan areas are west of the Mississippi river. Several communities have recorded a decline in the vehicle theft rate. For example, Miami fell from second in 2001 to sixth in 2002; Detroit declined from fourth in 2001 to 11th in 2002; Tuscan dropped from sixth in 2001 to 13th in 2002 and Jersey City, New Jersey fell from 10th in 2001 to 23rd in 2002. FBI statistics show that vehicle theft increased 4.2 percent during the first six-months of 2002, compared with the same period in 2001. Over 1.2 million vehicles are stolen each year, costing more than 8.2 billion dollars.

The recovery rate of stolen cars has declined from the mid 80 percent in the early 1990 to 62 percent in 2001. Many of these unrecovered vehicles are shipped overseas or driven across international borders. It is estimated approximately 200,000 stolen cars are illegally exported out of the country each year.

Experts suggest that people who live in communities near ports and international borders need to pay special attention to protecting their cars and trucks from thieves.

The drop in recoveries of stolen vehicles indicates growth in well organized professional theft rings who direct stolen vehicles to **"chop shops"** which dismantle them for parts or transport them out of the country.

More stolen vehicles are now being located due to the use of new Gamma Ray machines which x-ray shipping containers as they arrive at port facilities.

Thefts by automobile models 9

The 1989 Toyota Camry was the most popular car stolen in the last five years in the United States. In the years ending in 2002, the Camry held the top spot for stolen vehicles four out of five years.

The top ten vehicles stolen in 2002 according to CCC Information Services are indicated below:

1. 1989 Toyota Camry
2. 1991 Toyota Camry
3. 1990 Toyota Camry
4. 2000 Honda Civic Sl
5. 1994 Honda Accord EX
6. 1994 Chevrolet C1500 4x2
7. 1995 Honda Accord EX
8. 1988 Toyota Camry
9. 1994 Honda Accord LX
10. 1996 Honda Accord LX

Law enforcement agencies affected by increases in the export of stolen vehicles have joined forces to combat the problem. The FBI, United States Custom Office, NICB, several major insurers and state and local law enforcement agencies have formed the North American Export Committee (NAEC) which promotes the use of task forces, electronic data reporting and gamma ray (x-ray) machines to scan containers at ports. The U.S. Custom along with the

NICB has joined forces at 26 port and border locations to reduce the exportation of stolen vehicles from the United States. Their successful use of x-ray machines at six ports in Florida has caused many car thieves to move their export business to other areas in the U.S.

Insurer Discounts:

Twelve states (Florida, Illinois, Kentucky, Louisiana, Massachusetts, Minnesota, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island and Texas) requires insurers to give car owners discounts on their comprehensive insurance for anti-theft devices. Massachusetts residents are eligible for a minimum 25 percent discount if they have both an anti-theft device and an auto recovery system.

Viatical Settlements Investment Fraud ***10***

Historically, some insurance companies have offered an accelerated death benefits option which allows the insured an opportunity to receive up to 80% of the death benefit at any time within the last year of their projected life. The remaining 20% is then paid to the insured's estate.

On the other hand, the business of viatical settlements involves the selling of a policy death benefit, at less than face value, by a terminally ill person to a third party. This is accomplished, for a commission, with the assistance of a broker who offers the policies to settlement provider companies for bid, with the highest bidder obtaining the policy for resale to investors. The broker receives a commission based on the sale price.

Size of the Industry

The dollar amount of viaticated policies has skyrocketed in recent years. In 1990, approximately $80 million worth of life insurance was viaticated as compared to an estimated $1 billion in 1999.

Fraud in the unregulated viatical settlement industry has become rampant; as much as 40-50% of the life insurance policies viaticated may have been procured by fraud. Experts estimate that investors have lost more than $400 million in these types of investments since the industry started in the 1980's. One corporation alone, charged with 155 felony counts relating to criminal fraud had bad policies with a face value of $12.7 million.

Clean Sheeting

Unscrupulous individuals in the viatical industry procure policies by a practice referred to as "clean sheeting" which is the act of applying for life insurance while intentionally failing to disclose the applicant's status as being terminally ill. They can get away with it initially because most insurance companies avoid the added costs and invasiveness of medical exams and blood tests by relying on an honor system below a certain policy face value.

Many insurance agents and brokers assist and often encourage viators in committing the fraud because it not only provides more policies than would be available though legitimate means, but it also provides a much higher rate of return due to the fact they can be bought from viators so cheaply.

In a legitimate transaction, the ill person usually receives 50%-70% of the face value of the policy. However, a "clean sheeted" policy viaticated during the contestable period may offer as little as 10% of the face value because it carries the high risk of rescission, or cancellation by the insurance company, due to fraud.

Wet Ink Policies

After the policy is issued, the insured person will sell his policy, or multiple policies from different insurance companies, sometimes within weeks, to a settlement provider using a broker. This is referred to as a "wet ink policy" because the ink on the contract is still "wet" when the policy is sold.

The odds against an individual finding out that he is terminally ill within weeks of buying a policy are exceedingly high. To see that happen repeatedly within a short period of time with the same broker or provider is strong evidence that they are both well aware that the policies have been "clean sheeted" .

To hide the fact that the policy has been viaticated shortly after issuance, con artists will obscure viatication by simply changing the beneficiary to someone at the settlement provider firm. A second way is to employ a "collateral assignment" which is similar to where the insured seeks a loan from a third party and secures the loan by pledging the death benefits of the policy. In fraudulent transactions they pledge the death benefits but do not receive a loan.

Contestability Period

Finally, some settlement providers merely delay reporting that the policy has been viaticated until the contestability

period is over, falsely believing that it is not a crime then. An indication of culpability is that virtually all parties attempt to hide the viatication of fraudulently obtained policies from the insurance company for as long as possible.

The contestability clause for life insurance lasts for two years after issuance, during which time it may be rescinded by the insurer for fraud in the application. After this period ends, the insurer is obligated to pay the death benefit, regardless of any fraud in the application. Because policies viaticated during the contestability period may be rescinded, they bring, as mentioned, a much lower price in the market.

A Case Study

As an investor, you are offered the opportunity to purchase an interest in a life insurance policy in which the insured is terminally ill (i.e., viatical settlement).

You are told:

1.that your investment will produce a 100% rate of return because you are assigned a policy with a face value of twice your investment which you can claim upon their death;
2. that you will have the option of reselling your policy once it becomes incontestable (two years after the date the policy is issued) for 70% of the face value;
3. and that if the policy is contested or canceled by the insurer, the promoters will provide a replacement policy through a “replacement policy trust” managed by them.

They say these are better investments than stocks, mutual funds, annuities, and CD's because viatical investments have the following attributes:

"Full liquidity at maturity from rock solid 'A' rated insurance companies!"

"Tax advantaged & hassle free! 100% fixed rate of return which is fully secured."

"Zero risk to principal, a totally safe investment with no load & no fees!"

"Short holding periods with early buyout options available as well!"

"No speculation, no interest rate risk, no market risk, no economic risk!"

In addition they say you will be making a "humanitarian investment" because the terminally ill person will be able to use the funds to receive improved health care; pay off debts; take a vacation, reduce family stress, and enhance their quality of life. In exchange for your money you receive a Membership Certificate certifying that you are a member of Viatical Funding LLC.

After deducting the fees paid to sales agents, viator agents, and other intermediaries from your funds, you find that the ill person will actually be left with very little. In this case only $5,400, which is only 12% of your investment of $45,000, or 6% of the policy's face value of $90,000.

They fail to disclose to you that the insured was terminally ill prior to being insured, that they concealed this fact on the application, and thus subjected the policy to cancellation by the insurer.

Instead of being designated as the sole beneficiary you may find you share it with creditors and family members, and that the option to resell the ownership interests is not a guaranteed option, but rather an "assurance" that they will "make an effort" to facilitate a resale. In any event, you will not likely receive a promised 70% of the face value but only the amount another investor would be willing to pay, less commissions, which could be much less.

They also fail to mention:

1. the risk of the insured living much longer than the estimated life expectancy, thereby greatly reducing the annual yield;
2. the risk of their becoming insolvent and unable to replace a contested or canceled policy;
3. the risk of the life insurance policy lapsing, or that you will often have to pay the policy premiums for the duration of the policyholder's life;
4. the 15% commission the sales agent receives from your investment;
5. who is responsible for monitoring the health status and location of the insured, obtaining a death certificate, and making a claim to the insurance company.

Life Expectancy of the Insured

To determine their rate of return investors rely on a report which projects the life expectancy of the insured, but there are no minimum requirements as to who may generate these reports or projections. One company used a nurse and a plastic surgeon but could have used the janitor.

Viatical investing is highly speculative and risky. Even when the policyholder exists and is terminally ill, there is a high degree of uncertainty in predicting when they will die. New AIDS drugs and cancer treatments have compounded the risk for investors because they help policyholders live longer.

Viatical settlements are illegal under Canadian insurance legislation so Canadian investors should not be involved in these schemes at all.

Not Enough Sick People

One company pled guilty after being charged with conspiring to recruit insurance agents to defraud more than 3,000 investors while purchasing viaticated insurance policy investments over a three year period.

Another company, was ordered to pay $129 million restitution on a corporate guilty plea in this case where the three companies fleeced people with promises of high returns on purchases of life insurance policies from the terminally ill.

Investors were told that their money would be used to purchase a beneficial interest in viaticated insurance policies, and that medical overviews were being performed on the insured persons whose policies were being bought.

Although at least $115 million in investor monies was taken in, the promoters used only $6 million of these funds to buy insurance policies whose total face value was just over $7 million. They used the balance of the money for purposes totally unrelated to the purchase of viaticated insurance policies, such as the purchase of twenty-five houses in Florida, Vermont, South Carolina, Massachusetts, Georgia, and Toronto, two helicopters, thirty-four luxury automobiles,

three motorcycles, several jet skis and boats and a Fort Lauderdale burrito shop.

Industry Terminology

Cleansheeting: Refers to a fraudulent criminal act committed by a proposed life insurance applicant, and by life insurance agents who knowingly assist or conspire with the insurance applicants, by failing to disclose a pre-existing medical condition in response to a question on a life insurance application which would affect issuance of the policy.

Viator: A person who has a life threatening or terminal illness who sells or assigns their life insurance policy.

Viatical Settlement: The life insurance policy of a terminally ill person, sold or offered for sale, generally at less than face value, through a viatical settlement company.

Contestability: Policies are generally contestable for two years from the date of issue and are subject to being rescinded by the insurer for cause, such as application fraud and suicide.

Viatical Settlement Provider: A person who enters into a viatical settlement contract with a viator. Often referred to as a settlement company or funder.

Viatical Settlement Broker: A person who, for profit, offers or attempts to negotiate a settlement contract between a viator and one or more viatical settlement providers.

Viatical Settlement Sales Agent: A person other than a licensed viatical settlement provider who arranges for the

purchase of a viatical settlement or an interest in a viatical settlement from a viatical settlement provider.

Mortality Profile Report: A report based on a review of a viator's medical history, which gives a prognosis of a viators life expectancy. Usually done by a health-care professional and generally at the behest of the viatical settlement provider to calculate the value of a viatical contract.

Viatical Investment Broker: Defines a person or entity other than a licensed viatical settlement provider who solicits investors to purchase a viatical settlement interest from a viatical settlement provider.

We Chose to Keep Your Money

Some companies mislead investors when they sold viatical securities in the form of loan transactions. Investors lent money to them in order for them to purchase the benefits of life insurance policies from terminally ill individuals on the promise that they would receive a return on their investment of 21-25% per annum.

The funds, however, were not used to purchase life insurance policies but kept instead. Over 1100 investors nationwide are believed to have invested $80-100 million in these transactions in just ten months. No evidence of any valid life insurance policies being purchased has been discovered.

Repercussions for the Industry

Life insurance premiums are based on actuarial tables which are worthless in fraudulent applications. Insurance companies cannot afford to pay out large death benefits after

collecting small premiums for only a few years. Even if they don't go bankrupt the added costs are eventually passed on to other policyholders.

The viatical industry as a whole must take steps to better police itself. If it does not, it risks ceasing to exist as an industry either by being legislated out of existence or by being pushed out of the market after destroying investor confidence in its product. If this fraud is to be stopped, it will require the total commitment of the insurance industry. The first step is for the industry to wake up to the existence and scope of the problem.

Penalties

Currently a person charged with viaticating a fraudulently procured insurance policy worth $100,000 face value, who stands to gain tens of thousands of dollars, faces the same penalty as a shoplifter who takes a pack of cigarettes. A mere sixty days in jail is an encouragement, not a deterrent which may be why the industry watchdog has never received a single referral from the industry itself reporting such fraud.

Life Settlements

Once thriving on those dying from a terminal illness, medical advances, which are helping patients live longer, has caused the business to start targeting new clients - usually seniors with high payoffs - who may be willing to sell their life insurance policy to investors at a discount.

Life settlements, or the sale of a life insurance policy to a third party, are sometimes referred to as "senior settlements" because most of the life insurance policies purchased insure the life of a senior citizen.

The owner of the policy gets cash and the buyer becomes the new owner and/or beneficiary of the life insurance policy, pays all future premiums and collects the entire death benefit when the insured dies.

People decide to sell their life insurance policies for many reasons. Some common ones are the changed needs of dependents, a desire to reduce or eliminate premiums, and a need for additional cash to meet expenses.

State regulation of insurance generally does not extend to life settlements. Certain aspects of these transactions may fall under the various Securities Acts so there can be financial risks involved when entering into such arrangements.

You should consider contacting a professional tax advisor to find out the tax implications as life settlement proceeds are generally not tax free. Also know, if you are the seller that you will be required to provide certain medical and personal information to third parties who will be paid the proceeds from your policy upon your death. These third parties may sell your policy and pass along your medical and personal information to other individuals.

Typically, life settlements are offered to buyers, for resale to investors, at a discount from the death benefit. The discount is for the entire life of the policy, not an annual rate of return. An annual rate of return cannot be guaranteed. Your rate of return depends on when the insured dies and no one can predict a person's life expectancy. Keep in mind that a life settlement is not a liquid investment because the return on such an investment does not occur until the insured dies.

11

MOTOR VEHICLE CHOP SHOP AND ILLEGALLY OBTAINED AND ALTERED PROPERTY ACT

§ 1.1. Short title.

This act shall be known and may be cited as the Motor Vehicle Chop Shop and Illegally Obtained and Altered Property Act.

§ 1.2. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Chop shop."

Any building, lot or other premises where one or more persons engage in altering, destroying, disassembling, dismantling, reassembling, storing or possessing any motor vehicle or motor vehicle part known by such persons or persons to be illegally obtained, in order to either:

1. alter, counterfeit, deface, destroy, disguise, falsify, forge, obliterate or remove the identification, including the vehicle identification number of the motor vehicle or motor vehicle part in order to misrepresent the identity of the motor vehicle or motor vehicle part or to prevent the identification of the motor vehicle or motor vehicle part; or
2. sell or dispose of the motor vehicle or motor vehicle part.

"Motor vehicle."

A vehicle which is self-propelled except one which is propelled solely by human power or by electric power obtained from overhead trolley wires but not operated upon rails.

"Person."

A natural person, firm, copartnership, association or corporation.

"Vehicle identification number."

A combination of numerals or letters, or both, which the manufacturer assigns to a vehicle for identification purposes or, in the absence of a manufacturer assigned number, which the Department of Transportation assigns to a vehicle for identification purposes.

§ 1.3. Owning; operating or conducting a chop shop; penalty.

Any person who knowingly:

1. owns, operates or conducts a chop shop; or
2. transports, sells, transfers, purchases or receives any motor vehicle or motor vehicle part that was illegally obtained either to or from a chop shop commits a felony of the second degree and, upon conviction, shall be sentenced to imprisonment for not more than ten years or a fine of not more than $100,000, or both.

§ 1.4. Altered or illegally obtained property; penalty.

(a) Alteration or destruction of vehicle identification number.-- Any person who alters, counterfeits, defaces, destroys, disguises, falsifies, forges, obliterates or removes a vehicle identification number with the intent to conceal or misrepresent the identity or prevent the identification of a motor vehicle or motor vehicle part commits a felony of the third degree and, upon conviction, shall be sentenced to imprisonment for not more than seven years or a fine of not more than $50,000, or both.

(b) Disposition of vehicle.--Any person who purchases, receives, disposes, sells, transfers or possesses a motor vehicle or motor vehicle part with knowledge that the vehicle identification number of the motor vehicle or motor vehicle part has been altered, counterfeited, defaced, destroyed, disguised, falsified, forged,

obliterated or removed with the intent to conceal or misrepresent the identity or prevent the identification of a motor vehicle or motor vehicle part commits a felony of the third degree and, upon conviction, shall be sentenced to imprisonment for not more than seven years or a fine of not more than $50,000, or both.

§ 1.5. Exceptions.

(a) Scrap processor.--The provisions of section 3 shall not apply to a motor vehicle scrap processor who, in the normal legal course of business and in good faith, processes a motor vehicle or motor vehicle part by crushing, compacting or other similar methods, provided that any vehicle identification number is not removed from the motor vehicle or motor vehicle part prior to or during any such processing.

(b) Repair of vehicle.--The provisions of section 3 do not prohibit the removal of a vehicle identification number plate from a vehicle part that is damaged when such removal is necessary for proper repair or matching identification of a replacement vehicle part, but such removal is only allowed if the proper matching vehicle identification number plate is immediately and properly secured to the repaired or replacement part.

§ 1.6. Presumptions.

(a) Vehicles.--Any person or persons who transport, sell, transfer, purchase, possess or receive any motor vehicle or motor vehicle part upon which the vehicle identification number has been altered, counterfeited, defaced, destroyed, disguised, falsified, forged, obliterated or removed or who fails to keep, possess or produce the records required to be kept, possessed or produced for the motor vehicle or motor vehicle part pursuant to 75 Pa. C.S. § 6308 (relating to investigation by police officers) shall be prima facie evidence under section 3 of that person's or persons' knowledge that the motor vehicle or motor vehicle part was illegally obtained.

(b) Police report.--A police report which indicates that a motor vehicle or motor vehicle part was reported to police to be in a stolen status at the time it was possessed shall be prima facie evidence that the motor vehicle or motor vehicle part was possessed without permission of the owner.

§ 1.7. Loss of property rights to Commonwealth.

(a) Forfeitures generally.--The following shall be subject to forfeiture to the Commonwealth and no property right shall exist in them:

1. Any tool, implement or instrumentality, including, but not limited to, a motor vehicle or motor vehicle part, used or possessed in connection with any violation of this act.
2. All materials, products and equipment of any kind which are used, or intended for use, in violation of this act.
3. All books, records, microfilm, tapes and data which are used or intended for use in violation of this act.
4. All money, negotiable instruments, securities or other things of value used or intended to be used to facilitate any violation of this act and all proceeds traceable to any transactions in violation of this act.
5. All real property used, or intended to be used, to facilitate any violation of this act, including structures or other improvements thereon, and including any right, title and interest in the whole or any lot or tract of land and any appurtenances or improvements, which are used, or intended to be used, in any manner or part, to commit or to facilitate the commission of a violation of this act.

(b) Exceptions.--

1. No property shall be forfeited under this section, to the extent of the interest of an owner, by reason of any act or omission established by the owner to have been committed or omitted without the knowledge or consent of that owner.
2. No valid lien or encumbrance on real property shall be subject to forfeiture or impairment under this paragraph.

A lien which is fraudulent or intended to avoid forfeiture under this section shall be invalid.

(c) Process and seizure.--Property subject to forfeiture under this act may be seized by the law enforcement authority upon process issued by a court of common pleas having jurisdiction over the property. Seizure without process may be made if:

1. the seizure is incident to an arrest or a search warrant or inspection pursuant to 75 Pa.C.S. § 6308 (relating to investigation of police officers) or any other administrative inspection;
2. the property subject to seizure has been the subject of a proper judgment in favor of the Commonwealth in a criminal injunction or forfeiture proceeding under this act;
3. there is probable cause to believe that the property is dangerous to health or safety; or

4. there is probable cause to believe that the property has been used, or is intended to be used, in violation of this act.

(d) Seizure without process.--In the event seizure without process occurs, as provided in this act, proceeding for the issuance thereof shall be instituted forthwith.

(e) Custody of property.--Property taken or detained under this section shall not be subject to replevin but is deemed to be in the custody of the law enforcement authority subject only to the orders and decrees of the court of common pleas having jurisdiction over the forfeiture proceedings and of the district attorney or the Office of Attorney General. When property is seized under this act, the law enforcement authority shall place the property under seal and either:

1. remove the property to a place designated by it; or
2. require that the district attorney or the Office of Attorney General take custody of the property and remove it to an appropriate location for disposition in accordance with law.

(f) Use of property held in custody.--Whenever property is forfeited under this act, the property shall be transferred to the custody of the district attorney if the law enforcement authority seizing the property has local or county jurisdiction, or the Office of Attorney General if the law enforcement authority seizing the property has Statewide jurisdiction. The district attorney or the Office of Attorney General, where appropriate, may:

1. Retain the property for official use.
2. Sell any forfeited property which is not required to be destroyed by law and which is not harmful to the

public, but the proceeds from any such sale shall be used to pay all proper expenses of the proceeding for forfeiture and sale, including expenses of seizure, maintenance of custody, advertising and court costs. The balance of the proceeds shall be dealt with in accordance with subsections (g) and (h).

(g) Use of cash, property or proceeds of property.--Cash or proceeds of forfeited property transferred to the custody of the district attorney pursuant to subsection (f) shall be placed in the operating fund of the county in which the district attorney is elected. The appropriate county authority shall immediately release from the operating fund, without restriction, a like amount for the use of the district attorney in enforcing the criminal laws of this Commonwealth. The entity having budgetary control shall not anticipate future forfeitures or proceeds there from in adoption and approval of the budget for the district attorney.

(h) Distribution of property among law enforcement authorities.--If both State and municipal law enforcement authorities were substantially involved in effecting the seizure, the court having jurisdiction over the forfeiture proceedings shall equitably distribute the property between the district attorney and the Office of Attorney General.

(i) Annual audit of forfeited property.--It shall be the responsibility of every county in this Commonwealth to provide, through the controller, board of auditors or other appropriate auditor and the district attorney, an annual audit of all forfeited property and proceeds obtained under this section. The audit shall not be made public but shall be submitted to the Office of Attorney General. The county shall report all forfeited property and proceeds obtained under this section and the disposition thereof to the Office of Attorney General by September 30 of each year.

(j) Annual report; confidential information regarding property.--The Office of Attorney General shall annually submit a report to the Appropriations and Judiciary Committees of the Senate and to the Appropriations and Judiciary Committees of the House of Representatives, specifying the forfeited property or proceeds thereof obtained under this section. The report shall give an accounting of all proceeds derived from the sale of forfeited property and the use made of unsold forfeited property.

The Office of Attorney General shall adopt procedures and guidelines governing the release of information by the district attorney to protect the confidentiality of forfeited property or proceeds used in ongoing enforcement activities.

(k) Proceeds and appropriations.--The proceeds or future proceeds from forfeited property under this act shall be in addition to any appropriation made to the Office of Attorney General.

§ 1.8. Procedure with respect to seized property subject to liens and rights of lien holders.

(a) General procedure.--The proceedings for the forfeiture or condemnation of property, the sale of which is provided for under this act, shall be in which the Commonwealth shall be the plaintiff and the property the defendant. The Pennsylvania Rules of Civil Procedure shall apply to all forfeiture proceedings brought under this act. A petition shall be filed in the court of common pleas of the judicial district where the property is located, verified by oath or affirmation of an officer or citizen, containing the following:

1. A description of the property seized.
2. A statement of the time and place where seized.
3. The owner, if known.
4. The person or persons in possession, if known.

5. An allegation that the property is subject to forfeiture pursuant to section 7 and an averment of material facts upon which the forfeiture action is based.
6.
7. A prayer for an order of forfeiture that the property be adjudged forfeited to the Commonwealth and condemned and be ordered sold according to law unless cause be shown to the contrary.

(b) Notice to property owners.--A copy of the petition required under subsection (a) shall be served personally or by certified mail on the owner or upon the person or persons in possession at the time of the seizure. The copy shall have endorsed a notice, as follows:

To the claimant of within described property: You are required to file an answer to this petition, setting forth your title in and right to possession of, said property within 30 days from the service hereof, and you are also notified that if you fail to file said answer, a decree of forfeiture and condemnation will be entered against said property.

The notice shall be signed by the Attorney General, Deputy Attorney General, district attorney, deputy district attorney or assistant district attorney.

(c) Substitute notice.--If the owner of the property is unknown or there was no person in possession of the property when seized or if the owner or such person or persons in possession at the time of the seizure cannot be personally served or located within the jurisdiction of the court, notice of the petition shall be given by the Commonwealth through an advertisement in only one newspaper of general circulation published in the county where the property was seized once a week for two successive weeks.

No other advertisement of any sort shall be necessary, any other law to the contrary notwithstanding. The notice shall contain a statement of the seizure of the property with a description of the property and the place and date of seizure and shall direct any claimants to the property to file a claim on or before a date given in the notice, which date shall not be less than 30 days from the date of the first publication. If no claims are filed within 30 days of publication, the property shall summarily forfeit to the Commonwealth.

(d) Property owners not in jurisdiction.--For purposes of this section, the owner or other such person cannot be found in the jurisdiction of the court if:

1. A copy of the petition is mailed to the last known address by certified mail and is returned without a delivery.
2. A personal service is attempted once, but cannot be made at the last known address.
3. A copy of the petition is left at the last known address.

(e) Notice automatically waived.--The notice provisions of this section are automatically waived when the owner, without good cause, fails to appear in court in response to a subpoena on the underlying criminal charges. Forty-five days after such a failure to appear, if good cause has not been demonstrated, the property shall summarily forfeit to the Commonwealth.

(f) Preservation of the property subject for forfeiture.--Upon application of the Commonwealth, the court may enter a restraining order or injunction, require the execution of a satisfactory performance bond or take any other action to preserve the availability of property described in section 7 for forfeiture under this section either:

1. upon the filing of an information or in indictment charging a violation of this act for which criminal forfeiture may be ordered under this act and alleging that the property with respect to which the order is sought would be subject to forfeiture; or
2. prior to the filing of such an indictment or information, if, after notice to persons appearing to have an interest in the property and an opportunity for a hearing, the court determines that:
    i. There is a substantial probability that the Commonwealth will prevail on the issue of forfeiture and that failure to enter the order will result in the property being destroyed, removed from the jurisdiction of the court or otherwise made unavailable for forfeiture.
    ii. The need to preserve the availability of the property through the entry of the requested order outweighs the hardship on any party against whom the order is to be entered.

However, an order entered pursuant to this subsection shall be effective for not more than 90 days unless extended by the court for good cause shown or unless an indictment or information described in paragraph (1) has been filed.

(g) Temporary restraining order.--A temporary restraining order under subsection (f) may be entered upon application of the Commonwealth without notice or opportunity for a hearing when an information or indictment has not yet been filed with respect to the property if the Commonwealth demonstrates that there is probable cause to believe that the property with respect to which the order is sought would be subject to forfeiture under this act and that provision of notice will jeopardize the availability of the property for forfeiture. Such a temporary order shall expire not more than ten days after the date on which it is entered unless extended for good cause shown or unless the party against whom it is entered consents to an extension for a longer period. A hearing requested concerning an order entered under this subsection shall be held at the earliest possible time and prior to the expiration of the temporary order.

(h) Hearing regarding property; rules of evidence.--The court may receive and consider at a hearing held pursuant to subsections (f) or (g) evidence and information that would be inadmissible under the rules of evidence.

(i) Hearing time set.--Upon the filing of a claim for the property setting forth a right of possession, the case shall be deemed at issue and a time shall be fixed for the hearing.

(j) Owner's burden of proof.--At the time of the hearing if the Commonwealth produces evidence that the property in question was unlawfully used, possessed or otherwise subject to forfeiture under section 6, the burden shall be upon the claimant to show:

1. That the claimant is the owner of the property or the holder of a chattel mortgage or contract of conditional sale thereon.
2. That the claimant lawfully acquired the property.
3. That it was not unlawfully used or possessed by the claimant. In the event that it shall appear that the property was unlawfully used or possessed by a person other than the claimant, then the claimant shall show that the unlawful use or possession was without his knowledge or consent. Such absence of knowledge or consent must be reasonable under the circumstances presented.

(k) Court-ordered release of property.--If a person claiming the ownership of or right of possession to or claiming to be the holder of a chattel mortgage or contract of conditional sale upon the property, the disposition of which is provided for in this section, prior to the sale presents a petition to the court alleging over the property lawful ownership, right of possession, a lien or reservation of title and if, upon public hearing, due notice of which having been given to the Office of Attorney General or the district attorney, the claimant shall prove by competent evidence to the satisfaction of the court that the property was lawfully acquired, possessed and used by him or, it appearing that the property was unlawfully used by a person other than the claimant, that the unlawful use was without the claimant's knowledge or consent, then the court may order the property returned or delivered to the claimant. Such absence of knowledge or consent must be reasonable under the circumstances presented. Otherwise, it shall be retained for official use or sold in accordance with section 7(f).

Fraud Prevention Plans 12

Section 409 of the New York Insurance Law requires insurers to file with the Insurance Department a plan for the detection, investigation and prevention of insurance fraud. The Fraud Prevention Plan must include provisions for establishing a Special Investigating Unit (SIU), apart from any underwriting or claims units, to perform these functions. The following information is a guideline for insurers in regard to implementing this mandate.

1. The Insurance law permits insurers to use the services of an outside contractor to perform the function of an SIU. If an insurer uses an independent contractor to perform SIU functions, the agreement must include a statement that the contractor will cooperate with the Insurance Frauds Bureau. However, the law is clear that the insurer remains primarily responsible for the development and implementation of its Fraud Prevention Plan.

2. Each SIU should be established as a separate unit with its own budget line. The Department will review the source of each SIU's funding.

3. The Plan must include the name title, job description and geographical location of each investigator in the SIU, in addition to the territory to which the investigator is assigned. This information must be updated annually and submitted as part of the annual report that insurers must file with the department.

4. Each insurer has broad latitude in deciding how much of its resources will be dedicated to fraud prevention. However, companies must justify the adequacy of these resources.

5. SIU investigators hired after September 10, 1996 must have a bachelor's degree in criminal justice or a related field.

6. Fraud Prevention Plans must also include provisions for in-service training programs for investigative, underwriting and claims staff in identifying and evaluating suspected insurance fraud; development of public awareness programs; and development of a Fraud detection and Procedure Manual.

Insurers must report their experience, performance and cost effectiveness in implementing their Fraud Prevention Plans. This information will be analyzed and the results compared among all insurers. Following this comparison, some insurers may be required to amend their plans.

Illinois Insurance Immunity Statute

Background

Insurance companies have the right and affirmative duty on behalf of their stockholders, policyholders and the public at-large, to investigate and report fraudulent claims. *Amsden v. Grinnell Mutual Reinsurance Co.* 203 N.W.2d 252 (Iowa 1972). As stated by the United State Supreme Court in 1884; "[I]t is the duty of every citizen to communicate to [the] government any information which [they have] of the commission of an offense against its laws." *Vogel v. Cruaz*, 110 U.S. 311, 315, 4 S.Ct.12., 28 L.Ed. 158, 160 (1884).

There is often a large amount of valuable information that is uncovered by an insurer during the course of a claims investigation and that is also of value to a law enforcement agency's probe of the case. Thus, in order to effectively prosecute insurance fraud, cooperation and information sharing between insurance companies and law enforcement agencies is essential.

An insurer, however, is often reluctant to disclose its *suspicions* about possible fraud or to disclose incriminating information about its insured, because, that often results in various charges like defamation, harassment, malicious prosecution, bad faith, breach of privacy etc. Thus, under the common law there is only limited protection for insurance companies when they make disclosures of information to law enforcement.

In 1976 and in response to these concerns, Ohio became the first state to enact "arson reporting immunity" legislation, i.e., a law intended to assist insurers and law enforcement agencies in their effort to combat insurance fraud by providing limited immunity to insurers. Since then, each of the 50 states and the District of Columbia have passed varying forms of legislation designed to insulate an insurer, its employees and agents from civil liability for the disclosure of information to law enforcement or governmental agencies.

It is interesting to note that two decades have passed since the passage of the first arson reporting immunity law, but there has only been a handful of reported cases on this subject, none in Illinois. Furthermore, in a telephone survey conducted in 1985 by ABT Associates, Inc., for the National Institute of Justice, it was found that 33 percent of the insurance and arson investigative agencies surveyed believed that the immunity laws have been only "somewhat" effective in overcoming insurers' fears of legal action resulting from cooperation. Those who thought they were very

effective amounted to 47 percent. Needless to say, that left 20 percent who seemingly viewed the laws as ineffective.

This article will examine the current state of Illinois law regarding insurance immunity and reporting requirements, and study several of the reported cases on this subject.

Illinois Insurance Immunity Statute

The principal statute in Illinois regarding insurer immunity provides:

> No cause of action in the nature of defamation, invasion of privacy or negligence shall arise against any person for disclosing personal or privileged information in accordance with this Article, nor shall such a cause of action arise against any person for furnishing personal or privileged information to an insurance institution, agent or insurance-support organization; provided, however, this Section shall provide no immunity for disclosing or furnishing false information with malice or willful intent to injure any person (emphasis provided). 215 ILCS 5/1022.

It is widely viewed that for an immunity law to have substance, it must provide a higher level of protection to the insurer than that provided by common law. Arguably, a law with only limited or conditional immunity provides less motivation for an insurer to report a suspect fraud claim and, thereupon, subject itself to various charges of tort. In that regard, the Illinois immunity statute does not provide absolute immunity but is conditional based upon the absence of malice or willful intent.

Illinois Insurance Reporting Requirements

There are several laws in Illinois which outline the requirements for the disclosure or reporting of information on suspicious insurance claims. 215 ILCS 5/1014, *Disclosure Limitations and Conditions*, provides a general and comprehensive framework for proper disclosures of information in all cases.

In addition, Illinois law provides *specific* guidelines for the disclosure and reporting of information relating to suspicious fire claims (215 ILCS 145/1), and for the reporting and disclosure of information regarding suspicious motor vehicle claims (215 ILCS 5/155.24). Each of these statutes requires that an insurer comply with a government agency's request for information, and requires the insurer to voluntarily provide information to an appropriate government agency when it has reason to believe that a loss was caused by other than accidental means. As an aside, each statute states that an insurer shall have the right to request and receive relevant information from an authorized governmental agency.

The information required to be disclosed includes but is not limited to:

> (1) Any insurance policy relevant to a loss or potential loss under investigation and any application for such a policy
>
> (2) Policy premium payment records;
>
> (3) History of previous claims made by the insured; and
>
> (4) Materials relating to the investigation of the loss or potential loss, including statements of any person, proof of loss, and any other relevant evidence.

It is apparent that the *requirement* for an insurance company to report suspicious claims is intended to serve two purposes:

> 1) It ensures consistency because the insurer has no discretion in whether or not to report a suspect claim; and
>
> 2) It provides an additional level of immunity protection to an insurer, inasmuch as, the law requires the notification of a suspect claim to the appropriate agency.

Attempts to Suppress an Insurer's Disclosure

It is reasonable to presume that many people suspected of insurance fraud will seek to suppress an insurance company's disclosure of information to law enforcement by alleging wrongful conduct by the insurer. The following is an overview of several reported cases on this subject:

Absence of Malice

As noted previously, the Illinois immunity statute does not provide absolute immunity but is conditional based upon the absence of malice or willful intent. Evidence of malice can take various forms.

For example, in *Thomas v. Farm Bureau Ins. Co. of Arkansas, Inc.*, 287 Ark. 313, 698 S.W.2d 508 (1985), the insured, Charles Ray Thomas, insured a John Deere combine with Farm Bureau and it was destroyed by fire the following day. After the loss was reported, the insurer's mechanical engineer investigated the fire and concluded that the insured had not been truthful about the circumstances of the fire. Nevertheless, the insurance company offered $11,000 in settlement, which the insured refused.

Unlike Illinois law, Arkansas' immunity statute required any insurer that provided information to a [state] agency, to notify its insured in writing of such action within 30 days. In an alleged

violation of that provision, Farm Bureau verbally communicated with the state police. The trooper was then given the claims file and told by the insurer's agent to "go out there and scare the people so they would settle." The trooper later testified in a deposition that "it wasn't so much an investigation as a mission of intimidation . . . " Id. at 313, 314, S.W.2d at 508, 509. The trooper found no evidence of arson and no written notice was provided to the insured within the prescribed time period.

The court held that if Farm Bureau had honestly believed the insured was guilty of arson, it should have complied with the statute regarding written notice to the insured. If the insurer did not believe the circumstances of the fire were suspicious, then sending a policeman to investigate, in violation of the statute, is clearly relevant to whether it was acting maliciously and in bad faith.

Economic Coercion

In *Commonwealth of Pennsylvania v. Walter Ball and Barry Kabinoff*, 523 Pa. 216, 565 A.2d 1143 (1989), the insured agreed to appear for an examination under oath (EUO) and to produce financial and business information under a stipulation of confidentiality, specifically that none of the information would be divulged to any third person. The insurer's attorney responded on the record that the documents would remain confidential "absent any subpoenas being issued or any other such documents requesting the exhibits or notes of testimony."

After the EUO, the District Attorney invoked the requirements of the Pennsylvania Reporting Act, requested that Hartford produce the transcripts and documents obtained from the insured, and the company complied. The plaintiffs were later arrested and, in an effort to suppress the information, claimed that the insurer "economically coerced" them into incriminating themselves in violation of their rights under the Fifth Amendment.

The trial court suppressed the insurer's materials and the Supreme Court of Pennsylvania reversed. The Supreme Court concluded that the appellees were properly warned that whatever they said or delivered would be divulged to an appropriate authorized agency pursuant to the statute, and that the insurer would comply with a subpoena or any other such documents requesting the materials. Therefore, according to the court, the appellees waived whatever confidentiality they possessed.

Interestingly, the court stated, *in dicta*, and contrary to the law in a number of states, that coercion was not found in this case because the appellees could have insisted on awaiting the outcome of any criminal action before making statements in a civil proceeding. Other courts, however, have held that while the insured has the right to assert protection under the 5th Amendment, it has no application to a private examination arising out of a contractual relationship.

In short, the 5th Amendment is not a valid excuse for failure to comply with an EUO in many states. *See Galante v. Steel City Nat. Bank*, 66 Ill.App.3d 476, 23 Ill.Dec. 421, 384 N.E.2d 57 (1987), *Abraham v. Farmers Home Mutual Ins. Co.*, 439 N.W.2d 48 (Minn. 1989); and *Hickman v. London Assurance Corp.*, 184 Cal. 524, 18 A.L.R. 742, 195 P. 45 (1900). The Court in *Kisting v. Westchester Fire Ins. Co.*, 290 F.Supp. 141, 149 (N.D. Wis. 1968), reasoned that an insured should not be allowed to use the 5th Amendment as both a shield and a sword.

As an aside, in a similar case involving the request for suppression, the Connecticut Superior Court issued a protective order and allowed for an *in camera* inspection of the materials prior to the dissemination of the insurer's investigation to the state. *Southern New England Television Service, Inc. et al v. The Hartford Insurance Group*. 1992 WL 154416 (Conn. Super. June 23, 1992).

Non-Compliance With Administrative Procedures

In an effort to pierce an insurance company's veil of immunity, a party may allege that the insurer did not properly follow the administrative procedures when it provided information to the governmental agency. For example, in *Pearce v. United States Fidelity & Guaranty Co.*, 476 So.2d 750 (Fla. Dist. Ct. App. 1985), the plaintiff, sought to establish that the insurer was not immunized from suit for malicious prosecution because, in part, the insurer disclosed information to the state's Insurance Fraud Division by phone and in person, rather than on the prescribed forms, and because the disclosure of information was not made in response to a request for information by the Fraud Division, but was a voluntary disclosure of information by the insurer.

The court, in holding for the insurer, stated that it is unsound to say that the insurer is only immune when the disclosure is made on the Division-prescribed forms. The court further intimated that where the claim is one of malicious prosecution, it is an insurmountable task to separate information which may have been communicated informally from information communicated under the statutory formalities. Id. at 753.

Acting Under "Color of Law"

As noted previously, the objective of insurance immunity and reporting laws is to promote the exchange of critical information related to insurance fraud between insurance companies and law enforcement agencies. However, the insurer's "cooperation" with law enforcement often results in accusations that an insurance company is acting under the color of law, and jointly with the authorities to deprive the insureds of their constitutional rights.

For example, in the Wyoming Supreme Court case of *Hatch et al v. State Farm Fire & Casualty Company*, 842 P.2d 1089 (Wyo. 1992), the plaintiffs brought suit against State Farm alleging various torts in connection with the insurance company's investigation and handling of a fire loss at the insured's home. They alleged that State Farm wrongly gathered evidence and "secretly provided" select portions of the material to prosecutors, while withholding exculpatory evidence, in order to instigate arson charges against the insured. The plaintiffs further argued that State Farm concealed its actions under Wyoming's Arson Reporting Immunity Act and acted under the color of state law and jointly with state authorities to deprive the insureds of their constitutional rights.

The court held that the plaintiffs failed to prove the requisite "joint activity" between State Farm and the state, and that supplying information concerning suspected arson to state authorities, standing alone, is not enough to amount to "joint activity." In coming to that conclusion, the court discussed a "two-part approach" to determine whether a defendant's action can be deemed under color of state law:

> First, the deprivation must be caused by the exercise of some right or privilege created by the State or by a rule of conduct imposed by the State or by a person for whom the State is responsible . . . Second, the party charged with the deprivation must be a person who may fairly be said to be a state actor.

Id. quoting *Lugar v. Edmondson Oil Co., Inc.*, 457 U.S. 922, 937, 102 S.Ct. 2744, 2753, 73 L.Ed.2d 482 (1982).

The court further held that State Farm's conduct, as alleged by the plaintiff, satisfied neither part of the "Lugar test." First, State Farm was not exercising "some right or privilege created by the state" when it turned over information from its investigation to state

authorities. Rather, it was complying with the requirement set forth by state statute. Second, the plaintiff made no allegations as to how State Farm acted together with, or received significant aid from, state officials in the process of infringing on their constitutional rights.

Conclusion

In order to effectively prosecute insurance fraud, cooperation and information sharing between insurance companies and law enforcement agencies is vital. However, because immunity and reporting legislation and its interpretation by the courts is still in an embryonic stage, insurers must exercise caution in its cooperative efforts. Thus, it is important that all materials reflect a good faith careful investigation that is coupled with objectivity and fairness.

It is further recommended that legal counsel be retained to ensure that disclosure is proper, and to insure against the inadvertent disclosure of documents that may be subject to attorney-client or work-product privileges.

ILLINOIS COMPILED STATUTES
CHAPTER 215 - ACT 5

5/1014. Disclosure limitations and conditions

§ 1014. Disclosure Limitations and Conditions. An insurance institution, agent or insurance-support organization shall not disclose any personal or privileged information about an individual collected or received in connection with an insurance transaction unless the disclosure is:

(A) with the written authorization of the individual, provided:

(1) if such authorization is submitted by another insurance institution, agent or insurance-support organization, the authorization meets the requirements of Section 1007 of this Article, or

(2) if such authorization is submitted by a person other than an insurance institution, agent or insurance-support organization, the authorization is:

(a) dated,

(b) signed by the individual, and

(c) obtained one year or less prior to the date a disclosure is sought pursuant to this subsection; or

(B) to a person other than an insurance institution, agent or insurance-support organization, provided such disclosure is reasonably necessary:

(1) to enable such person to perform a business, professional or insurance function for the disclosing insurance institution, agent or insurance-support organization and such person agrees not to disclose the information further without the individual's written authorization unless the further disclosure:

(a) would otherwise be permitted by this Section if made by an insurance institution, agent, or insurance-support organization, or

(b) is reasonably necessary, for such person to perform its function for the disclosing insurance institution, agent, or insurance-support organization, or

(2) to enable such person to provide information to the disclosing insurance institution, agent, or insurance-support organization for the purpose of:

(a) determining an individual's eligibility for an insurance benefit or payment, or

(b) detecting or preventing criminal activity, fraud, material misrepresentation or material nondisclosure in connection with an insurance transaction; or

(C) to an insurance institution, agent, insurance-support organization or self-insurer, provided the information disclosed is limited to that which is reasonably necessary:

(1) to detect or prevent criminal activity, fraud, material misrepresentation or material nondisclosure in connection with insurance transactions, or

(2) for either the disclosing or receiving insurance institution, agent or insurance-support organization to perform its function in connection with an insurance transaction involving the individual; or

(D) to a medical care institution or medical professional for the purpose of:

(1) verifying insurance coverage or benefits,

(2) informing an individual of a medical problem of which the individual may not be aware, or

(3) conducting an operations or services audit, provided only such information is disclosed as is reasonably necessary to accomplish the foregoing purposes; or

(E) to an insurance regulatory authority; or

(F) to a law enforcement or other governmental authority:

(1) to protect the interests of the insurance institution, agent or insurance-support organization in preventing or prosecuting the perpetration of fraud upon it, or

(2) if the insurance institution, agent or insurance-support organization reasonably believes that illegal activities have been conducted by the individual; or

(G) otherwise permitted or required by law; or

(H) in response to a facially valid administrative or judicial order, including a search warrant or subpoena; or

(I) made for the purpose of conducting actuarial or research studies provided:

(1) no individual may be identified in any actuarial or research report,

(2) materials allowing the individual to be identified are returned or destroyed as soon as they are no longer needed, and

(3) the actuarial or research organization agrees not to disclose the information unless the disclosure would otherwise be permitted by this Section if made by an insurance institution, agent or insurance-support organization; or

(J) to a party or a representative of a party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the insurance institution, agent or insurance support organization, provided:

(1) prior to the consummation of the sale, transfer, merger or consolidation only such information is disclosed as is reasonably necessary to enable the recipient to make business decisions about the purchase, transfer, merger or consolidation, and

(2) the recipient agrees not to disclose the information unless the disclosure would otherwise be permitted by this Section if made by an insurance institution, agent or insurance-support organization; or

(K) to a person whose only use of such information will be in connection with the marketing of a product or service, provided:

(1) no medical-record information, privileged information, or personal information relating to an individual's character, personal habits, mode of living or general reputation is disclosed, and no classification derived from such information is disclosed,

(2) the individual has been given an opportunity to indicate that he or she does not want personal information disclosed for marketing purposes and has given no indication that he or she does not want the information disclosed, and

(3) the person receiving such information agrees not to use it except in connection with the marketing of a product or service; or

(L) to an affiliate whose only use of the information will be in connection with an audit of the insurance institution or agent or the marketing of an insurance product or service, provided the affiliate agrees not to disclose the information for any other purpose or to unaffiliated persons; or

(M) by a consumer reporting agency, provided: the disclosure is to a person other than an insurance institution or agent; or

(N) to a group policyholder for the purpose of reporting claims experience or conducting an audit of the insurance institution's or agent's operations or services, provided the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit; or

(O) to a professional peer review organization for the purpose of reviewing the service or conduct of a medical-care institution or medical professional; or

(P) to a governmental authority for the purpose of determining the individual's eligibility for health benefits for which the governmental authority may be liable; or

(Q) to a certificate holder or policyholder for the purpose of providing information regarding the status of an insurance transaction; or

(R) to a lien holder, mortgagee, assignee, lessee, or other person shown on the records of an insurance institution or agent as having a legal or beneficial interest in a policy of insurance; provided that information disclosed is limited to that which is reasonably necessary to permit such person to protect its interest in such policy.

ILLINOIS COMPILED STATUTES
CHAPTER 215 - ACT 145

145/1. Release of information by insurers--Penalty

§ 1. (a) The Fire Marshal, the director of the Department of Insurance or personnel from any other authorized fire department

or law enforcement agency charged with the responsibility of investigating a fire loss or potential fire loss, may request any insurance company that has investigated or is investigating a fire loss or potential fire loss of real or personal property to release any factual information in its possession which is pertinent to this type of loss or potential loss and has some relationship to the loss or potential loss itself. The company shall release the information and cooperate with any official authorized to request such information pursuant to this Section. The information shall include, but is not limited to:

(1) Any insurance policy relevant to a fire loss or potential fire loss under investigation and any application for such a policy;

(2) Policy premium payment records;

(3) History of previous claims made by the insured for fire loss;

(4) Material relating to the investigation of the loss or potential loss, including statements of any person, proof of loss, and any other relevant evidence.

(b) If an insurance company has reason to believe that a fire loss to its insured's real or personal property was caused by other than accidental means, the company shall notify the Fire Marshal, the director of the Department of Insurance or any other appropriate law enforcement agency charged with the responsibility to investigate fire losses and furnish such persons with all relative material acquired during its investigation of the fire loss, cooperate with and take such reasonable action as may be requested by any law enforcement agency, and cooperate with the Court and administrative agencies of the State, and any official from the Fire Marshal's office, the office of the director of the Department of Insurance or any law enforcement agency charged with the

responsibility to investigate the fire. Such insurance company may request officials and departmental and agency personnel receiving information on fire losses or potential fire losses to release information relative to any investigation it has made concerning any such fire loss or potential loss reported by such company. Subject to the provisions of subsection (a) and paragraphs (I), (iii), (iv), (v), (vii) and (viii) of subsection (c) of Section 7 of the Freedom of Information Act, such insurance company shall have the right to receive, within a reasonable time, not to exceed 30 days after the receipt of such request, the relevant information requested.

(c) In the absence of malice, no insurance company, or person who furnishes information on its behalf, or authorized person, department or agency as defined in subsection (a) who releases information, is liable for damages in a civil action or subject to criminal prosecution for any oral or written statement made or any other action taken that is necessary to supply information required pursuant to this Section.

(d) The officials and departmental and agency personnel receiving any information furnished pursuant to this Section shall hold the information in confidence until such time as its release is required pursuant to this Section or a criminal or civil proceeding.

(e) Any official referred to in paragraph (a) of this Section may be required to testify as to any information in his possession regarding the fire loss of real or personal property in any civil action in which any person seeks recovery under a policy against an insurance company for the fire loss.

(f) As used in this Section, "insurance company" includes the Illinois Fair Plan Underwriting Association, and all district, county and township mutual insurance companies.

(g)

(1) No person shall intentionally or knowingly refuse to release any information properly requested, pursuant to paragraph (a) of this Section.

(2) No person shall refuse to make the necessary notification of a fire loss pursuant to paragraph (b) of this Section.

(3) No person shall refuse to supply to the proper authorities pertinent information required to be furnished pursuant to paragraph (b) of this Section.

(4) No person shall fail to hold in confidence information required to be held in confidence by paragraph (d) of this Section.

(h) Whoever violates paragraph (g)(1), (2), (3) or (4) of this Section is guilty of a Class C misdemeanor and is subject to a fine not to exceed $100. It shall not be considered a violation of this Section if an insurance company in good faith, believes it has done everything required of it by this Statute.

(I) A fire department or law enforcement agency that has investigated or is investigating a fire loss or potential fire loss of real or personal property may release to an insurer of such property any factual information, including statements, in its possession which is pertinent or related to the type of loss or potential loss.

ILLINOIS COMPILED STATUTES
CHAPTER 215 - ACT 5

5/155.24. Motor Vehicle Theft and Motor Insurance Fraud Reporting and Immunity Law s 155.24. Motor Vehicle Theft and Motor Insurance Fraud Reporting and Immunity Law.

(a) As used in this Section: (1) "authorized governmental agency" means the Illinois Department of State Police, a local governmental police department, a county sheriff's office, a State's

Attorney, a municipal attorney, a United States district attorney, a duly constituted criminal investigative agency of the United States government, the Illinois Department of Insurance, the Illinois Department of Professional Regulation and the office of the Illinois Secretary of State; (2) "relevant" means having a tendency to make the existence of any information that is of consequence to an investigation of motor vehicle theft or insurance fraud investigation or a determination of such issue more probable or less probable than it would be without such information; and (3) information will be "deemed important" if within the sole discretion of the authorized governmental agency such information is requested by that authorized governmental agency.

(b) Upon written request to an insurer by an authorized governmental agency, an insurer or agent authorized by an insurer to act on its behalf shall release to the requesting authorized governmental agency any or all relevant information deemed important to the authorized governmental agency which the insurer may possess relating to any specific motor vehicle theft or motor vehicle insurance fraud. Relevant information may include, but is not limited to:

(1) Insurance policy information relevant to the motor vehicle theft or motor vehicle insurance fraud under investigation, including any application for such a policy.

(2) Policy premium payment records which are available.

(3) History of previous claims made by the insured.

(4) Information relating to the investigation of the motor vehicle theft or motor vehicle insurance fraud, including statements of any person, proofs of loss and notice of loss.

(c) When an insurer knows or reasonably believes to know the identity of a person whom it has reason to believe committed a

criminal or fraudulent act relating to a motor vehicle theft or a motor vehicle insurance claim or has knowledge of such a criminal or fraudulent act which is reasonably believed not to have been reported to an authorized governmental agency, then for the purpose of notification and investigation, the insurer or an agent authorized by an insurer to act on its behalf shall notify an authorized governmental agency of such knowledge or reasonable belief and provide any additional relevant information in accordance with paragraph (b) of this Section.

(d) When an insurer provides any of the authorized governmental agencies with notice pursuant to this Section it shall be deemed sufficient notice to all authorized governmental agencies for the purpose of this Act.

(e) The authorized governmental agency provided with information pursuant to this Section may release or provide such information to any other authorized governmental agency.

(f) Any insurer providing information to an authorized governmental agency pursuant to this Section shall have the right to request and receive relevant information from such authorized governmental agency, and receive within a reasonable time after the completion of the investigation, not to exceed 30 days, the information requested.

(g) Any information furnished pursuant to this Section shall be privileged and not a part of any public record. Except as otherwise provided by law, any authorized governmental agency, insurer, or an agent authorized by an insurer to act on its behalf which receives any information furnished pursuant to this Section, shall not release such information to public inspection. Such evidence or information shall not be subject to subpoena duces tecum in a civil or criminal proceeding unless, after reasonable notice to any insurer, agent authorized by an insurer to act on its behalf and authorized governmental agency which has an interest in such

information and a hearing, the court determines that the public interest and any ongoing investigation by the authorized governmental agency, insurer, or any agent authorized by an insurer to act on its behalf will not be jeopardized by obedience to such a subpoena duces tecum.

(h) No insurer, or agent authorized by an insurer on its behalf, authorized governmental agency or their respective employees shall be subject to any civil or criminal liability in a cause of action of any kind for releasing or receiving any information pursuant to this Section. Nothing herein is intended to or does in any way or manner abrogate or lessen the common and statutory law privileges and immunities of an insurer, agent authorized by an insurer to act on its behalf or authorized governmental agency or any of their respective employees.

Vanishing Premium Insurance Policies Fraud

Several years ago, the life insurance industry began marketing individual life insurance policies which they could sell using "vanishing premium" sales illustrations. These policies proved attractive to consumers looking for permanent life insurance without
having to pay premiums for life. Many estate planners also recommended their clients purchase joint life or second-to-die policies using the "vanishing premium" method to fund estate taxes. With the use of computer-generated sales illustrations, life insurers and life insurance agents routinely represented that the "vanishing premium" life insurance policy only required premium payments for a few years and thereafter the policy "paid for itself" out of interest or dividend earnings.

In many cases, these sales illustrations were based upon unrealistic assumptions about future interest rates and the insurance company's earnings. What then happened is, in later years, while the policyholder was paying his scheduled premiums for the number of years illustrated, the insurance company quietly reduced its interest rates or dividends to lower but more realistic levels. About the time the policyholder was expecting to stop making premium payments and let the policy pay for itself as represented, the company or agent would come back to the policyholder with a "revised" illustration showing the need for many more years of premium payments. The policyholder having budgeted to stop making payments for the life insurance, was then presented with a shocking and financially threatening dilemma: 1) either continue making expensive premium payments for many more years, or 2) risk having the insurance policy lapse for non-payment.

Fortunately, the laws of Texas and many other states provide life insurance consumers with a cause of action for damages caused by deceptive and misleading insurance sales practices. Successful suits have been prosecuted against many of North America's largest life insurance companies and their agents.

Funeral Home Industry

The funeral home industry is a $ 15 billion business.
The first thing everyone has to remember, when you walk into a funeral home and begin talking about funeral arrangements, the funeral director must give you a printed price list. That is federal regulation. If you walk into a funeral home and such a list is not given to you when you begin the discussion or anyone seems cagey, that's not a good sign.

And if that should happen, it be wise to walk out the door. This may be more difficult for people who are facing death immediately and are shocked by it and feel like they don't have any other choice. It is possible to go to another funeral home and you could find that the attitude is different and the prices could be a lot lower, too.

The main thing, when you walk into the door, you better be given this price list or forget about it. If you walk in and start talking about arrangements for an aunt or father, they should sit down and start talking to you with a price list in hand. If they don't, that's a very bad sign.

Experts suggest that you bring a friend with you. Hopefully the person you bring will not be as emotionally drained as you are. If you lose a child tragically, the husband and wife are probably going to go, but bring someone else, a trusted confidante who does not have much intense emotional investment and say.

Another good idea is to try to plan ahead. This does not mean that you should pay ahead.

In most situations, it is a very bad idea to pay for your funeral in advance, because all 50 states have different regulations on how

well or how poorly your money is protected. It's something you should do as a family. You should have an idea what you want, what to expect, what you are looking for so that you don't get gouged.

Make it a conversation with your family and friends, and know your rights. You have rights under the Federal Trade Commission funeral rule. Unfortunately, an AARP study a few years ago found among those surveyed only 8 percent of the people surveyed knew about this rule. The federal commission said they must give you printed itemized price lists. They have disclosures on the price lists saying you have the right to buy only what you want and that certain things are not required by law or if they are required by law, they will be explained to you."

There are also alternatives to consider, such as direct cremation, immediate burial, skipping some of the ceremonies and having a memorial service at a later date.

Funerals: A Consumer Guide

When a loved one dies, grieving family members and friends often are confronted with dozens of decisions about the funeral - all of which must be made quickly and often under great emotional duress. What kind of funeral should it be? What funeral provider should you use? Should you bury or cremate the body, or donate it to science? What are you legally required to buy? What other arrangements should you plan? And, as callous as it may sound, how much is it all going to cost?

Each year, Americans grapple with these and many other questions as they spend billions of dollars arranging more than 2 million funerals for family members and friends. The increasing trend toward pre-need planning - when people make funeral arrangements in advance - suggests that many consumers want to

compare prices and services so that ultimately, the funeral reflects a wise and well-informed purchasing decision, as well as a meaningful one.

A Consumer Product

Funerals rank among the most expensive purchases many consumers will ever make. A traditional funeral, including a casket and vault, costs about $6,000, although "extras" like flowers, obituary notices, acknowledgment cards or limousines can add thousands of dollars to the bottom line. Many funerals run well over $10,000.

Yet even if you're the kind of person who might haggle with a dozen dealers to get the best price on a new car, you're likely to feel uncomfortable comparing prices or negotiating over the details and cost of a funeral, pre-need or at need. Compounding this discomfort is the fact that some people "overspend" on a funeral or burial because they think of it as a reflection of their feelings for the deceased.

Pre-Need

To help relieve their families of some of these decisions, an increasing number of people are planning their own funerals, designating their funeral preferences, and sometimes even paying for them in advance. They see funeral planning as an extension of will and estate planning.

Planning

Thinking ahead can help you make informed and thoughtful decisions about funeral arrangements. It allows you to choose the specific items you want and need and compare the prices offered by several funeral providers. It also spares your survivors the stress

of making these decisions under the pressure of time and strong emotions.

You can make arrangements directly with a funeral establishment or through a funeral planning or memorial society - a nonprofit organization that provides information about funerals and disposition but doesn't offer funeral services. If you choose to contact such a group, recognize that while some funeral homes may include the word "society" in their names, they are not nonprofit organizations.

One other important consideration when planning a funeral pre-need is where the remains will be buried, entombed or scattered. In the short time between the death and burial of a loved one, many family members find themselves rushing to buy a cemetery plot or grave - often without careful thought or a personal visit to the site. That's why it's in the family's best interest to buy cemetery plots before you need them.

You may wish to make decisions about your arrangements in advance, but not pay for them in advance. Keep in mind that over time, prices may go up and businesses may close or change ownership. However, in some areas with increased competition, prices may go down over time. It's a good idea to review and revise your decisions every few years, and to make sure your family is aware of your wishes.

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Put your preferences in writing, give copies to family members and your attorney, and keep a copy in a handy place. Don't designate your preferences in your will, because a will often is not found or

read until after the funeral. And avoid putting the only copy of your preferences in a safe deposit box. That's because your family may have to make arrangements on a weekend or holiday, before the box can be opened.

Prepaying

Millions of Americans have entered into contracts to prearrange their funerals and prepay some or all of the expenses involved. Laws of individual states govern the prepayment of funeral goods and services; various states have laws to help ensure that these advance payments are available to pay for the funeral products and services when they're needed. But protections vary widely from state to state, and some state laws offer little or no effective protection. Some state laws require the funeral home or cemetery to place a percentage of the prepayment in a state-regulated trust or to purchase a life insurance policy with the death benefits assigned to the funeral home or cemetery.

If you're thinking about prepaying for funeral goods and services, it's important to consider these issues before putting down any money:

What are you are paying for? Are you buying only merchandise, like a casket and vault, or are you purchasing funeral services as well?

What happens to the money you've prepaid? States have different requirements for handling funds paid for prearranged funeral services.

What happens to the interest income on money that is prepaid and put into a trust account?

Are you protected if the firm you dealt with goes out of business?

Can you cancel the contract and get a full refund if you change your mind?

What happens if you move to a different area or die while away from home? Some prepaid funeral plans can be transferred, but often at an added cost.
Be sure to tell your family about the plans you've made; let them know where the documents are filed. If your family isn't aware that you've made plans, your wishes may not be carried out. And if family members don't know that you've prepaid the funeral costs, they could end up paying for the same arrangements. You may wish to consult an attorney on the best way to ensure that your wishes are followed.

Federal Funeral Rule

Most funeral providers are professionals who strive to serve their clients' needs and best interests. But some aren't. They may take advantage of their clients through inflated prices, overcharges, double charges or unnecessary services. Fortunately, there's a federal law that makes it easier for you to choose only those goods and services you want or need and to pay only for those you select, whether you are making arrangements pre-need or at need.

The Funeral Rule, enforced by the Federal Trade Commission, requires funeral directors to give you itemized prices in person and, if you ask, over the phone. The Rule also requires funeral directors to give you other information about their goods and services. For example, if you ask about funeral arrangements in person, the funeral home must give you a written price list to keep that shows the goods and services the home offers. If you want to buy a casket or outer burial container, the funeral provider must show you descriptions of the available selections and the prices before actually showing you the caskets.

Many funeral providers offer various "packages" of commonly selected goods and services that make up a funeral. But when you

arrange for a funeral, you have the right to buy individual goods and services. That is, you do not have to accept a package that may include items you do not want.

According to the Funeral Rule:

- you have the right to choose the funeral goods and services you want (with some exceptions).
- the funeral provider must state this right in writing on the general price list.
- if state or local law requires you to buy any particular item, the funeral provider must disclose it on the price list, with a reference to the specific law.
- the funeral provider may not refuse, or charge a fee, to handle a casket you bought elsewhere.
- a funeral provider that offers cremations must make alternative containers available.
- What Kind of Funeral Do You Want?

Every family is different, and not everyone wants the same type of funeral. Funeral practices are influenced by religious and cultural traditions, costs and personal preferences. These factors help determine whether the funeral will be elaborate or simple, public or private, religious or secular, and where it will be held. They also influence whether the body will be present at the funeral, if there will be a viewing or visitation, and if so, whether the casket will be open or closed, and whether the remains will be buried or cremated.

Among the choices you'll need to make are whether you want one of these basic types of funerals, or something in between.

"Traditional," full-service funeral

This type of funeral, often referred to by funeral providers as a "traditional" funeral, usually includes a viewing or visitation and formal funeral service, use of a hearse to transport the body to the funeral site and cemetery, and burial, entombment or cremation of the remains.

It is generally the most expensive type of funeral. In addition to the funeral home's basic services fee, costs often include embalming and dressing the body; rental of the funeral home for the viewing or service; and use of vehicles to transport the family if they don't use their own. The costs of a casket, cemetery plot or crypt and other funeral goods and services also must be factored in.

Every family is different, and not everyone wants the same type of funeral.

Direct burial

The body is buried shortly after death, usually in a simple container. No viewing or visitation is involved, so no embalming is necessary. A memorial service may be held at the graveside or later. Direct burial usually costs less than the "traditional," full-service funeral. Costs include the funeral home's basic services fee, as well as transportation and care of the body, the purchase of a casket or burial container and a cemetery plot or crypt. If the family chooses to be at the cemetery for the burial, the funeral home often charges an additional fee for a graveside service.

Direct cremation

The body is cremated shortly after death, without embalming. The cremated remains are placed in an urn or other container. No viewing or visitation is involved, although a memorial service may be held, with or without the cremated remains present. The remains can be kept in the home, buried or placed in a crypt or niche in a

cemetery, or buried or scattered in a favorite spot. Direct cremation usually costs less than the "traditional," full-service funeral. Costs include the funeral home's basic services fee, as well as transportation and care of the body. A crematory fee may be included or, if the funeral home does not own the crematory, the fee may be added on. There also will be a charge for an urn or other container. The cost of a cemetery plot or crypt is included only if the remains are buried or entombed.

Funeral providers who offer direct cremations also must offer to provide an alternative container that can be used in place of a casket.

Choosing a Funeral Provider

Many people don't realize that they are not legally required to use a funeral home to plan and conduct a funeral. However, because they have little experience with the many details and legal requirements involved and may be emotionally distraught when it's time to make the plans, many people find the services of a professional funeral home to be a comfort.

Consumers often select a funeral home or cemetery because it's close to home, has served the family in the past, or has been recommended by someone they trust. But people who limit their search to just one funeral home may risk paying more than necessary for the funeral or narrowing their choice of goods and services.

Comparison shopping need not be difficult, especially if it's done before the need for a funeral arises. If you visit a funeral home in person, the funeral provider is required by law to give you a general price list itemizing the cost of the items and services the home offers. If the general price list does not include specific prices of caskets or outer burial containers, the law requires the

funeral director to show you the price lists for those items before showing you the items.

Sometimes it's more convenient and less stressful to "price shop" funeral homes by telephone. The Funeral Rule requires funeral directors to provide price information over the phone to any caller who asks for it. In addition, many funeral homes are happy to mail you their price lists, although that is not required by law.

When comparing prices, be sure to consider the total cost of all the items together, in addition to the costs of single items. Every funeral home should have price lists that include all the items essential for the different types of arrangements it offers. Many funeral homes offer package funerals that may cost less than purchasing individual items or services. Offering package funerals is permitted by law, as long as an itemized price list also is provided. But only by using the price lists can you accurately compare total costs.

Be sure to consider the total cost of all the items.

In addition, there's a growing trend toward consolidation in the funeral home industry, and many neighborhood funeral homes are thought to be locally owned when in fact, they're owned by a national corporation. If this issue is important to you, you may want to ask if the funeral home is locally owned.

Funeral Costs

Funeral costs include:

1. Basic services fee for the funeral director and staff

The Funeral Rule allows funeral providers to charge a basic services fee that customers cannot decline to pay. The basic

services fee includes services that are common to all funerals, regardless of the specific arrangement. These include funeral planning, securing the necessary permits and copies of death certificates, preparing the notices, sheltering the remains, and coordinating the arrangements with the cemetery, crematory or other third parties. The fee does not include charges for optional services or merchandise.

2. Charges for other services and merchandise

These are costs for optional goods and services such as transporting the remains; embalming and other preparation; use of the funeral home for the viewing, ceremony or memorial service; use of equipment and staff for a graveside service; use of a hearse or limousine; a casket, outer burial container or alternate container; and cremation or interment.

3. Cash advances

These are fees charged by the funeral home for goods and services it buys from outside vendors on your behalf, including flowers, obituary notices, pallbearers, officiating clergy, and organists and soloists. Some funeral providers charge you their cost for the items they buy on your behalf. Others add a service fee to their cost. The Funeral Rule requires those who charge an extra fee to disclose that fact in writing, although it doesn't require them to specify the amount of their markup. The Rule also requires funeral providers to tell you if there are refunds, discounts or rebates from the supplier on any cash advance item.

Calculating the Actual Cost

The funeral provider must give you an itemized statement of the total cost of the funeral goods and services you have selected when you are making the arrangements. If the funeral provider doesn't

know the cost of the cash advance items at the time, he or she is required to give you a written "good faith estimate." This statement also must disclose any legal, cemetery or crematory requirements that you purchase any specific funeral goods or services.

The Funeral Rule does not require any specific format for this information. Funeral providers may include it in any document they give you at the end of your discussion about funeral arrangements.

Services and Products

Embalming
Many funeral homes require embalming if you're planning a viewing or visitation. But embalming generally is not necessary or legally required if the body is buried or cremated shortly after death. Eliminating this service can save you hundreds of dollars. Under the Funeral Rule, a funeral provider:

- may not provide embalming services without permission.
- may not falsely state that embalming is required by law.
- must disclose in writing that embalming is not required by law, except in certain special cases.
- may not charge a fee for unauthorized embalming unless embalming is required by state law.
- must disclose in writing that you usually have the right to choose a disposition, such as direct cremation or immediate burial, that does not require embalming if you do not want this service.
- must disclose in writing that some funeral arrangements, such as a funeral with viewing, may make embalming a practical necessity and, if so, a required purchase caskets

For a "traditional," full-service funeral:

A casket often is the single most expensive item you'll buy if you plan a "traditional," full-service funeral. Caskets vary widely in style and price and are sold primarily for their visual appeal. Typically, they're constructed of metal, wood, fiberboard, fiberglass or plastic. Although an average casket costs slightly more than $2,000, some mahogany, bronze or copper caskets sell for as much as $10,000.

When you visit a funeral home or showroom to shop for a casket, the Funeral Rule requires the funeral director to show you a list of caskets the company sells, with descriptions and prices, before showing you the caskets. Industry studies show that the average casket shopper buys one of the first three models shown, generally the middle-priced of the three.

Caskets vary widely in style and price.

So it's in the seller's best interest to start out by showing you higher-end models. If you haven't seen some of the lower-priced models on the price list, ask to see them - but don't be surprised if they're not prominently displayed, or not on display at all.

Traditionally, caskets have been sold only by funeral homes. But with increasing frequency, showrooms and websites operated by "third-party" dealers are selling caskets. You can buy a casket from one of these dealers and have it shipped directly to the funeral home. The Funeral Rule requires funeral homes to agree to use a casket you bought elsewhere, and doesn't allow them to charge you a fee for using it.

No matter where or when you're buying a casket, it's important to remember that its purpose is to provide a dignified way to move the body before burial or cremation. No casket, regardless of its qualities or cost, will preserve a body forever. Metal caskets frequently are described as "gasketed," "protective" or "sealer" caskets. These terms mean that the casket has a rubber gasket or some other feature that is designed to delay the penetration of water into the casket and prevent rust. The Funeral Rule forbids claims that these features help preserve the remains indefinitely because they don't. They just add to the cost of the casket.

Most metal caskets are made from rolled steel of varying gauges - the lower the gauge, the thicker the steel. Some metal caskets come with a warranty for longevity. Wooden caskets generally are not gasketed and don't have a warranty for longevity. They can be hardwood like mahogany, walnut, cherry or oak, or softwood like pine. Pine caskets are a less expensive option, but funeral homes rarely display them. Manufacturers of both wooden and metal caskets usually warrant workmanship and materials.

For cremation:

Many families that opt to have their loved ones cremated rent a casket from the funeral home for the visitation and funeral, eliminating the cost of buying a casket. If you opt for visitation and cremation, ask about the rental option. For those who choose a direct cremation without a viewing or other ceremony where the body is present, the funeral provider must offer an inexpensive unfinished wood box or alternative container, a non-metal enclosure - pressboard, cardboard or canvas - that is cremated with the body.

Under the Funeral Rule, funeral directors who offer direct cremations:

- may not tell you that state or local law requires a casket for direct cremations, because none do;
- must disclose in writing your right to buy an unfinished wood box or an alternative container for a direct cremation; and
- must make an unfinished wood box or other alternative container available for direct cremations.

Burial Vaults or Grave Liners

Burial vaults or grave liners, also known as burial containers, are commonly used in "traditional," full-service funerals. The vault or liner is placed in the ground before burial, and the casket is lowered into it at burial. The purpose is to prevent the ground from caving in as the casket deteriorates over time. A grave liner is made of reinforced concrete and will satisfy any cemetery requirement. Grave liners cover only the top and sides of the casket. A burial vault is more substantial and expensive than a grave liner. It surrounds the casket in concrete or another material and may be sold with a warranty of protective strength.

State laws do not require a vault or liner, and funeral providers may not tell you otherwise. However, keep in mind that many cemeteries require some type of outer burial container to prevent the grave from sinking in the future. Neither grave liners nor burial vaults are designed to prevent the eventual decomposition of human remains. It is illegal for funeral providers to claim that a vault will keep water, dirt or other debris from penetrating into the casket if that's not true.

Before showing you any outer burial containers, a funeral provider is required to give you a list of prices and descriptions. It may be less expensive to buy an outer burial container from a third-party dealer than from a funeral home or cemetery. Compare prices from several sources before you select a model.

Preservative Processes and Products

As far back as the ancient Egyptians, people have used oils, herbs and special body preparations to help preserve the bodies of their dead. Yet, no process or products have been devised to preserve a body in the grave indefinitely. The Funeral Rule prohibits funeral providers from telling you that it can be done. For example, funeral providers may not claim that either embalming or a particular type of casket will preserve the body of the deceased for an unlimited time.

Cemetery Sites

When you are purchasing a cemetery plot, consider the location of the cemetery and whether it meets the requirements of your family's religion. Other considerations include what, if any, restrictions the cemetery places on burial vaults purchased elsewhere, the type of monuments or memorials it allows, and whether flowers or other remembrances may be placed on graves.

Cost is another consideration. Cemetery plots can be expensive, especially in metropolitan areas. Most, but not all, cemeteries require you to purchase a grave liner, which will cost several hundred dollars. Note that there are charges - usually hundreds of dollars - to open a grave for interment and additional charges to fill it in. Perpetual care on a cemetery plot sometimes is included in the purchase price, but it's important to clarify that point before you buy the site or service. If it's not included, look for a separate endowment care fee for maintenance and grounds keeping.

If you plan to bury your loved one's cremated remains in a mausoleum or columbarium, you can expect to purchase a crypt and pay opening and closing fees, as well as charges for

endowment care and other services. The FTC's Funeral Rule does not cover cemeteries and mausoleums unless they sell both funeral goods and funeral services, so be cautious in making your purchase to ensure that you receive all pertinent price and other information, and that you're being dealt with fairly.

Veterans Cemeteries

All veterans are entitled to a free burial in a national cemetery and a grave marker. This eligibility also extends to some civilians who have provided military-related service and some Public Health Service personnel. Spouses and dependent children also are entitled to a lot and marker when buried in a national cemetery. There are no charges for opening or closing the grave, for a vault or liner, or for setting the marker in a national cemetery. The family generally is responsible for other expenses, including transportation to the cemetery. For more information, visit the Department of Veterans Affairs' website at www.cem.va.gov. To reach the regional Veterans office in your area, call 1-800-827-1000.

In addition, many states have established state veterans cemeteries. Eligibility requirements and other details vary. Contact your state for more information.

Beware of commercial cemeteries that advertise so-called "veterans' specials." These cemeteries sometimes offer a free plot for the veteran, but charge exorbitant rates for an adjoining plot for the spouse, as well as high fees for opening and closing each grave. Evaluate the bottom-line cost to be sure the special is as special as you may be led to believe.

Most states have a licensing board that regulates the funeral industry. You may contact the board in your state for information or help. If you want additional information about making funeral

arrangements and the options available, you may want to contact interested business, professional and consumer groups. Some of the biggest are:

AARP Fulfillment
601 E Street, NW
Washington, DC 20049
1-800-424-3410
www.aarp.org
AARP is a nonprofit, nonpartisan organization dedicated to helping older Americans achieve lives of independence, dignity and purpose. Its publications, Funeral Goods and Services and Pre-Paying for Your Funeral, are available free by writing to the above address. This and other funeral-related information is posted on the AARP website.

Council of Better Business Bureaus, Inc.
4200 Wilson Blvd., Suite 800
Arlington, VA 22203-1838
www.bbb.org
Better Business Bureaus are private, nonprofit organizations that promote ethical business standards and voluntary self-regulation of business practices.

Funeral Consumers Alliance
33 Patchen Road
South Burlington, VT 05403
1-800-765-0107
www.funerals.org
FCA, a nonprofit, educational organization that supports increased funeral consumer protection, is affiliated with the Funeral and Memorial Society of America (FAMSA).

Cremation Association of North America
401 North Michigan Avenue
Chicago, IL 60611
(312) 644-6610
www.cremationassociation.org
CANA is an association of crematories, cemeteries and funeral homes that offer cremation.

International Cemetery and Funeral Association
1895 Preston White Drive, Suite 220
Reston, VA 20191 1-800-645-7700
www.icfa.org
ICFA is a nonprofit association of cemeteries, funeral homes, crematories and monument retailers that offers informal mediation of consumer complaints through its Cemetery Consumer Service Council. Its website provides information and advice under "Consumer Resources."

International Order of the Golden Rule
13523 Lakefront Drive
St. Louis, MO 63045
1-800-637-8030
www.ogr.org
OGR is an international association of about 1,300 independent funeral homes.

Jewish Funeral Directors of America Seaport Landing
150 Lynnway, Suite 506
Lynn, MA 01902
(781) 477-9300
www.jfda.org
JFDA is an international association of funeral homes serving the Jewish community.

National Funeral Directors Association
13625 Bishop's Drive
Brookfield, WI 53005
1-800-228-6332
www.nfda.org/resources
NFDA is the largest educational and professional association of funeral directors.

National Funeral Directors and Morticians Association
3951 Snapfinger Parkway, Suite 570
Decatur, GA 30035
1-800-434-0958
www.nfdma.com
NFDMA is a national association primarily of African-American funeral providers.

National Selected Morticians
5 Revere Drive, Suite 340
Northbrook, IL 60062-8009
1-800-323-4219
www.nsm.org
NSM is a national association of funeral firms that have agreed to comply with its Code of Good Funeral Practice. Consumers may request a variety of publications through NSM's affiliate, the Consumer Information Bureau, Inc.

Funeral Service Consumer Assistance Program
PO Box 486
Elm Grove, WI 53122-0486
1-800-662-7666
FSCAP is a nonprofit consumer service designed to help people understand funeral service and related topics and to help them resolve funeral service concerns. FSCAP service representatives

and an intervener assist consumers in identifying needs, addressing complaints and resolving problems. Free brochures on funeral related topics are available.

Funeral Service Educational Foundation
13625 Bishop's Drive
Brookfield, WI 53005
1-877-402-5900
FSEF is a nonprofit foundation dedicated to advancing professionalism in funeral service and to enhancing public knowledge and understanding through education and research.

Solving Problems

If you have a problem concerning funeral matters, it's best to try to resolve it first with the funeral director. If you are dissatisfied, the Funeral Consumer's Alliance may be able to advise you on how best to resolve your issue. You also can contact your state or local consumer protection agencies listed in your telephone book, or the Funeral Service Consumer Assistance Program.

You can file a complaint with the FTC by contacting the Consumer Response Center by phone, toll-free, at 1-877-FTC-HELP (382-4357); TDD: 1-866-653-4261; by mail: Consumer Response Center, Federal Trade Commission, 600 Pennsylvania Avenue, NW, Washington, DC 20580; or on the Internet at www.ftc.gov, using the online complaint form. Although the Commission cannot resolve individual problems for consumers, it can act against a company if it sees a pattern of possible law violations.

Planning for a Funeral

Shop around in advance. Compare prices from at least two funeral homes. Remember that you can supply your own casket or urn.

Ask for a price list. The law requires funeral homes to give you written price lists for products and services.

Resist pressure to buy goods and services you don't really want or need.

Avoid emotional overspending. It's not necessary to have the fanciest casket or the most elaborate funeral to properly honor a loved one.

Recognize your rights. Laws regarding funerals and burials vary from state to state. It's a smart move to know which goods or services the law requires you to purchase and which are optional.

Apply the same smart shopping techniques you use for other major purchases. You can cut costs by limiting the viewing to one day or one hour before the funeral, and by dressing your loved one in a favorite outfit instead of costly burial clothing.

Plan ahead. It allows you to comparison shop without time constraints, creates an opportunity for family discussion, and lifts some of the burden from your family.

Prices to Check

Make copies of this page and check with several funeral homes to compare costs.

"Simple" disposition of the remains:
Immediate burial
Immediate cremation

If the cremation process is extra, how much is it?

Donation of the body to a medical school or hospital
"Traditional," full-service burial or cremation:

Basic services fee for the funeral director and staff
Pickup of body
Embalming
Other preparation of body
Least expensive casket
Description, including model #

Preneed Funeral Arrangements

The death of a loved one is often a devastating experience, complicated by the many arrangements that must be made. With all the considerations, many people find themselves unable to grieve until after all the funeral arrangements have been finalized. Given the tumult this causes, one is distracted and, hence, vulnerable to those who might be inclined to take advantage of the bereaved. If one gives thought to these arrangements ahead of time, one may spare oneself additional grief.

Preneed Funeral Arrangements
In recent years, more and more people have opted to take matters into their own hands and arrange their or a loved one's funeral prior to their deaths. These arrangements are commonly referred to as "preneed funeral arrangements" or "prepaid funeral agreements." Through these arrangements, people are able to decide in advance

what type of funeral they will have, while at the same time eliminating some of the stress that family members frequently experience. Consumers may also be able to lock in today's prices for a future funeral.

What You Should Know

Concerned about abuses to preneed arrangements, the Legislature enacted the Preneed Act of 1993 to strengthen existing laws. Its purpose is to protect consumers who pay for their funerals in advance by regulating preneed funeral agreements between funeral directors and consumers.

The law requires funeral directors to give consumers:

1. a Statement of Funeral Goods and Services, which describes in detail the exact goods and services the consumer is purchasing. For example, what type of casket will be used for the burial.
2. a Prepaid Agreement, which outlines the terms and conditions of the agreement including the amount of money paid and where the money will be deposited. The consumer's preneed funds may be placed in either an interest-bearing trust account or a funeral insurance policy, either of which must be placed in the consumer's name. Consumers may also use the proceeds from an existing life insurance policy to pay for their funerals in advance.

Consumers should ask the funeral director to fully explain all the options available to them regarding the establishment of a prepaid funeral agreement.

Keep the following in mind:

- The Statement of Funeral Goods and Services and Prepaid Agreement must be presented, prepared and signed at the same time. Consumers should not accept any documents that have not been completely filled in and signed in their presence by the funeral directors.
- The money entrusted with the funeral director, *must* be deposited in an interest-bearing account or used to purchase a funeral insurance policy within 30 days of the agreement.

- The preneed funeral arrangements may be moved to any funeral home at any time by the consumer.
- Regardless of the options selected, *the money paid to the funeral directors for preneed funerals belongs to the consumer and must be made available to the consumer upon request at any time.*

By law, preneed funerals may only be funded by funeral trusts or funeral insurance policies.

Funeral Trusts

Consumers who choose to pay for their funerals through funeral trusts, may do so by selecting either a simple trust, in which the money is deposited into a special "payable on death" ("POD") account with a local bank, or into a "pooled" trust account managed by a trustee.

The POD account must be established in the consumer's name. The funds in the account can only be paid to the funeral home when the intended funeral recipient has died.

The other type of funeral trust allows preneed money to be pooled with other pre need funds. These trust accounts are managed by a trustee. Pooled funeral trusts of more than 200 people can charge a commission that is not to exceed 1 percent per year. Pooled funeral trusts that consist of fewer than 200 people cannot charge a commission. Individual licensees or funeral directors' associations may act as trustees of the pooled funds.

Funeral Insurance Policies

Pre need funeral arrangements can also be funded by funeral insurance policies, which are limited solely to paying the costs of one's funeral and/or burial. These policies are sold by a number of insurance companies through licensees of the Board of Mortuary Science.

Like any other insurance policy, at the time of death, the face value of the policy is payable to the policy's beneficiary, who is responsible for paying the funeral director.

Checks should be made payable to the insurance company - not to the funeral home. Funeral directors frequently earn a commission from the sales of such policies. This fact should be disclosed to the consumer.

Guaranteed Funerals/Nonguaranteed Funerals

Funeral directors, at their option, may guarantee that the prices charged for the funeral's goods and services will not be subject to price increases or inflation. This enables the consumer to lock into a funeral at a certain price, regardless of how long it is from the date of the arrangements to the time the funeral actually occurs.

However, funeral directors may elect not to provide price guarantees. In this case, consumers should know that the money prepaid for the funeral may not be sufficient to cover the cost of the funeral at a future date.

Whichever option you select, it must be disclosed in writing to you at the time of the funeral arrangement.

Know the warning signs. There are certain steps consumers can take to make sure their pre need funds are safe.

- Call the bank or association where the funeral trust account has been opened to verify that your pre need money has been deposited.
- In addition to having to be licensed with the Division of Consumer Affairs' Board of Mortuary Science, funeral directors who sell funeral insurance policies must also be licensed with the New Jersey Department of Insurance. Ask to see the funeral director's licenses.
- Consumers purchasing funeral insurance policies, should receive those policies within a reasonable amount of time. If months have lapsed and you still have not received your policy, call the insurance company.
- Whether you've put your pre need funds into a funeral trust account or in a funeral insurance policy, make sure

you receive at least one statement each year detailing the status of your account.

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Note: Before entering into a pre need funeral agreement, discuss your plans with your family and/or attorney to make sure the agreement is consistent with your will and estate planning.

No-Fault Auto Insurance Fraud in New York State

More cars are insured in New York—8.6 million—than in any state except California. For this reason, problems in the state's $8.2 billion private passenger auto insurance market get the prompt attention of the nearly 100 auto insurers doing business here. Recently, a problem emerged like no other in the history of auto insurance in New York State.

Investigations by insurers and law enforcement agencies show that organized crime rings along with a small number of unscrupulous medical providers and attorneys are manipulating the personal injury protection (PIP) part of the New York state no-fault auto insurance plan at the expense of the state's policyholders. These elements are actually imposing a tax on every honest driver in New York State. Sadly and ironically, the current New York system is enabling this explosion of abuse.

Scope of the PIP Problem in New York State

Medical no-fault (PIP) claim costs are rising faster in New York—by far—than anywhere else in the country and they are accelerating. Last year claims costs in the state rose by almost one-third (32.1%,) more than twice the 15.0% increase in second-place Florida (see Figure 1). In 1999, claims costs in New York rose by 11.1% while in 1998 the increase was just 4.5%. The sudden surge in claims costs is the result of greater frequency of claims as well as extraordinarily large increases in the average cost per claim. Both phenomena are almost entirely fraud-driven. Medical no-fault claim frequency in New York is 30% above the median no-fault state while New York's average cost per claim is more than double the no-fault median.(1)

The astonishing rise in frequency and cost of medical no-fault claims cannot be explained by any economic factors such as increases in medical inflation. Medical professionals under the no-fault law in New York State are paid according to a fee schedule which fixes the price for medical goods and services. According to the U.S. Bureau of Labor Statistics, the cost of providing medical services rose 4.1% last year. However, the average PIP claim in New York State jumped 19% over the first nine months of 2000 and 63.5% over the period 1995 to the end of the third quarter 2000, according to insurance industry figures from the National Association of Independent Insurers. This compares with a 33% increase in average PIP claims over the same time period for other states. In addition, the average bodily injury liability claim in New York, as of the third quarter 2000, is 64% higher than the average for other states, which, even taking into consideration the higher cost of medical treatment in New York, is a substantial difference. (Bodily injury liability claims are filed when the policyholder injures someone else and that person's claim reaches the threshold to file a lawsuit.)

Evidence of major fraud in New York's no-fault auto insurance system is irrefutable. As illustrated in Figure 2, the number of auto no-fault fraud reports received by the New York Insurance Fraud Bureau (IFB) has nearly tripled in recent years, from 4,393 in 1995 to 12,372 last year.(2) No-fault fraud reports now account for 55% of all reported insurance frauds, up from just 22% in 1995 (Figure 3). The National Insurance Crime Bureau reports that last year, 90% of its fraud referrals in New York involved auto insurance fraud. The rapid increase in no-fault fraud reports masks what otherwise would be a significant overall decline in reported insurance fraud in New York. Excluding no-fault auto, the number of fraud reports actually plunged by 38% between 1995 and 2000!

Economic Implications

The economic implications for New York drivers are painfully obvious. Because rates have not kept pace with costs, auto insurers on average are paying out almost twice as much as in PIP claims as they collect in premiums. For every $100 insurers took in during the first nine months of 2000, they paid out more than $177 in claims. Not surprisingly, auto insurers are forced to withdraw from the market and/or raise prices.

Sharply higher costs and the withdrawal of capacity from the market are leading to higher auto insurance premiums and forcing more drivers to seek coverage through New York's Automobile Insurance Plan (the NYAIP is the state's market of last resort for high-risk drivers), where the cost of automobile insurance is significantly higher. Already the number of applications to the plan is surging (see Figure 4). In 2000, the plan received 227,131 applications, an increase of 62% over the 140,288 applications received in 1999. Through the first nine weeks of 2001, applications to the plan were up 277% over the same period last year. It is estimated that the NYAIP will receive at least 500,000 applications this year, a 125% increase over 2000.

No-fault fraud is leading directly to higher auto insurance costs in New York State, particularly in the most fraud-ravaged parts of New York City. As of March 1, 2001, a clean adult driver in Brooklyn insured through the NYAIP carrying just the mandatory liability coverage of 25/50/10 and basic no-fault coverage will pay $3,100. The no-fault portion of the coverage alone accounts for $1,681 or 54% of the total premium. Adding collision or comprehensive coverage will cost an additional $4,000. Increasing

limits of liability to 100/300 adds another $700 to the premium. A 24-year old male in Brooklyn, for example, would pay $5,831 just for mandatory coverage. If the driver has tickets or accidents or is an inexperienced driver, the above premium could be as much as 200% higher. In many cases, the annual cost of insurance could well exceed the value of the car itself.

It is estimated that no-fault fraud will cost insurance companies doing business in New York State and their policyholders one billion dollars this year alone. Insurers have already spent millions of dollars to battle medical no-fault fraud in New York through investigations and prosecutions of those who perpetrate fraud, but the problem remains overwhelming. Only serious reforms, along with the continued efforts of insurers and law enforcement agencies can stop this. Failure to address this problem swiftly will force honest policyholders to subsidize fraudulent and abusive criminal activities and will reinforce the notion that New York's no-fault system is an open checkbook for criminals.

New York's No-Fault System: What it Is and What it's Intended to Do

New York's no-fault auto insurance laws became effective on February 1, 1974. Today, 23 states, the District of Columbia and Puerto Rico have some form of auto no-fault statute in force. No-fault auto insurance systems were developed to keep auto insurance costs low by keeping small claims out of the courts. Each insurance company compensates its own policyholders for the cost of minor injuries regardless of who was at fault in the accident. These so-called "first-party" benefits, which are a mandatory coverage, vary from state to state. In New York, a policyholder is eligible to receive compensation for medical fees, lost wages, funeral costs and other out-of-pocket expenses without having to prove the fault of the other driver. This type of coverage

is referred to as “Personal Injury Protection” (PIP) coverage. New York’s no-fault law also restricts the injured party’s right to sue for non-economic damages such as pain and suffering unless the severity of their injuries satisfies certain “verbal thresholds” (permanent significant disfigurement, for example) or when the total cost of a claim exceeds $50,000. If a claim exceeds the $50,000 threshold or the verbal threshold is satisfied, the injured party may sue for damages as a bodily injury claim. There is an incentive for claimants and their attorneys to “build-up” a claim in order to establish a basis for a potentially much more lucrative filing of a bodily injury suit.

The Nature of Fraud in New York Medical No-Fault Coverage

Fraud in New York’s medical no-fault system is a billion dollar business. The sheer magnitude of the problem in dollar terms and the fact that claims costs are accelerating far more rapidly than in any other state suggests a deliberate, well-organized and sophisticated effort to defraud auto insurers. It is well known from insurer and law enforcement investigations that organized criminal elements have conspired with “medical mills” for the express purpose of defrauding the no-fault system. Casual or opportunistic fraud and ordinary claims inflation are not the drivers of such dramatic change.

The Anatomy of a Fraud

The more common crimes associated with auto insurance are staged accidents, stolen identities, fraudulent police reports, and “jump-ins.” These fraudulent activities are aimed at creating an accident scenario from which costly and fraudulently contrived medical claim payments can be forced from auto insurers.

Typically, owners and managers of medical clinics pay "runners" or recruiters to arrange minor auto accidents and send individuals supposedly injured in the accidents to the clinics for treatment. The runners recruit drivers to cause the accident and passengers to ride in the cars. Being a runner is a lucrative business, with each "referral" earning the runner a fee ranging from $800 to $1,300—paid by the attorney or medical mill. Usually, two to four passengers are recruited to maximize the profit per accident. Insurers have also reported that the same vehicle is sometimes used in several staged accidents. One insurer reported receiving 21 PIP claims from a single vehicle involved in three separate accidents within a short period of time. Another insurer received eight PIP claims from the same insured on three different vehicles within a span of just four months. The individual was receiving treatment for all eight incidents simultaneously. When investigated, none of the cars involved in the alleged accidents could be found, none of the "injured" parties would talk. The policyholder was found to have a long criminal record.

Although staged accidents are intended to cause no real injuries to the defendant driver or passengers, the accidents are reported to police so that a record can be created to support the fraudulent insurance claims. Some claimants, despite the absence of any apparent injuries, insist on being transported to a hospital by ambulance in order to establish the "legitimacy" of their claims. Runners then direct them to clinics for bogus medical treatment, often driving the "passengers" there themselves. The clinics then submit claims under the insurance policy of the runner or another ring member who had insured the car.

Medical bills often reach $10,000 to $20,000 per passenger and can go as high as $50,000 per passenger under the New York no-fault law. A single staged accident with multiple claimants generally results in billings for hundreds or even thousands of treatments.

The details of a typical claim are displayed in Case Study 1. The four claimants alleging injury from this accident had a combined total of 482 treatments within approximately four months of the date of loss (date of accident). Billings to the claimant's auto insurer totaled $41,902. The nature and frequency of treatments strongly suggest the fraudulent nature of this claim. Collectively, the four people alleging injury in this particular "accident" received 149 chiropractic/orthopedic treatments, 139 physical therapy sessions (including massage therapy), 133 acupuncture treatments, 28 "diagnostic" procedures (such as MRIs) and numerous other medical services including treatments for purported neurological, psychological and dental problems. Claimants also received transportation to and from visits to clinics on numerous occasions (a permitted benefit under the New York's PIP laws), including one day where no treatments were rendered. New York's PIP laws also permit claimants to receive a wide range of medical supplies. Claimants in this case received supplies ranging from massage devices to "tens units" (an electrical device used to relax muscles) with at least one claimant receiving a whirlpool. Also shown in Case Study 1 is a calendar documenting the types and dates of treatments for one of the claimants for just one month. Receiving medical treatments was nearly a full-time occupation for this particular claimant.

Medical services sought by such fraud rings are not only unnecessary, but many services are never actually provided at all. Passengers typically make false claims of multiple injuries to maximize their claims and, in addition, file lawsuits against companies alleging bodily injuries. Settlements of these lawsuits range from $3,500 to $22,000 per passenger.

Owners and managers of unscrupulous medical clinics give kickback payments to runners and also produce fraudulent bills to

insurers in which the unauthorized signature of doctors has been cut out from other documents and pasted on fake medical bills.

Lastly, provisions of the no-fault law itself are contributing to the medical fraud problem. The law currently can be manipulated to effect excessive medical utilization, expensive testing, along with other palliatives to build up a pain and suffering claim to meet the definition of serious injury. Medical treatment authorized under the present law includes aromatherapy, biofeedback, massage, acupuncture, thermograph and psychotherapy sessions for post-traumatic stress. Over utilization of these non-primary treatments allows claimants to build up medical expenses in order to satisfy the no-fault verbal definition for lawsuit eligibility. This was the same problem being experienced in New Jersey before new no-fault medical protocols were introduced there in 1998.

The Many Faces of Medical Fraud

Flaws in New York's no-fault laws have permitted perpetrators of fraud to get away with a surprisingly wide array of abuses. Virtually all insurers have indicated significant fraud and abuse in the following areas:

Provider Billing:

Billing practices associated with "medical mills" are a major source of fraud in New York's medical no-fault system. Many insurers have seen numerous cases where the provider has billed for services not rendered on behalf of the insured. Insurers have used their Special Investigation Units (SIUs) to interview policyholders who have verified that they did not receive any of the treatment billed on their behalf. In addition, insurers have required that some policyholders submit to examinations under oath which revealed facts that ultimately led to denial of payment

for medical bills. Insurers have also inspected numerous medical facilities, even demanding actual sign-in sheets to verify visits by insureds. In several instances, insurers have found that certain medical facilities do not even exist and the provider was just running a medical billing mill.

Durable Medical Suppliers:

Insurers have seen numerous occasions where policyholders have complained that they did not receive all of the durable medical supplies that the insurer was billed for. Some insurers have mentioned that the same piece of equipment has been billed for on multiple occasions or resold to another person and that the price charged is far in excess of the device's actual value. One insurer, for example, recently investigated a case in which it was billed for supplies allegedly provided to three separate claimants. Each of the three bills and supporting justification were identical, except the name was changed, suggesting that the provider probably did not provide the devices as billed. Many insurers feel that fraud committed by providers of durable medical devices is significant. SIU units have also investigated numerous claims where the provider "padded" the bill with additional items that the insured didn't receive although they received certain items.

Transportation "Provider" Bills:

Despite the clear and obvious conflict of interest, some of the attorneys and doctors in New York actually own a share of the transportation companies involved in transporting claimants to their "clinics." Insurers have been able to prove that the insured "did not" receive any transportation to the doctor's office, although significant billing was received. Transportation costs to and from a medical clinic can easily build up into the thousands of dollars. SIUs have been successful in determining that in many instances

the insured was unaware of this billing practice and did not receive this service.

Lost Wages:

In some cases, unemployed insureds attempt to file for loss wage benefits under the No-Fault provisions to supplement their payout. Some have forged documents, increasing their hourly rate, number of hours or days worked to enhance the benefits they receive.

Household Help:

The No-Fault coverage allows for the injured insured to be compensated for household help required because of their injury. Some insureds have claimed to have a household helper when upon verification one never existed at all. Some of the insureds that have actually had household help have attempted to inflate the actual days or hours that the help have worked.

Exotic Medical Treatments:

Most insurers are receiving bills for excessive use of services and procedures that are often of questionable medical value. Insurers routinely are billed for:

Aromatherapy

Biofeedback

Acupuncture

Psychotherapy

Massages

Whirlpool Sessions

Electrical Stimulation

Thermography

Treatment Frequency:

Treatments such as those listed above as well as others are often administered with such extraordinary frequency that a strong suspicion of fraud is aroused. Chiropractic and physical therapy sessions, for example, often account for one-third of all treatments rendered, acupuncture another third. In contrast, treatment protocols designed for workers compensation and managed care programs utilize a narrower range of modalities as well as effective controls on the frequency of treatments while at the same time achieving maximal medical recovery.

Other Types of Fraud:

Identity Fraud
Claimants in PIP fraud cases are generally paid to feign accidents and injuries. In order to protect their own identities, identities of other individuals are often stolen and medical claims are made on those stolen identities. This practice also permits the same individual to receive “treatments” under many different assumed (stolen) identities.

Bounced Checks

Many policyholders planning to commit fraud obtain insurance using checks that they know will bounce. Many states, though not New York, have laws that allow insurers to deny coverage if an insurance policy is obtained using a check that is returned because of insufficient funds.

Legal Abuse

Lawsuits

New York's legal system is also suffering from abuse at the hands of a relatively small number of law firms who represent New York's PIP medical mills. Attorneys at these firms try to force payment from insurers before the insurer has had an adequate opportunity to review a suspected fraudulent claim by filing and threatening to file bad faith law suits against them. Most insurers are reporting that the number of suits filed against them increased by 100% to 200% last year. One insurer reporting a 164% surge in suits indicated that 74% of those suits were generated by just three law firms.

Attorneys flood the courts with lawsuits by exploiting the fact that claimants (more often the medical mill in cases suspected of PIP fraud) have 180 days or nearly six months to submit proof of expenses to insurers. The insurer, on the other hand, has just 30 days to determine whether to pay or deny such claims. Because suspicious cases often involve multiple claimants receiving hundreds of treatments from numerous providers for up to six months before bills are submitted to insurers, the documentation associated with a single claim could be a foot or more thick. Thorough reviews of suspicious claims are time consuming. If the insurer misses the 30-day deadline, attorneys automatically initiate a legal action against the insurer and file a complaint with the New York Insurance Department.

It is important to note that the proportion of PIP claims with attorney involvement in New York State is above the national average while New York City is far above the national average. According to the Insurance Research Council, 30% of PIP claimants nationally are represented by attorneys compared to as many as 57% in New York City.(3) The data are for 1997 and are the most recent available. It's likely that more current information on attorney involvement would indicate an even greater disparity.

Inequities in the Arbitration Process

Arbitration is a dispute resolution option that provides parties with a forum and a mechanism to settle their differences without resorting to the courts. The advantages of arbitration include speedier resolution of disputes, lower costs and less uncertainty relative to a court proceeding jury trial. Under New York's no-fault laws, however, the process is anything but equitable.

First, for a claim to be heard by an arbitrator the insurer must pay a fee of $345 while the claimant (usually an attorney representing the medical provider) pays a fee of just $40. If the claimant wins even $1 in a dispute, the insurer must pay the claimant's arbitration fee. If the insurer wins, the insurer must still pay its own expenses and is not reimbursed for the $400 arbitration fee.

This lopsided and obviously inequitable system has led to a flood of arbitrations against insurers. In 1989, the New York Insurance Department received 9,000 requests for no-fault arbitration and quickly conciliated about 6,500 of these disputes. About 1,000 disputes that year went to court. Last year, over 73,000 no-fault disputes were submitted for arbitration with a similar number going to court. Virtually none of these requests for arbitration come from claimants. In fact, over 98% these disputes originate

with medical providers. One major auto insurer in the state reported a 243% increase in arbitrations in 2000 over 1999.

Solutions to the Problem

A number of legislative and regulatory reforms have been suggested to address the problematic trends discussed here without affecting benefits to truly injured parties or slowing payments to honest policyholders, medical providers or attorneys.

One measure involves shortening the time for both accident victims and medical professionals to file claims, as other states have done, to give more opportunity to investigate suspicious bills.

Under current law, claimants have 90 days to submit a claim and 180 days to submit proof of medical, wage loss, or other expenses. One new rule, aimed at curbing fraudulent injury claims, would reduce the claim filing period to 30 days and proof of work loss to 45 days. Health care providers would be required to submit written proof of loss within 45 days, down from 180 days. Extensions would be allowed if the claimant could establish "clear and reasonable justification" for failing to meet the deadline. The Insurance Department says that the reduced notification time would allow insurers to look sooner at the treatment plan, thus providing fewer opportunities for unnecessary diagnostic tests and treatments.

Other significant changes being proposed include:

A “Runner Bill” making the act of being a middleman between a claimant and a medical provider or attorney a Class E felony. Passage of such a bill permits prosecution of a key party to no-fault fraud.

A bill to allocate $10 million of the $12 million balance in the state's Auto Theft and Fraud Bureau Account (but not authorized by the Legislature to be spent) to the Auto Theft and Fraud Prevention Board dedicated solely to the investigation and prosecution of no-fault fraud. Use of the money in this way is logical because the funds are contributed by all of the state's policyholders who will benefit directly from the elimination of this type of fraud. Police departments and district attorneys want to be more involved in the fight against no-fault fraud but are constrained by tight budgets and the particularly high costs of prosecuting such cases.

A requirement that a no-fault insurer receive notice within five days of treatment from a medical provider for an assignment of benefits to be valid. This bill will provide the carrier with prompt notice of who is treating a claimant so that cost containment efforts can be immediately deployed and the fraud mitigated or eliminated. (This requirement was part of the 1998 reform in New Jersey).

A bill to clarify that a no-fault insurer can take more than 30 days to pay or deny a claim when the carrier suspects fraud (and has reported the claim to the Insurance Frauds Bureau) or the carrier is questioning the causality of injuries in the accident. (This bill would remedy the Court of Appeals in the Presbyterian Hospital v. Maryland Casualty case, which appears to force 30-day decisions even in cases of suspected fraud).

A bill requiring that arbitration be the sole remedy for the resolution of no-fault disputes for medical provider assignees. Presently, when attorneys know they will lose a case in arbitration

they go to court since trial judges and referees are generally less knowledgeable about no-fault regulations and case law. Over 98% of disputes involve medical assignees and the arbitration system is very fair, with full-time paid arbitrators selected and reviewed by a panel consisting of both trial lawyers and insurers. The arbitration process also allows applicants to appeal to a master arbitrator and file for a trial when the award exceeds $5,000.

Revision of Insurance Department Regulation 68 regarding arbitration so that each party pays one-half the cost of arbitration. Also, any party that prevails in the whole shall have its half of the arbitration costs paid by the loser.

A bill granting insurers the authority to void (cancel from the date of policy inception) a policy that the insurer suspects was taken out with the intent of committing fraud. Innocent claimants will be able to obtain benefits from the Motor Vehicle Accident Indemnification Corporation.

A bill stating that an insurer receiving payment of a deposit premium with a bad check would not provide coverage under the policy. Such a provision is currently law in 37 states. In most cases, perpetrators of staged accidents pay their deposit with a bad check in order to keep their investment to a minimum.

A bill to establish pre-certification requirements for certain medical procedures, reduce unnecessary medical procedures, develop medical treatment protocols and/or establish alternatives to the current workers' compensation fee schedules. If enacted, insurers would be able to better challenge questionable and unnecessary medical treatments. Insurers are also seeking

clarification that the rules and procedures associated with the workers' compensation fee schedule (and not just the fee schedule itself) also apply to no-fault auto.

Why Can't Insurers and Law Enforcement Agencies Fix the Problem?

A natural question to ask is why can't the state's insurers and law enforcement agencies fix the problem on their own? Insurers could simply deny claims they suspected of fraud and law enforcement could arrest and prosecute suspecting perpetrators of fraud.

It's not that simple for several reasons. Challenging cases suspected of no-fault fraud is a lengthy, expensive and uncertain process. As mentioned earlier, New York state law permits medical providers to build up a claim for up to 180 days before proof of expenses must be submitted to insurers. Insurers, faced with a mountain of medical expenses from a myriad of medical providers must decide within 30 days whether to accept or deny the claim. Claims suspected of fraud are not exempted from this 30-day rule (the so-called Presbyterian Hospital decision). If an insurer denies a claim based on the suspicion of fraud a lawsuit will most likely be generated by the attorney representing the medical mill.

Investigations into fraudulent activity are very expensive. The following "simple" case of fraud is illustrative of the problems insurers face (see Case Study 2). A major insurer recently received a first notice of claim involving a single claimant from an attorney nearly three months after the purported date of loss. The insurer subsequently received expense billings from medical providers totaling $17,188 for the single claimant. Suspicious of fraud, the insurer decided to investigate the claim. Initially, the claimant's attorney refused to produce the accident vehicle for inspection. When the vehicle was finally surrendered from inspection, there

was no visible damage. Independent medical examinations (IMEs) were ordered for the claimant as was an examination under oath (EUO). The IMEs came back negative and the claimant no-showed for a total of three EUOs. These developments led the insurer to deny the vast majority of billed charges. The insurer's cost associated with the investigation of this case so far amounts to $3,626—which includes the costs of the IMEs, travel expenses, police report, plate check, EUO transcriber, legal, clerical and underwriting support, postage, etc. Costs, however, will continue to mount. The claimant has filed a lawsuit and the claimant's attorney threatens to do the same. The insurer could face between 12 and 40 arbitration actions/suits over the next six years.

A suit by a group of insurers against a pair of medical fraud ring leaders shows just how expensive taking a case all the way to court can be.(4) In January 2000 a group of insurers joined forces to file a civil suit for relief under the federal Racketeer Influence and Corrupt Organization (RICO) Act against a group of organized perpetrators of fraud. Collectively, these insurers paid $2.6 million in fraudulent claims and were successful in recovering $1.2 million of that amount. Thirteen months after the coalition of insurers filed their RICO, their expenses in support of that action so far total approximately $500,000 in legal, investigative and administrative time. Costs will likely mount as several of the defendants refuse to settle with their cases appearing to be headed for trial.

Aggressive efforts by insurers and law enforcement are vital, but clearly cannot do the job alone in a system open to abuse. Dishonest operators have found ways to exploit some weaknesses in what was once a model no-fault system. These can be repaired. New York drivers do not have to support criminals.

THE RICO ACT
(Racketeer Influenced and Corrupt Organization Act)

I. Introduction: The Mafia as a Helpful Context

Although the RICO Act can be used in many contexts, the statute is most easily understood in its intended context: the Mafia. In the context of the Maifa, the defendant person (i.e., the target of the RICO Act) is the Godfather. The "racketeering activity" is the criminal activities in which the Mafia engages, e.g., extortion, bribery, loan sharking, murder, illegal drug sales, prostitution, etc. Because the Mafia family has engaged in these criminal actions for generations, the criminal actions constitute a pattern of racketeering activity. The government can criminally prosecute the Godfather under RICO and send him to jail even if the Godfather has never personally killed, extorted, bribed or engaged in any criminal behavior. The Godfather can be imprisoned because he operated and managed a criminal enterprise that engaged in such acts. Moreover, under section 1964(c) of the RICO Act, the victims of the Mafia family (i.e., the extorted businessman, the employers whose employees were bribed, debtors of the loan shark, the family of a murder victim) can sue the Godfather civilly and recover the economic losses they sustained by reason of the Mafia family's pattern of racketeering.

As a practical matter, the closer a plaintiff's case is to the Mafia scenario described above, the better chance the plaintiff has in succeeding under the RICO Act. Given the diverse factual scenarios that may confront attorneys and parties under RICO, it is always helpful to analogize non-Mafia factual scenarios to the prototypical RICO claim against the Mafia. It is always helpful to ask: who stands in the position of the Godfather, i.e., the defendant person? What is the equivalent of the Mafia family, i.e., the

enterprise? This will give you a good start in evaluating the merits of any RICO claim you confront. If the facts are well-suited to the Mafia analogy, you likely have a stronger claim.

II. What constitutes a RICO violation?

RICO's substantive liability provisions are found in section 1962, which has four subsections labeled (a), (b), (c) and (d).

In plain English, section 1962(a) generally makes it unlawful for a person to use an enterprise to launder money generated by a pattern of racketeering activity. *Lightening Lube, Inc. v. Witco Corp.*, 4 F.3d 1153, 1188 (3d Cir. 1993).

Section 1962(b) makes it unlawful for a person to acquire or maintain an interest in an enterprise through a pattern of racketeering activity. Section 1962(b) is perhaps the most difficult RICO claim to express in practical terms. A stereotypical violation of section 1962(b) occurs when a victim business owner cannot make payments to a loan shark; upon default, the loan shark says: "you're either going to die or you're going to give me your business." Given the threat to this life, the victim transfers control of his business to the loan shark. Usually, the victim business owner remains the owner on paper but the loan shark controls the business and receives all income from the business. Thus, the loan shark has acquired and maintained interest or control over an enterprise (i.e. the business) through a pattern of racketeering (i.e., loan sharking and extortion).

Section 1962(d) makes it unlawful for a person to conspire to violate subsections (a), (b) or (c) of the RICO Act.

By far the most useful and common civil RICO claim is found under section 1962(c), which makes it unlawful for a person to manipulate an enterprise for purposes of engaging in, concealing, or benefiting from a pattern of racketeering activity. Given its broad utility, the general elements of a RICO claim will be discussed in the context of a section 1962(c) claim. Distinctions will then be made between section 1962(c) claims and claims under 1962(a), (b) and (d).

A. Section 1962(c) Claims

Section 1962(c) prohibits any defendant person from operating or managing an enterprise through a pattern of racketeering activity. So long as a civil RICO plaintiff is injured by reason of the defendant's operation or management of the enterprise through a pattern of racketeering, the plaintiff is entitled to treble damages, attorneys' fees and costs under section 1964(c) (commonly referred to as RICO's civil liability provision).

Section 1962(c)'s utility stems from its breadth. Section 1962(a) and (b) claims are relatively narrow. To have standing under sections 1962(a) and (b), the plaintiff must allege more than injury following from the racketeering activity. Under section 1962(a), a civil plaintiff has standing only if he has been injured by reason of the defendants' investment of the proceeds of racketeering activity. Under section 1962(b), a civil plaintiff has standing only if he has been injured by reason of the defendants' acquisition or maintenance of an interest in or control over an enterprise through a pattern of racketeering activity. These distinctions will be discussed in greater detail in the section of this memorandum that is particularly concerned with the section 1962(a) and 1962(b) claims.

The elements of a section 1962(c) civil claim can be described in many ways. Generally, to establish a claim under section 1962(c), the plaintiff must prove that (1) a defendant person (2) was employed by or associated with an enterprise (3) that engaged in or affected interstate commerce and that (4) the defendant person operated or managed the enterprise (5) through a pattern (6) of racketeering activity, and (7) the plaintiff was injured in its business or property by reason of the pattern of racketeering activity.

1. *Defendant Persons*

Section 1962 refers to defendants as "persons," and only those defendants who are named as persons under section 1962 can be held liable for violations of RICO. A defendant "person" can be an individual or corporation - it makes no difference so long as the defendant person engaged in a pattern of criminal activity.

Parties often confuse the defendant "person" with the RICO enterprise and equate the RICO enterprise with a criminal enterprise. Many times, the RICO enterprise is an enterprise that perpetrates crime (e.g., a Mafia family), but many other times the RICO enterprise may be the victim of the criminal activity or a passive instrument of the defendants' criminal acts. *See National Organization for Women v. Scheidler*, 510 U.S. 249, 259 n.5 (1994). For example, John Doe is a purchasing agent for ABC Company. Sally Smith sells office products to ABC Company. Sally's prices are grossly inflated, so John Doe refuses to buy ABC's office supplies from her. One day, Sally offers to make a personal payment of $1000 per month to John for so long as ABC buys its office supplies from her. John accepts the offer. After several months of paying Sally's grossly inflated prices, ABC discovers the bribes, fires John and sues Sally under RICO. For purposes of its RICO claim against Sally, ABC could allege that it was the RICO enterprise through which Sally perpetrated her pattern of racketeering activity. *See Reves v. Ernst & Young*, 507 U.S. 170, 184 (1993) ("[a]n enterprise . . . might be 'operated' or 'managed' by others 'associated with' the enterprise who exert control over it as, for example, by bribery"). Thus, ABC can be the RICO enterprise even though it is a totally innocent victim and the plaintiff in the case.

The important thing to remember is that only a "person" can be held liable under section 1962(c). Naming an entity as simply a RICO enterprise does not impose any liability on that entity. Banks, law firms, insurance companies, advertising agencies that unknowingly facilitate a defendant's criminal activities are often named as the enterprise or part of the enterprise through which the defendant conducted his pattern of racketeering. No liability can attach to a person or entity who is merely named as a member of the enterprise or who is merely named as the enterprise itself.

Another confusing aspect of RICO is that it uses the term "person" to refer to both defendants and plaintiffs. As noted above, "person" as used in section 1962(c) refers to the defendant person. Section

1964(c), RICO's civil liability provision, states, however, that any "person injured in their business or property by reason of a RICO violation" is entitled to damages under the statute. Person, under section 1964(c), refers to the plaintiff, the victim, or the party injured by the criminal acts - not the defendant.

2. ***Enterprise***

To establish liability under any subsection of section 1962, a plaintiff must allege the existence of an enterprise. As noted above, an enterprise may be an illegitimate enterprise, such as a Mafia family, or a wholly legitimate enterprise, such as a corporation. *United States v. Turkette*, 452 U.S. 576, 580-81 (1981). Although an enterprise can be a legal entity, such as a partnership, corporation or association, it can also be an individual or simply a relatively loose-knit group people or legal entities. These latter groups are referred to as "association-in-fact" enterprises under the statute. 18 U.S.C. § 1961(4).

Association-in-fact enterprises are probably the must useful and abundant forms of RICO enterprises, but they are also the most difficult to grasp on an analytical level. When Congress passed the RICO Act, the phrase "association-in-fact" enterprise was probably intended to apply directly to the Mafia, because a Mafia family is not a formal legal entity nor is it an individual, rather it is a "union or group of individuals associated in fact although not a legal entity." *Id.* Corporate parents and their subsidiaries allegedly engaged in criminal activities have also been named as association-in-fact enterprises. Most courts will accept any informal group as an association-in-fact enterprise so long as the group possesses three characteristics: (a) some continuity of structure and personnel; (b) a common or shared purpose; and (c) an ascertainable structure distinct from that inherent in the pattern of racketeering. *Diamonds Plus, Inc. v. Kolber*, 960 F.2d 765, 769 (8th Cir. 1992).

Continuity of structure and personnel means that you cannot have a group whose membership is constantly in a state of flux. There must be something more than a fleeting consistency with regard to

the number of group members and the identity of the group members.

a. *Enterprise / Racketeering Activity Distinction*

There is tension between the last two elements of an association-in-fact enterprise. A group's common or shared purpose can be to carry out criminal activity, but if the group's only common or shared purpose is to carry out criminal activity then the group may not have an ascertainable structure distinct from the pattern of racketeering. This tension is commonly referred to as the enterprise / racketeering activity distinction. To the extent an enterprise carries out legitimate objectives, in addition to allegedly criminal actions, the enterprise / racketeering activity distinction is not problematic. *Id.* at 770 n.5 ("though it is not required, proof the enterprise conducts lawful activity unrelated to the pattern of racketeering activity will often serve to prove the enterprise is separate from the pattern of racketeering). With regard to wholly criminal association-in-fact enterprises, one court has stated:

. . . [A] distinct structure might be demonstrated by proof that the group engaged in a diverse pattern of crimes or that it has an organizational pattern or system of authority beyond what was necessary to perpetrate the predicate crimes. The command system of a Mafia family is an example of this type of structure as is the hierarchy, planning, and division of profits within a prostitution ring.

United States v. Bledsoe, 674 F.2d 647, 665 (8th Cir.), cert denied, 459 U.S. 1040 (1982). "The focus of the inquiry is whether the enterprise encompasses more than what is necessary to commit the predicate RICO offense." *Diamonds Plus, Inc.*, 960 F.2d at 770. It is not enough than individual members of the enterprise carry an activities distinct from the pattern of racketeering; the group as a whole must have a common link other than the racketeering activity. *McDonough v. National Home Ins. Co.*, 108 F.3d 174, 177 (8th Cir. 1997).

b. *Person / Enterprise Distinction*

In addition to being distinct from the pattern of racketeering activity, the enterprise must also be distinct from the defendant person. The person / enterprise distinction arises from the long-standing common law maxim that a person cannot conspire with himself. *River City Markets, Inc. v. Fleming Foods West, Inc.*, 960 F.2d 1458, 1461 (9th Cir. 1992). The person / enterprise distinction is most problematic in the context of corporations. As one court noted:

Because a corporation can only function through its employees and agents, any act of the corporation can be viewed as an act of such an enterprise, and the enterprise is in reality no more than the defendant himself. [Citation omitted.] Thus, where employees of a corporation associate together to commit a pattern of predicate acts in the course of their employment and on behalf of the corporation, the employees in association with the corporation do not form an enterprise distinct from the corporation.

Riverwoods Chappaqua Corp. v. Marine Midland Bank, N.A., 30 F.3d 339, 344 (2d Cir. 1995). In short, the person / enterprise distinction is not satisfied (and a RICO claim will fail) where the corporation is named as the defendant person who engages in a pattern of racketeering activity through an association-in-fact enterprise consisting exclusively of its officers and/or employees. *Id.* On the other hand, a corporation is a separate legal entity from its incorporators - even if the corporation is owned and controlled by a sole shareholder. Thus, one can successfully name as defendant persons the individual shareholder(s), officers, directors or employees who engage in a pattern of racketeering activity through their corporate enterprise. *See Cedric Kushner Promotions, Ltd. v. Don King*, 533 U.S. 158, 163-64 (2001); *Jaguar Cars, Inc. v. Royal Oaks Motor Car Co., Inc.*, 46 F.3d 258, 269 (3d Cir. 1995). Under such circumstances, however, only the shareholder(s), officers, directors or employees will face individual liability under RICO. Because it is merely the enterprise, the corporation cannot face any liability.

In order for a corporation to be named as a defendant person, the corporation must engage in a pattern of racketeering activity through an enterprise that includes more than itself or its subparts. Some courts do not consider an enterprise consisting of a corporation's subsidiaries, affiliates, dealers or captive agents to be sufficiently distinct from the corporate defendant:

. . . [W]here a large, reputable manufacturer deals with its dealers or other agents in the ordinary way, so that their role in the manufacturer's illegal acts is entirely incidental, differing not at all from what it would be if these agents were the employees of a totally integrated enterprise, the manufacturer plus its dealers and other agents (or any subset of the corporate family) do not constitute an enterprise within the meaning of the statute.

Fitzgerald v. Chrysler Corp., 116 F.3d 225, 228 (7th Cir. 1997).

However, if a complaint alleges that a corporation engages in a pattern of racketeering activity through legal entities beyond its control, such as independent banks, law firms, accounting firms, or public relations firms, the person / enterprise distinction will more than likely be satisfied.

Some defendants have attempted to allege that the person / enterprise distinction cannot be met where an individual defendant person is also alleged to be part of an association-in-fact enterprise consisting of other individuals. For example, Joe Doe is alleged to be the defendant person who engages in a pattern of racketeering activity through an association-in-fact enterprise consisting of John Doe, Sally Smith and Bob Johnson. Most courts have held that in such cases the individual and association-in-fact enterprise that includes the individual -- are distinct: "]logically, one can associate with a group of which he is a member, with the member and the group remaining distinct entities." *River City Markets, Inc.*, 960 F.2d at 1461.

3. *An Enterprise Engaged in or Affecting Interstate Commerce*

At first blush, one would think that RICO's interstate commerce requirement would receive a great deal of attention from the

courts, given that RICO is a federal statute and a nexus with interstate commerce is necessary to confer jurisdiction on a federal court. RICO's interstate commerce requirement is seldom, however, discussed by the courts - probably because a RICO claim must be predicated upon underlying acts of racketeering. When a RICO claim is based upon violations of federal criminal statutes (see 18 U.S.C. § 1961(1)(B)), the nexus with interstate commerce is necessarily established by the commission of the underlying federal crime. Moreover, because the U.S. Constitution confers the postal powers upon the federal government, acts of mail fraud, even intrastate use of the mails, have an inherent nexus with interstate commerce. *United States v. Elliott*, 89 F.3d 1360 (8th Cir. 1996). Because violations of the mail fraud statute are almost always alleged in a RICO complaint, a nexus with interstate commerce is almost always present. Finally, the state crimes upon which a RICO claim may be predicated (see 18 U.S.C. § 1961(1)(A)) are not minor offenses, and when such significant crimes are committed through an "enterprise" (rather than a mere individual), they are seldom confined to a single state.

To the extent the courts have discussed RICO's interstate commerce requirement in particular, a plaintiff's burden does not appear onerous. In *United States v. Beasley*, 72 F.3d 1518 (11th Cir.), *cert. denied*, 518 U.S. 1027 (1996), the court held that "[t]o satisfy [RICO's] interstate commerce requirement, only a slight effect on interstate commerce is required." *Id*. at 1526; *see also* United States v. Riddle, 249 F.3d 529, 538 (6th Cir.), *cert. denied*, 534 U.S. 930 (2001) ("a de minimus connection suffices for a RICO enterprise that 'affects' interstate commerce"). In short, the interstate commerce requirement is usually not a major stumbling block in RICO litigation. *But see Musick v. Burke*, 913 F.2d 1390, 1398 (9th Cir. 1990) (holding that the interstate effect of the enterprise's activities must not be insubstantial as a matter of practical economics and that the plaintiff's mere purchase of products drawn from interstate commerce did not demonstrate the

"minimal" interstate nexus necessary to establish jurisdiction under RICO).

4. *Defendants' Operation or Management of the Enterprise*

Section 1962(c) also requires that the defendant "conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs." The Supreme Court has interpreted this language to mean that a defendant must "operate or manage" the enterprise. Reeves v. Ernst & Young, 507 U.S. 170, 183 (1993). This leads one to the question: what does it mean to operate or manage an enterprise? The Supreme Court has stated that although an enterprise is operated and management by its "upper management" the "operation and management" standard does not limit liability under RICO to "upper management":

> An enterprise is "operated" not just by upper management but also by lower-rung participants in the enterprise who are under the direction of upper management. An enterprise also might be "operated" or "managed" by "others associated with" the enterprise who exert control over it as, for example, by bribery.

Reves, 507 U.S. at 184. Given the Supreme Court's crystal clear guidance in *Reves*, the question of whether a particular defendant actually operates or manages an enterprise is generally considered by the lower courts to be a question of fact that is left to the jury. *United States v. Allen*, 155 F.3d 35, 42-43 (2d Cir. 1998). Professionals, however, are one group of defendants who have clearly benefited from the Supreme Court's "operation or management" test. Generally, courts have held that a professional (such as a lawyer, banker, consultant or an accountant) carrying-out their duties in accordance with generally accepted standards of the professional and without knowledge of the RICO violations, cannot be considered operators or managers of an enterprise and, thus, cannot be held liable under the statute. See Reves, 507 U.S. at 186 (dismissing RICO claim against accounting firm); *Handeen v. Lemaire*, 112 F.3d 1339, 1350-51 (8th Cir. 1997) (discussing

whether the defendant law firm operated or managed the alleged enterprise).

5. ***The Pattern***

In *H.J. Inc.* v. Northwestern Bell, 492 U.S. 229 (1989), the Supreme Court determined that the factors of relatedness and continuity combine to produce a pattern of racketeering. As a result of the Supreme Court's decision in *H.J. Inc.*, the statutory definition of pattern (18 U.S.C. § 1961(5)) has been rendered meaningless for all practical purposes.

a. *Relatedness*

To be related, the criminal actions that form the pattern must "have the same or similar purposes, results, participants, victims, or methods of commission, or otherwise are interrelated by distinguishing characteristics." *Id*. at 240. For example, a related pattern of criminal activity probably exists when: 1) the defendant's purpose is to defraud insurance companies by burning down his buildings; 2) insurance companies make several loss payments as a result of the defendant's pattern of arson; 3) the defendant uses an individual or group of individuals to ignite the fires that burn his buildings; 4) the victims are always the defendant's insurance companies and the firefighters who are injured or killed as a result of the defendant's acts of arson; and 5) the defendant always uses the same inconspicuous-type of an electrical malfunction and accelerant to ignite the fires. On the other hand, a pattern of criminal activity may not be related when: 1) the defendant's purpose is, at times, to defraud insurance companies while at other times to bribe police officers, extort neighborhood business owners or engage in money laundering; 2) the results of the defendant's activities vary, sometimes people are extorted, other times buildings are burned, other times drugs are traded; 3) the defendant uses a wide variety of people to engage in these activities and seldom (if ever) associates with the same person twice; 4) the defendant's victims are sometimes insurance companies, sometimes neighboring business persons, sometimes

the communities served by the police he bribes, sometimes the IRS who is deprived of tax revenue by his money laundering.

b. *Continuity*

Continuity may be close-ended or open-ended. *Id.* at 241. "A party alleging a RICO violation may demonstrate continuity over a closed period by proving a series of related predicates extending over a substantial period of time." *Id.* at 242.

There is no rigid rule that a close-ended pattern must last one year, but the one year milestone is a good rule of thumb. *See Religious Technology Ctr. v. Wollersheim*, 971 F.2d 364, 366 (9th Cir. 1992) ("[w]e have found no case in which a court has held the requirement to be satisfied by a pattern of activity lasting less than a year"). Generally, if your pattern lasts a year or more, the courts will find close-ended continuity. If a pattern lasts less than a year, the plaintiff will have to explain persuasively why criminal activity lasting only a few months constitutes a pattern.

Open-ended continuity exists when criminal conduct is a specifically threatened to be repeated or to extend indefinitely into the future. *H.J. Inc.*, 492 U.S. at 242-43. An open-ended pattern is best exemplified by a mobster's threat to burn down a business unless the owner pays $1,000 per month. The extortionate threat is specific and unlimited in duration: whenever you stop paying $1,000 per month (whether it's tomorrow or ten years from now) your building will burn. Thus, the business owner could immediately state a RICO claim on the basis of this single threat, even if the threat was never made again or no money was ever paid. Threats of indefinite duration also exist where criminal conduct has become a regular way of conducting the defendants' ongoing legitimate business.

c. *Multiple Schemes and the Pattern*

Before the *H.J. Inc.* decision, many different tests were used to determine the existence of a pattern. Most popular among these early approaches to the issue of pattern was the "multiple scheme" approach, whereby the courts held that to prove a pattern, the plaintiff had to establish that a defendant engaged in more than one

racketeering scheme and injured more than one victim. *H.J. Inc.* expressly rejected the multiple scheme approach on the basis that it was not supported by the text or history of the statute. *H.J. Inc.*, 492 U.S. at 240.

Regardless of *H.J. Inc.*, some courts have been reluctant to abandon the multiple scheme approach. *See, e.g., Western Associates Ltd. Partnership, ex rel. Ave. Associates Ltd. Partnership v. Market Square Associates*, 235 F.3d 629, 634-35 (D.C. Cir. 2001); *Midwest Grinding Co., Inc. v. Spitz*, 976 F.2d 1016, 1021-22 (7th Cir. 1992). Unless a party is litigating in one of these circuits, the multiple scheme approach should not be relied upon. The multiple scheme approach is not only contrary to *H.J. Inc.* but it can be detrimental to the elements one must establish pursuant to *H.J. Inc.* For example, *H.J. Inc.'s* relatedness requirement is more likely met when the "methods of commission" are similar - multiple schemes may indicate a dissimilarity in the methods of commission. Likewise, *H.J. Inc.* holds that a pattern is related if the victims are similar, arguing that there are multiple, unrelated victims only undermines plaintiffs' relatedness arguments under *H.J. Inc.*

The fundamental problem with the multiple scheme approach is that almost any pattern can be depicted as either one scheme or multiple schemes, depending upon the outlook of the person analyzing the pattern. For example, a defendant bribes an employee. As a result, the employer's invoices (which are mailed to the defendant) are reduced as a result of the bribes, and the defendant's checks to pay the invoices also reflect the reductions obtained as a result of the illegal bribes. This scenario can be depicted as a single scheme designed to obtain the employer's services at a below market rate, or it can be depicted as multiple schemes: to bribe the employee, to defraud the employer through the use of the U.S. mails by causing the employer to transmit invoices reflecting the unlawfully obtained price breaks, and to defraud the employer through the use of the U.S. mails by transmitting checks that reflect the unlawfully obtained price

breaks. There is no objective way to define a pattern as involving either a single scheme or multiple schemes.

6. **Racketeering Activity**

Without the element of racketeering activity, a RICO claim would be difficult to prove, but because one must also prove racketeering activity in addition to pattern, enterprise, operation and management, etc., a RICO claim is among the most difficult violations to establish. It has been said that the need to prove racketeering activity essentially requires a plaintiff or prosecutor to prove a crime within a CRIME. A plaintiff or prosecutor has no chance of proving the "greater" CRIME, i.e., the RICO violation, unless they can first establish a "lesser" crime, i.e., an act of racketeering (sometimes called a predicate act).

Section 1961(1) of the RICO Act lists all of the crimes upon which a RICO violation may be predicated. A RICO claim can be predicated on not only numerous federal criminal violations, but also on violations of certain state criminal laws. With regard to the state crimes, the RICO Act states that a violation can be predicated upon "any act or threat involving murder, kidnapping, gambling, arson, robbery, bribery, extortion, dealing in obscene matter, or dealing in a controlled substance . . . which is chargeable under State law and punishable by imprisonment for more than one year." Thus, to prove a RICO claim, a plaintiff or prosecutor must first allege and prove an entire murder case, kidnapping case, arson case, robbery case, etc. Only if the evidence supports these "lesser" charges, can the plaintiff or prosecutor proceed with the remaining elements of the "greater" RICO claim, e.g., pattern, enterprise, operation and management.

A RICO claim can also be predicated upon the violation of many, many federal criminal statutes. The federal crimes relate to a number of areas, including: counterfeiting, extortion, gambling, illegal immigration, obscenity, obstruction of justice, prostitution, murder for hire, interstate transportation of stolen property, and criminal infringement of intellectual property rights. These are but

a few of the areas of federal criminal law out of which a RICO claim can arise.

Regardless of whether a RICO claim is predicated upon state or federal criminal violations (or a combination of both), the defendant need not be criminally convicted before a civil plaintiff can sue for treble damages under RICO. *Sedima, S.P.R.L. v. Imrex Co.*, 473 U.S. 479, 493 (1985). The statute requires only that the criminal activities are "chargeable" or "indictable" under state or federal law, not that the defendant has already been charged or indicted. 18 U.S.C. § 1961(1). There is one exception to this rule: since Congress amended the RICO Act in 1995, civil RICO claims cannot be predicated on securities fraud violations unless the defendant has been criminally convicted of a securities fraud violation. 18 U.S.C. § 1964(c). What follows is a discussion of some of the more useful and common acts of racketeering.

a. *Mail and Wire Fraud*

The extensive use of RICO in the civil context is almost solely attributable to the inclusion of mail and wire fraud as predicate acts. *Sedima, S.P.R.L. v. Imrex Co.*, 473 U.S. 479, 500 (1985). The mail and wire fraud statutes essentially make it criminal for any one to use the mails or wires to advance a scheme to defraud. Note that the fraudulent statements themselves need not be transmitted by mail or wire; it is only required that the scheme to defraud be advanced, concealed or furthered by the use of the U.S. mail or wires. *See* 18 U.S.C. §§ 1341, 1343. Because every business or corporation in the United States uses the mails or wires to make money, any business who allegedly engages in common law fraud arguably violates the federal mail and wire fraud statutes. As a result, almost any business that allegedly engages in common law fraud can theoretically be sued under the RICO Act.

Use of the mail and wire fraud statutes against businesses, however, is not unlimited. As general rule, a scheme to defraud must involve misrepresentations as to past or presently existing fact. "It is settled law that 'a promise of future action or a prediction of future events cannot, standing alone, be a basis for

fraud because it is not a representation, there is no right to rely on it, and it is not false when made.'" *Hall v. Burger King Corp.*, 912 F.Supp. 1509, 1544 (S.D. Fla. 1995) (*Kamenesh v. City of Miami*, 772 F.Supp. 583, 594 (S.D. Fla.1991) (quoting *Cavic v. Grand Bahama Dev. Co.*, 701 F.2d 879, 883 (11th Cir.1983)). In the context of RICO, one court of appeals has stated: "[b]reach of contract is not fraud, and a series of broken promises therefore is not a pattern of fraud. It is correspondingly difficult to recast a dispute about broken promises into a claim of racketeering under RICO." *Perlman v. Zell*, 185 F.3d 850, 853 (7th Cir. 1999). Thus, if an advertisement merely promises or opines that a product will perform in a certain way, it may be difficult to prove that the business has engaged in a scheme to defraud. The business must make false factual representations, e.g., falsely say that a survey established that 3 out of 4 dentists prefer brand X toothpaste, when in fact the survey established that 3 out of 4 disfavored use of brand X toothpaste. The RICO Act is almost single-handedly responsible for the small print disclaimers that appear on every newspaper and T.V. advertisement and for the fast-talking and whispered disclaimers that we hear on the radio. All of those disclaimers essentially say that all the statements made in the advertisement are opinions or are based upon assumptions that may or may not apply to the circumstances of any individual consumer. So, the next time you're squinting to read the fine-print or waiting for the radio announcer to run out of breath, you can thank the RICO Act.

Perhaps the biggest limitation on a plaintiff's ability to convert any common law fraud claim into a RICO claim predicated on the federal mail and wire fraud statutes is the aversion most federal courts have toward RICO claims predicated only on mail and wire fraud violations. The Supreme Court commented on this aversion in *Sedima, S.P.R.L. v. Imrex Co.*, 473 U.S. 479 (1985):

Underlying the Court of Appeals' [dismissal of the claim] was its distress at the "extraordinary, if not outrageous," uses to which civil RICO has been put. [Citation omitted.] Instead of being used

against mobsters and organized criminals, it has become a tool for everyday fraud cases brought against "respected and legitimate enterprises." [Citation omitted.] . . .

* * * *

The "extraordinary" uses to which civil RICO has been put appear to be primarily the result of the breadth of the predicate offenses, in particular the inclusion of wire [and] mail . . . fraud. . . .

Id. at 499-500; *see also Midwest Grinding*, 976 F.2d at 1025 (". . . we do not look favorably upon many instances of mail and wire fraud to form a pattern" (citing numerous cases).) Thus, even if a RICO plaintiff has clearly alleged a pattern of mail and wire fraud violations, courts may still view the RICO claim as beyond the intended scope of the RICO Act and may actively try to find a way to avoid application of the RICO Act to what is more properly a simple claim of common law fraud. Plaintiffs should always attempt to base their RICO claims on more than just alleged violations of the mail and wire fraud statutes. With hard work, a plaintiff should be able to identify other acts of racketeering under almost any factual scenario.

b. *Bank Fraud*

The bank fraud statute is potentially just as broad as the mail and wire fraud statutes, but for some reason, plaintiffs often fail to include bank fraud as a predicate act in a RICO claim. The bank fraud statute states:

Whoever knowingly executes, or attempts to execute, a scheme or artifice:

c. to defraud a financial institution, or

d. to obtain any of the moneys, funds, credits, assets, securities, or other property owned by, or under the custody or control of, a financial institution, by means of false or fraudulent pretenses, representations, or promises shall be fined not more than $1,000,000 or imprisoned for not more than 30 years, or both.

18 U.S.C. § 1344 (emphasis added). Bank fraud is probably not a common predicate act because people read the first subsection and believe the fraud must be against a financial institution and fail to

read the second subsection's language concerning funds "under the custody or control of" a bank. Under section 1344(2), bank fraud potentially arises even if the victim is not a bank and even if the bank did not lose any of its own property pursuant to a scheme to defraud. Bank fraud arguably occurs whenever a scheme to defraud enables the perpetrator to obtain any funds "under the custody or control of" a bank. Thus, if a scheme to defraud results in elderly victims mailing checks to the perpetrator, which are then cashed and the proceeds pocketed by the perpetrator, the perpetrator has arguably engaged in bank fraud. If a scheme to defraud results in "sweepstakes winners" departing with their credit card numbers, which are then used by the perpetrator to acquire goods and services for himself, the perpetrator has arguably engaged in bank fraud. In short, the bank fraud statute is arguably violated whenever a scheme to defraud results in the victim authorizing a bank to release funds to the perpetrator. Bank fraud is a predicate act that should not be overlooked.

An allegation of bank fraud should also be considered whenever the defendant has forged checks or endorsements on checks.

c. *Extortion*

What laypeople call extortion, lawyers call a violation of the Hobbs Act. The Hobbs Act states:

Whoever in anyway or degree obstructs, delays, or affects commerce or the movement of any article or commodity in commerce, by robbery or extortion or attempts or conspires so to do, or commits or threatens physical violence to any person or property in furtherance of a plan or purpose to do anything in violation of this section shall be fined under this title or imprisoned not more than twenty years, or both.

As used in this section:

(1) The term "robbery" means the unlawful taking or obtaining of personal property from the person or in the presence of another, against his will, by means of actual or threatened force, or violence, or fear of injury, immediate or future, to his person or property, or property in his custody or possession, or the person or

property of a relative or member of his family or of anyone in his company at the time of the taking or obtaining.
(2) The term "extortion" means the obtaining of property from another, *with his consent*, induced by wrongful use of actual or threatened force, violence, or fear, or under color of official right.
(3) The term "commerce" means commerce within the District of Columbia, or any Territory or Possession of the United States, all commerce between any point in a State, Territory, Possession, or the District of Columbia and any point outside thereof, all commerce between points within the same State through any place outside such State and all commerce over which the United States has jurisdiction.
18 U.S.C. § 1951 (emphasis added). In essence, the Hobbs Act elevates all but the simplest acts of robbery and extortion to the level of federal crimes.

i. The Issue of Consent

The important distinction between robbery and extortion is that consent is not an aspect of the former. Robbery is just that - robbery: the perpetrator takes a club, hits the victim over the head, and runs away with the victim's purse or semi-tractor full of cigarettes. Consent does not enter into the picture; rather, robbery involves the taking of property by force or threat of force, against the victim's will.

By its very nature, however, extortion causes the victim to consent to the taking of property. Extortion does not necessary involve the use of force or the threat of the use of force. For example, all of the following are examples of extortion: the victim storeowner "voluntarily" pays a Mafia enforcer $1000 per month because the Mafia enforcer said, "pay us $1000 per month of we'll break your legs"; a male police officer stops a female driver and demands that she have sex with him or he will cause her license to be cancelled; an employee demands personal payments from customers of his employer or the customers will not receive product they need to

stay in business or the customers will receive shoddy service. Only the Mafia enforcers use the threat of force to extort payments. The police officer uses the threat of license revocation. The employee uses the threat of order cancellation or shoddy service. Nonetheless all the acts described constitute extortion because the threat resulted (or was intended to result) in the victim's consent to depart with valuable property or rights.

Because of the aspect of consent, victims of extortion often do not realize they are being extorted, or they may realize they are being extorted but fear reporting the crime to law enforcement because they have "participated" in the offense. For example, the store owner paying $1000 per month to the Mafia may fear that if he reports the payments to police, he will be indicted for aiding and abetting (i.e., financing) the Mafia's illegitimate activities. The female driver who "consented" to sex with the police offer may not report the crime on the basis of a belief that there can be no rape if the woman consents. The customers may not report the extortion of the employee out of fear that the employer will look to the customers to pay damages to the employer's reputation or profitability once the employee's extortion scheme is brought to light.

Perpetrators will also commonly threaten the victim with false charges of bribery if the victim reports the extortion. For example, in the commercial context, an employee may demand personal payments in exchange for the service that the customer is already supposed to receive under its contract with the employer, but when the customer reports the extortion, the employee claims that the customer was bribing the employee to receive favorable treatment (beyond what the employer was obligated to provide the customer under contract), e.g., below market prices, or confidential information that would enable the customer to be more competitive. In highly specialized industries where untrained law enforcement officers may be unable to discern the nature of the benefits running between the business parties, it boils down to the

employee's word against the customer's and the apparent credibility of each party. Although the customer may be the victim of extortion, the customer may be reluctant to report the crime out of fear that law enforcement will believe the perpetrator's bribe story, rather than the true extortion story, and charge the victim with bribery.

These legitimate fears, however, are the very reason why extortion is such a serious crime. Robbery is a serious crime because of the use or threatened use of force. Extortion is a serious crime because it causes victims to believe they are perpetrators, and by exploiting that fear, the extortionist can repeatedly and openly engage in acts of extortion with little threat of being prosecuted. Victims of extortion must never forget, however, that extortion by its very nature involves the victim's consent. The mere fact that a victim has consented to depart with property in response to threats of physical or economic injury does not legitimize the perpetrator's actions. The element of consent is an essential element of extortion.

ii. Extortion under Color Of Official Right

Many people are confused by extortion "under color of official right." Extortion under color of official right occurs when an agent of the government uses his or her legitimate governmental powers to obtain an illegitimate objective. For example, a police officer may have the authority to revoke a driver's license but he cannot offer to forego the legitimate exercise of his power in exchange for sexual favors from the driver. Likewise, a city council member may have the authority to rezone an area of town and thereby effectively put a company out of business, but the council member cannot threaten rezoning unless the company contributes to his re-election campaign. In short, governmental agents have a great deal of discretion when deciding how to exercise the powers of the government. When an agent engages in extortion "under color of official right," he is essentially using the governmental powers with which he has been trusted to gain personal or illegitimate rewards.

iii. Extortion vs. Legitimate Exercise of Government Power

Extortion "under color of official right" should not be confused with the legitimate exercise of government power. Governmental power, by its nature, is legalized extortion, e.g.,: unless you abide by the law, you'll go to jail; unless you buy car insurance, your license will be revoked; unless you pay taxes, you'll go to jail and be fined; unless you register your gun, your gun will be confiscated. But for the government's authority to jail people and fine people and confiscate their property, how many of us would abide by the law? If we all naturally treated each other in a decent manner, there would be no need for government. From the first day that man emerged from the wilderness, however, most political philosophers and most of our experiences have taught us that if left to our own devices, people will rob from each other, abuse each other, and kill each other. Thus, pursuant to the basic social contract upon which all governments are based, people have consented to the government's use of extortion to keep all of us in line and to make sure that we all abide by the prevailing standards of decency.

The government's power to extort proper behavior from each of us is limited only by "due process," i.e., the government can't send someone to jail unless they first receive a fair trial, a law cannot be enforced unless it is properly approved by our elected officials and thereafter monitored by our courts, etc. A citizen cannot complain that he or she is being extorted by their government if the government is simply enforcing a law that complies with society's sense of due process. It is difficult to imagine when an official act of government could constitute extortion. When considering official government action, the appropriateness of the government's action is measured by the Constitution -- not by the criminal law of extortion. If the government does not have the power to enforce a law against a citizen (i.e., if the government does not have the power to extort certain behavior from a citizen), the law is unconstitutional - not extortionistic.

iv. Other Predicate Acts Related to Extortion

There are many other predicate acts listed in section 1961(1) that are mirror images of extortion. There are circumstances when obstruction of justice (18 U.S.C. §§ 1503, 1510, 1511, 1512 or 1513) will also constitute extortion, e.g., an employer engaged in illegal activity may threaten an employee: "testify to X when the police talk to you or you'll be fired" or "you'll be killed." By this single threat, the employer may have violated both the Hobbs Act and an obstruction of justice statute. A RICO claim may also be predicated on the extortionate credit transactions (18 U.S.C. §§ 891-894). Such crimes usually arise in the loan-sharking context, where the loan-shark will demand a usurious interest rate and if that usurious rate is not paid, the loan-shark will assault the debtor, burn down the debtor's business, or require the debtor to surrender his business to the loan-shark. Thus, violations of the loan-sharking statutes and the Hobbs Act are also frequently seen hand-in-hand.

d. *Interstate Transportation of Stolen Property*

Title 18, section 2314 of the U.S. Code is violated whenever a person (1) has knowledge that certain property has been stolen or obtained by fraud, and (2) transports the property, or causes it to be transported, in interstate commerce. *Pereira v. United States*, 347 U.S. 1, 9 (1954). The stereotypical violation of section 2314 occurs in the context of stolen vehicles. For example, a defendant steals a car in Minneapolis and drives it to a chop-shop in Chicago, where he sells the car or cars and pockets the cash.

Section 2314, however, is a broad statute. Although the statute is popularly referred to as the Interstate Transportation of Stolen Property Act, the statute not only prohibits the interstate transportation of stolen property, but prohibits the interstate transportation of "any goods, wares, merchandise, securities or money, of the value of $5000 or more." The inclusion of "money" as an item of stolen property that cannot be lawfully transported in the interstate commerce greatly expands the scope of the act. The statute is arguably violated whenever a scheme to defraud results

in a check (representing stolen money) being draw on an out-of-state bank. For example, a defendant in Minnesota calls a victim in California and tells the victim that if she sends him $5000 she will get a car worth $50000. The victim sends a check drawn on a bank in California. The defendant receives the check and negotiates it at a Minnesota bank. The funds are ultimately transferred via the interstate banking system from the victim's bank account in California to the defendant's bank account in Minnesota. The defendant never receives the promised car, so there is no property (let alone stolen) property that crosses state lines. Nonetheless, the statute is still violated because the defendant essentially stole $5000 from the victim and caused it to be transported across interstate lines through the interstate banking system. Accordingly, whenever a victim and defendant are located in different states, one should carefully analyze the flow of money because stolen money may very well cross state lines and may give rise to a violation of section 2314.

III. Civil Remedies Under Section 1964(c)

When passed by Congress in 1970, the expectation was that most RICO claims would be brought by U.S. Attorneys in the criminal context. In the 1980s, however, RICO's tail (i.e., it's civil remedies provision) began to wag the dog. Civil RICO claims exploded, and ever since, the number of criminal RICO claims filed every year is a small fraction of the number of civil actions brought under RICO. Congress paid so little attention to RICO's civil remedy provision that it failed to specify a statute of limitations for civil RICO claims.

RICO's civil remedies provision, section 1964(c), states:

Any person injured in his business or property by reason of a violation of section 1962 of this chapter may sue therefore in any appropriate United States district court and shall recover threefold the damages he sustains and the cost of the suit, including reasonable attorney's fees . . . .

Although apparently straight-forward, this provision contains several nuances that must be considered before filing any civil RICO claim.

A. Injured "by reason of" a Violation of Section 1962

Civil RICO is a specialized cause of action intended to control specifically targeted criminal activity. The effectiveness of such a remedy should not be diminished by the misguided attempts of plaintiffs who see mail and wire fraud violations in every civil lawsuit. Recognizing the need to maintain the integrity of the statute, numerous federal courts have held that, in RICO litigation, a cause of action will not lie unless the plaintiff can establish that the subject damages are directly caused "by reason of" the criminal activities that RICO was designed to address.

In traditional tort cases, the issue of proximate cause is one of fact that can be resolved only by the jury (sometimes called the finder-of-fact). Given that RICO is a statutory creation reflecting unique Congressional concerns, RICO's proximate cause standard presents policy considerations that are exclusively within the competence of the court. As indicated by the Circuit Court in *Brandenburg v. Seidel*, 859 F.2d 1179 (4th Cir. 1988) (emphasis added):

[RICO] require[s] not only cause in fact, but "legal" or "proximate" causes as well, the latter involving a policy rather than a purely factual determination: "Whether the conduct has been so significant and important a cause that the defendant should be held responsible." (Citations omitted.) As such, the legal cause determination is properly one of law for the court, taking into consideration such factors as the foresee ability of the particular injury, the intervention of other independent causes, and the factual directness of the causal connection.

Id. at 1189.

In *Holmes v. Securities Investor Protection Corp.*, 503 U.S. 258 (1992), the United States Supreme Court also held that RICO's proximate cause analysis presented a legal, not factual, issue:

Here [in analyzing RICO] we use "proximate cause" to label generically the judicial tools used to limit a person's responsibility

for the consequences of that person's own acts. At bottom, the notion of proximate cause reflects "ideas of what justice demands, or of what is administratively possible and convenient." [Citation omitted.]
Id. at 268.
It is difficult to determine whether injuries are proximately caused by a RICO violation. One thing is certain, RICO plaintiffs must do more than merely demonstrate monetary loss. In considering *Holmes*, the Sixth Circuit stated that "[plaintiffs] employ flawed logic in their insistence that an 'actual monetary loss' equates with a 'direct injury.' . . . The [Holmes] Court held that RICO contains a proximate cause requirement . . . . This requirement forces the plaintiff to demonstrate a direct relationship between the injury suffered and the alleged injurious conduct. Thus, the concept of direct injury refers to the relationship between the injury and the defendants' action, not the plaintiff's pocketbook." *Firestone v. Galbreath*, 976 F.2d 279,285 (6th Cir. 1992).

2. **Intervening Factors**

Generally, there may be a proximate cause defense, i.e., a victim's injuries may be too far removed from the RICO violation, whenever a factor intervenes between the injury and the violation, breaking the direct link that should commonly exist. There are at least three factors that can break the link of proximate causation: intervening non-predicate acts; intervening independent factors; and intervening third-party victims.

a. *Non-Predicate Activity*

Only predicate acts of racketeering activity provide a basis for recovery under RICO section 1964(c). *Brandenburg*, 859 F.2d at 1188. RICO does not provide redress for individuals injured by other wrongful acts, such as negligence or breach of contract. *Id.* (defendants' acts of negligence were not actionable under RICO); *Grantham and Mann v. American Safety Prods.*, 831 F.2d 596, 606 (6th Cir. 1987) (RICO claim dismissed where defendants' injurious conduct, i.e., breach of contract, did not constitute a predicate act). [In fact, courts should dismiss garden variety business fraud claims

masquerading as RICO claims.] Mendelovitz v. Vosicky, 40 F.3d 182, 187 (9th Cir. 1994).

For example, a plaintiff may allege that the defendant breached a contract and that the defendant never intended to perform under the contract, thereby fraudulently inducing the plaintiff to enter the contract. The plaintiff will argue that the mail and wire fraud statutes were violated because the defendant used the mails or wires to lull the plaintiff and fraudulently induce the plaintiff to enter the agreement. Because the mail and wire fraud statutes were allegedly violated, the plaintiff may argue that it not only has a breach of contract claim but a RICO claim. Courts are not likely to find a direct link between injury and proximate cause under such facts. Rather the courts are likely to rule that the defendant's breach of contract is the direct cause of the plaintiff's damages, and breach of contract is not a criminal act upon which a RICO claim can be based.

Similarly, a plaintiff may allege that he invested in a financial institution because he saw advertisements proclaiming how conservatively the institution was managed. In fact, the institution is poorly managed, and because it is poorly managed, the plaintiff eventually loses his entire investment. If the plaintiff brings a common law claim based on the negligent management of the institution and a RICO claim based on the false advertisements (distributed by mail and wire), the courts are likely to rule that the negligence of the institution's management is the direct cause of injury, not the alleged RICO violation. Because negligence is not a criminal act upon which a RICO claim can be predicated, the court would dismiss the RICO claim.

b. *Independent Contributing Factors*

The United States Supreme Court has instructed the lower courts not to apportion damages among acts violative of RICO and other independent factors. *See Holmes*, 503 U.S. at 259 (RICO claim dismissed, in part, because the broker-dealers' bad business practices could have been responsible for the plaintiffs' injury). "When factors other than the defendant's fraud are an intervening

direct cause of plaintiff's injury, that same injury cannot be said to have occurred by reason of the defendant's actions." *First Nationwide Bank v. Gelt Funding Corp.*, 27 F.3d 763, 770 (2d Cir. 1994). For example, in *First Nationwide Bank*, the plaintiff brought a RICO claim alleging that the defendant misrepresented the value of real estate acquired with non-recourse loans made by the plaintiff. The Second Circuit dismissed the claim:

The key reasons for requiring direct causation include avoiding unworkable difficulties in ascertaining what amount of the plaintiff's injury was caused by the defendant's wrongful action as opposed to other external factors, and apportioning damages between causes. (Citing Holmes.)

* * * *

. . . The value and profitability of multi-unit apartment complexes in New York . . . depend upon many factors that influence the general real estate market including changes in rent controls laws, property taxes, vacancy rates, the level of city services provided, and increased operating expenses including electric and heating oil prices. Given the complexity of the New York real estate market, and the fact that [plaintiff's] losses came in the wake of a downturn in the real estate market, [plaintiff] must allege loss causation with sufficient particularity such that we can determine whether the factual basis for its claim, if proven, could support an inference of proximate cause. (Citation omitted.) [Plaintiff cannot] meet this burden . . . .

* * * *

. . . [N]o social purpose would be served by encouraging everyone who suffers a [commercial] loss . . . to pick through [a defendant's statements] with a fine tooth comb in the hope of uncovering a misrepresentation.

Id. at 770-72; *see also Imagineering, Inc. v. Kiewit Pacific Co.*,, 976 F.2d at 1303, 1312 (9th Cir. 1992) ("essentially, the [RICO proximate cause rule] has more to do with problems of proof than with foresee ability"); *Shepard v. American Honda Motor Co. Inc.*, 822 F. Supp. 625,630 (N.D. Cal. 1993)(dismissing plaintiff's claim

for lost profits and losses attributable to the diminished value of an automobile dealership because "here a multitude of imaginable factors have contributed to the diminished profitability of the [plaintiff's] dealership and its diminished market value, apart from the alleged wrongful conduct of defendants.") A civil RICO plaintiff must prove "injury by reason of" the defendant's RICO violation. 18 U.S.C. § 1964(c). Injuries caused by disease, market fluctuations, war, and acts of God are not compensable under RICO. The injuries must be directly caused by the criminal acts upon which the RICO claim is based.

c. *Directly Injured Third-party Victims*

In *Sedima*, the United States Supreme Court expressly stated that a "defendant who violates § 1962 is not liable for treble damages . . . to those who have not been injured." 473 U.S. at 496-97. When the Supreme Court adopted the proximate cause requirement in *Holmes*, it considered traditional applications of the proximate cause requirement: "[under the common law,] a plaintiff who complained of harm flowing merely from the misfortunes visited upon a third person by the defendant's acts was generally said to stand at too remote a distance to recover." 503 U.S. at 268-69. Perhaps the best example of the application of this rule is found in *Firestone v. Galbreath*, 976 F.2d 279 (6th Cir. 1992). In *Firestone*, the plaintiffs were the biological grandchildren of a decedent and the beneficiaries of the decedent's will. The plaintiffs alleged that, during the decedent's life, the decedent's step-family looted the estate, through a pattern of racketeering, and were liable under RICO. The court disagreed:

The grandchildren allege that by stealing from their grandmother during her lifetime, the defendants decreased the size of [the decedent's] estate, and consequently the size of their inheritance. This is only an indirect injury because any harm to the grandchildren flows merely from the misfortunes allegedly visited upon [the decedent] by the defendants. [Citation omitted.] The estate suffered the direct harm; it, not [the grandchildren], lost the property. Consequently, the grandchildren lack standing to bring

an individual RICO claim, and the district court correctly dismissed it.
Id. at 285.
Many visitors to RICOAct.com want to bring RICO claims against the officers of corporations in which they hold shares and claim that the officers defrauded the shareholders through their management of the corporation. The rule expressed in *Galbreath*, however, would bar the claims of the shareholders against the corporate officers. Like the grandchildren in *Galbreath*, the shareholders are not directly injured. The corporation, like the estate, is the party directly injured by the officers' alleged fraud. Thus, only the corporation (through a shareholder derivative action) would have standing to bring the claim alleged by the shareholders.

2. Mail and Wire Fraud - Reasonable Reliance

To establish a criminal violation of the mail or wire fraud statues, the prosecuting attorney need not establish that anyone relied on the defendant's fraudulent statements. To prove injury "by reason of" mail and wire fraud, however, a civil RICO plaintiff must usually establish that they relied upon the defendant's fraudulent statements. As explained by the Fifth Circuit in *Summit Properties, Inc. v. Hoechst Celanese Corp.*, 214 F.3d 556 (2000):
. . . the government can punish unsuccessful schemes to defraud because the underlying [criminal] mail fraud violation does not require reliance, but a civil plaintiff "faces an additional hurdle" and must show an injury caused "by reason of" the violation. . . .
* * * *
In general, fraud addresses liability between persons with direct relationships - assured by the requirement that a plaintiff has either been the target of the fraud [such as fraudulent statements made to a competitor's customers] or has relied upon the fraudulent conduct of the defendants.
Id. at 559-560. Thus, when a civil RICO claim is predicated upon fraudulent activity, the plaintiff must establish "reasonable

reliance," just as a plaintiff has to establish reasonable reliance to obtain judgment in a common law fraud case.

Under civil RICO there is at least one limited exception to the need to prove reasonable reliance. A target of a scheme to defraud may be able to establish injury "by reason of" a RICO violation even if the target of the scheme did not rely on any fraudulent statements. For example, in *Procter & Gamble Co. v. Amway Corp.*, 242 F.3d 539 (5th Cir. 2001), Procter & Gamble ("P&G") alleged that Amway was attempting to lure away customers by falsely representing that P&G was affiliated with satanic worship. P&G, of course, never relied on any alleged misrepresentations of its satanic affiliations. Nonetheless, the court stated that, under the circumstances, P&G was not required to prove reliance:

> . . . in [a previous case,] we ruled that a target of a fraud that did not itself rely on the fraud may pursue a RICO claim if the other elements of proximate cause are present.
>
> * * * *
>
> Consequently, P&G's claims based on Amway's alleged spreading of the Satanism rumor to lure customers from P&G are claims on which relief can be granted. P&G has alleged that using the wire and the mail, Amway attempted to lure P&G's customers away by fraud. Although P&G did not rely on the fraud, this falls into the narrow exception [which states:]. . . . [a] defendant's competitors might recover for injuries to competitive position. [Citation and quotation marks omitted.] Thus, if P&G's customers relied on the fraudulent rumor in making decisions to boycott P&G products, this reliance suffices to show proximate causation.

Id. at 565. Thus, even without reliance, if a plaintiff's business is targeted by and injured by the fraudulent statements of a competitor, the exception set forth in *Procter & Gamble* may enable the plaintiff to establish proximate cause.

B. Injury to Business or Property

Damages for emotional distress or any personal injury are not compensible under RICO. *See, e.g., Grogan v. Platt*, 835 F.2d 844, 846 (11th Cir. 1988); *James v. Meow Media, Inc.*, 90 F. Supp.2d

798, 814 (W.D. Ky. 2000); *Moore v. Eli Lilly & Co.*, 626 F. Supp. 365, 367 (D. Mass. 1986); *City and County of San Fransisco v. Philip Morris*, 957 F. Supp. 1130, 1138-39 (N.D. Cal. 1997). Thus, if acts of extortion do not allegedly cause any plaintiff to depart with their money or property, the acts of extortion do not afford a civil plaintiff any standing under RICO. 18 U.S.C. § 1964(c). Any emotional distress associated with extortion is not compensable under RICO. Also, if the threat was "pay me a $1000 per month or I will break you legs," and the victim chooses the latter option, RICO does not provide the victim with a means to recover damages for the pain and suffering caused by getting his legs broken.

Likewise, although murder is a predicate act, the survivors of a murder victim cannot recover the lost wages of the victim, i.e., those wages that would have been earned throughout the remainder of the victim's life had he not been murdered. For example, in *Grogan v. Platt*, 835 F.2d 844 (11th Cir. 1988), two FBI agents were killed in a shoot-out with members of a criminal organization. Other FBI agents were injured. The survivors of the two killed agents and the injured agents brought a RICO claim against the responsible members of the criminal organization, seeking to recover the agents' lost wages. The court dismissed the claims of the killed and wounded FBI agents:

Relying on the assumption that Congress intends the ordinary meanings of the words it employs, [citation omitted], [plaintiffs] argue that the common sense interpretation of the words "business or property" includes the economic damages that result from injury to the person. We are not convinced that [plaintiff's] contention accurately captures the ordinary meaning of those words. In our view, the ordinary meaning of the phrase "injured in his business or property" excludes personal injuries, including the pecuniary losses there from. . . .

Id. at 846-47. Although RICO does not enable civil plaintiffs to recover the lost wages of murder victims or those injured by criminal conduct, plaintiffs seeking such damages may seek

redress for such losses in more traditional ways, e.g., by bringing a wrongful death claim or assault and battery claims.

IV. SECTION 1962(a) & (b) CLAIMS

Legitimate civil RICO claims under sections 1962(a) & (b) are few and far between. Although frequently alleged, very few survive a motion to dismiss. For this reason, there is a dearth of case law related to civil claims under these subsections. To the extent authority exists, that authority is generally pro-defendant.

A. Association-in-Fact Enterprises Under Sections 1962(a) & (b)

The relationship of the defendant persons to the enterprise varies, depending upon the subsection serving as the basis for liability. Unlike section 1962(c), liability under sections 1962(a) and (b) does not hinge upon the defendant's operation or management of the enterprise. Under section 1962(a), the defendant must use or invest the proceeds of racketeering activity in the enterprise. As noted, section 1962(a) is primarily concerned with money laundering activities.

Under section 1962(b), the defendant must acquire or maintain an interest in or control of an enterprise through a pattern of racketeering activity. The type of "interest" contemplated in section 1962(b) is not just any "interest" but a proprietary one, such as the acquisition of stock, and the "control" contemplated is the power gained over an enterprise's operations by acquiring such an interest. *Whaley v. Auto Club Ins. Assoc.*, 891 F. Supp. 1237, 1240-41 (E.D. Mich. 1995) (citing *Reves v. Ernst & Young*, 507 U.S. 170 (1993)).

Given the informal nature of association in-fact enterprises, i.e., they usually do not have any accounts receivable and do not file taxes, it is difficult if not impossible to invest and launder money through an association in fact enterprise for purposes of a section 1962(a) claim. Because association in fact enterprises also do not issue stock and are not legal entities capable as being controlled in the manner envisioned by section 1962(b), such claims are seldom, if ever, based upon association in fact enterprises.

B. Injury "by reason of" a Section 1962(a) Violation

As noted, a section 1962(c) claim provides relief to persons injured "by reason of" predicate acts. 18 U.S.C. § 1964(c). To have standing under section 1962(a), "the plaintiff must allege an injury resulting [by reason of] the investment of racketeering income distinct from an injury caused by the predicate acts themselves." *Id.; Lightening Lube, Inc.*, 4 F.3d at 1188; *St. Paul Mercury Ins. Co. v. Williamson*, 224 F.3d 425, 441 (5th Cir. 2000); *Nugget Hydroelectric, L.P. v. Pacific Gas and Elec. Co.*, 981 F.2d 429, 437 (9th Cir. 1992). This allegation is required because section 1962(a) "does not state that it is unlawful to receive racketeering income ... [rather] the statute prohibits a person who has received such income from using or investing it in the proscribed manner." *Grider v. Texas Oil & Gas Corp.*, 868 F.2d 1147, 1149 (10th Cir.), *cert. denied*, 493 U.S. 820 (1989).

To circumvent section 1962(a)'s standing requirement, plaintiffs often allege a "reinvestment" injury caused by reason of a violation of section 1962(a). For example, plaintiffs will allege that the defendants, through an enterprise, acquired money through a pattern of racketeering and then used and invested the proceeds of the racketeering back into the enterprise to keep it alive so that it continued to injure others, and eventually the plaintiff. *Lightening Lube, Inc.*, 4 F.3d at 1188. Such reinvestment injuries are generally an insufficient basis for a section 1962(a) claim:

> . . . we have held that the fact that a plaintiff claims that the injury allegedly perpetrated on it would not have occurred without the investment of funds from the initial racketeering activity does not change the fact the plaintiff's alleged injury stems from the pattern of racketeering, and not from the investment of funds by the defendant.

Id.

Over the long term, corporations generally reinvest their profits regardless of the source. Consequently, almost every racketeering act by a corporation will have some connection to the proceeds of a previous act. Section 1962(c) is the proper avenue to redress

injuries caused by the racketeering acts themselves. If plaintiffs' reinvestment injury concept were accepted, almost every pattern of racketeering by a corporation would be actionable under § 1962(a), and § 1962(c) would become meaningless. *Id.*; *see also Simon v. Value Behavioral Health, Inc.*, 208 F.3d 1073, 1083 (9th Cir. 2000), *cert. denied*, 531 U.S. 1104 (2001) (even if plaintiff was injured by defendants' fraud, plaintiffs section 1962(a) claim was dismissed because plaintiff failed to allege that defendants' "investment drove him out of business or harmed him directly in some way"); *but see In re Sahlen & Assoc., Inc. Sec. Litig.*, 773 F. Supp. 342, 366-67 (S.D. Fla. 1991).

Given that a plaintiff has standing only if he has been injured "by reason of" the defendant's investment, true civil RICO claims under section 1962(a) are rare. The following hypothetical facts may present such a claim: The Godfather buys an interest in "Sven's Grocery." Sven simply thinks the Godfather is a wealthy old gentleman. Two days later, the Godfather is arrested, and newspapers report that "Sven's Grocery" is connected to the Mafia. The Department of Justice ("DOJ") then confiscates all of Sven's business records and seals off the store, causing Sven to close for two weeks. Given the loss of business caused by the DOJ's investigation of the Godfather's investment in Sven's grocery, Sven has arguably been injured "by reason of" a violation of section 1962(a).

What does not constitute a section 1962(a) claim? Sven is the Godfather and uses the grocery store to launder money and forces Lena, the owner of a neighboring knitting shop, to pay him protection money. Lena sues Sven under section 1962(a), claiming that Sven has invested her protection money payments into the grocery store, enabling it to remain open, and enabling Sven to continue to extort protection payments. Lena probably has a claim under section 1962(c), but not under section 1962(a). Her injuries flow from the racketeering activity (extortion), not from Sven's investment of the proceeds of the extortion.

C. Injury "by reason of" a Section 1962(b) Violation

Just as a civil plaintiff must show injury caused "by reason of" the defendant's investment to prevail under section 1962(a), a plaintiff must show injury "by reason of" the defendant's acquisition or control of an interest in a RICO enterprise to prevail under section 1962(b). 18 U.S.C. § 1964(c); *Advocacy Organization for Patients and Providers v. Auto Club Ins. Ass'n*, 176 F.3d 315, 329 (6th Cir. 1999); *Crowe v. Henry*, 43 F.3d 198, 205 (5th Cir. 1995). Injury flowing from defendants' predicate acts is alone not enough to confer standing under section 1962(b). *Lightening Lube, Inc.*, 4 F.3d at 1190. "Such an injury may be shown, for example, where the owner of an enterprise infiltrated by the defendant as a result of racketeering activities is injured by the defendant's acquisition or control of his enterprise." *Casper v. Paine Webber Group, Inc.*, 787 F.Supp. 1480, 1494 (D.N.J.1992). In addition, the plaintiff must establish that the interest or control of the RICO enterprise by the person is as a result of racketeering. *Banks v. Wolk*, 918 F.2d 418, 421 (3d Cir. 1990).

V. CONSPIRACIES TO VIOLATE RICO - SECTION 1962(d)

A RICO claim is broad but a RICO conspiracy claim is even broader. Anyone who agrees or conspires to pursue the same criminal objective can be held liable for a RICO violation. *Salinas v. United States*, 522 U.S. 22, 63-64 (1997). "If conspirators have a plan which calls for some conspirators to perpetrate the crime and others to provide support, the supporters are as guilty as the perpetrators." *Id.* at 64. A conspirator must simply intend to further an endeavor which, if completed, would satisfy all elements of a civil RICO claim. *Id.* at 65. Thus, there are two ways to effectively defend against a RICO conspiracy claim: 1) the defendant must prove he never intended to further the criminal endeavor; or 2) the defendant must prove that the endeavor did not satisfy the elements of a civil RICO claim. Because the first defense is fact based, it is seldom an appropriate defense to raise in a dispositve motion. The best way to undermine a claim for conspiracy on a dispositive motion is to undermine the legal sufficiency of the allegations

supporting the substantive offense. *See Howard v. American Online Inc.*, 208 F.3d 741, 751 (9th Cir. 2000) (a claim under section 1962(d) may not stand unless the plaintiffs can sustain a viable claim under another subsection of section 1962).

A RICO plaintiff does not have standing to bring a RICO claim under section 1962(d) unless it is injured by an act of racketeering. For example, in *Beck v. Prupis*, 529 U.S. 494 (2000), the plaintiff was an executive who allegedly discovered that his corporation was engaged in a scheme to defraud regulators, shareholders and creditors. The plaintiff claimed that when he discovered the scheme and threatened to expose the conspiracy, he was terminated from his job and thereby sustained his own financial loss. The question was whether the plaintiff sustained a compensable injury since his wrongful termination (although not an act of racketeering itself) occurred in furtherance of the defendants' efforts to conceal the conspiracy to defraud regulators, shareholders, and creditors. The Supreme Court held that the plaintiff lacked standing, stating: "a person my not bring suit under § 1964(c) predicated on a violation of § 1962(d) for injuries caused by an overt act that is not an act of racketeering or otherwise unlawful under the statute." *Id.* at 507.

VI. RICO'S STATUTE OF LIMITATIONS

The most obscure aspects of the RICO Act relate to the statute of limitations applicable to civil RICO claims. Statutes of limitation are designed impose an obligation of diligence on plaintiffs (i.e., if a person is wrongfully injured, they cannot sit on their rights indefinitely) and to enable some degree of predictability and conclusion for defendants (i.e., defendants must be able to assume that after a certain period they cannot be called upon to answer for wrongs they committed in the distant past).

Congress failed to include either a criminal or civil statute of limitations when it passed the RICO Act. Congress' oversight was easily remedied with regard to the criminal statute of limitations. Title 18, section 3282 of the U.S. Code is the "catch-all" statute of limitation for federal crimes. It states that "no person shall be

prosecuted . . . unless the indictment is found or the information is instituted within five years next after such offense shall have been committed." With regard to criminal prosecutions, it is generally held that a prosecution is timely so long as the defendant has committed one predicate act (that forms part of the pattern for which he is being prosecuted) within five years or less of the indictment. See *United States v. Darden*, 70 F.3d 1507 (8th Cir. 1995).

RICO's missing statute of limitations was more problematic with regard to civil claims. First, there is no "catch-all" limitations period applicable to civil claims established by Congress. Second, assuming civil RICO claims are subject to a statute of limitations, when does the statute of limitations begin to run? Does it run with the first predicate act or the last predicate act? Does it re-start with each new predicate act committed by the defendant? Does it run when the plaintiff is injured? What if the plaintiff is unaware of its injury? Is the running of the statute of limitations then postponed until after the plaintiff discovered its injury? Until the United States Supreme Court provided direction, all of these questions presented tremendous problems for the courts confronting statute of limitations defenses under the RICO Act.

A. Limitations Period

RICO claims are subject to a four-year statute of limitations. The United States Supreme Court adopted this limitations period and applied it to all RICO claims in the case of *Agency Holding Corp. v Malley-Duff & Associates, Inc.*, 483 U.S. 143 (1987). Because RICO did not have its own statute of limitations, common law rules dictated that RICO claims should be subject to the statute of limitations applied to the most analogous claim under state law. The Supreme Court did not favor this approach because it would have resulted in civil RICO claims being subject to 50 different limitations periods, and no one could determine the limitations period until a particular claim was brought in a particular jurisdiction. The Supreme Court decided it was more fair and efficient to borrow the limitations period from another federal

statute, which would result in a uniform statute of limitations period regardless of the jurisdiction in which a particular RICO claim was filed. Because Congress essentially copied RICO's civil remedy provision (18 U.S.C. § 1964(c)) from the civil remedies provision of the Clayton Anti-trust Act, 15 U.S.C. § 15(a), the Supreme Court adopted the Clayton Act's four year statute of limitations as the limitations period applicable to all federal civil RICO claims.

B. Accrual of a Civil RICO Claim

Providing RICO with a limitations period, however, was not the end but the very beginning of the menacing problems that the Supreme Court faced with regard to RICO's statute of limitations. The next immediate question that had to be answered was: when does the limitations period begin to run? When lawyers ask this question, they say: when does a RICO claim accrue? This was a far more difficult question for the Supreme Court to answer.

1. ***Early Conflicting Accrual Rules***

The United States Courts of Appeals adopted three different accrual rules. The United States Court of Appeals for the Second Circuit was the first to consider the issue in *Bankers' Trust Co. v. Rhoades*, 859 F.2d 1096 (2d Cir. 1988), *cert. denied*, 490 U.S. 1007 (1989). In *Bankers' Trust*, the Second Circuit analogized RICO claims to medical malpractice claims that may give rise to latent injuries. For example, a physician may negligently leave a sponge in a patient during surgery, the sponge may not give rise to problems until years later when it becomes the source of an infection that otherwise would not have occurred. Under these circumstances, one cannot possibly charge the patient with an obligation to bring his malpractice claim before he had any reason to believe that malpractice occurred, i.e., before the forgotten sponge caused an infection. Likewise, in the RICO context, an employee may be taking bribes from a vendor and in exchange the employee may buy products (on behalf of his employer) from the vendor at inflated prices. The employer may not discover this bribe scheme until the employee's personal taxes are audited by the IRS

and the bribe payments are discovered and reported by the IRS to the employer. If the employer could not reasonably have discovered the inflated prices before the IRS audit, then he cannot be charged with an obligation to bring a RICO claim at an earlier date. In essence, the common law generally postpones the running of the statute of limitations until the plaintiff knew or reasonably should have known of its injury. The Second Circuit saw no reason to depart from this common law rule in the context of a RICO claim and, accordingly, adopted the common law "discovery of injury" rule as the accrual standard for a RICO claim.

The United States Court of Appeals for the Third Circuit was the next circuit court to consider RICO's accrual rule. In *Keystone Ins. Co. v. Houghton*, 863 F.2d 1125 (3d Cir. 1988), the Third Circuit was critical of the "discovery of injury" rule adopted by the Second Circuit in *Bankers' Trust*:

"Because a potential plaintiff has not been injured under RICO until the pattern element has been satisfied, it is inappropriate to start the period before the pattern is fully developed." [Citation omitted.] The simple discovery [of injury] rule mistakenly focuses upon injury - not "RICO injury." Under the simple discovery [of injury] rule if a plaintiff suffers a single injury as a result of a predicate act but the second predicate act which establishes the necessary "pattern" occurs five years after the injury to the plaintiff, that plaintiff's claim is barred by the four-year civil RICO statute of limitations. Yet the original damage to the plaintiff is not in fact a RICO injury until, at a minimum, the second predicate act establishes the necessary pattern. In such cases the purpose of the statute is defeated by the simple discovery [of injury] rule.

Id. at 1134. In short, the Third Circuit was concerned that under the "discovery of injury" accrual rule, a RICO claim could accrue and the statute of limitations could begin to run upon a single act of racketeering that resulted in a single injury, even though a RICO claim can be brought only after a defendant engages in a pattern of racketeering activity. Thus, in the opinion of the Third Circuit, a RICO claim could be barred by the "discovery of injury" rule

before the claim ever came into existence, i.e., before the defendant engaged in a pattern of racketeering activity.

To avoid the perceived problems under the "discovery of injury" rule, the Third Circuit adopted the "last predicate act" rule, which postponed the running of the statute of limitations until the commission of the last predicate act that formed the pattern of racketeering upon which the plaintiff's claim was based - regardless of when the plaintiff had knowledge of its injury resulting from the defendant's racketeering. *Id.*

This tension between the common law's traditional "discovery of injury" rule and RICO's unique pattern of racketeering activity concept appeared to require a completely new accrual rule. A pattern of racketeering activity could last for decades, well beyond four years. Many courts were conflicted by an accrual rule that could bar a civil RICO claim because the plaintiff was aware of its injury four or more years before bringing its lawsuit - even though the defendants' pattern of racketeering activity may have never ended and was still on-going at the time the suit was filed.

Even more troubling was the prospect that, like the plaintiff's injury, a pattern of racketeering activity could be concealed from the plaintiff, and without knowledge of the pattern of racketeering activity, the plaintiff could not file suit even if it was aware of its injury. For example, returning to the bribery scheme discussed above: what if the employer compared the prices it was paying to the bribing vendor to the prices being charged by other vendors and confronted the employee, saying: "why do we pay this vendor so much - other vendors will sell us the same thing for a lot less." The employee receiving the bribes responds: "yes, we are paying a little more but this vendor provides such a high degree of service that it's worth it - anytime we need something, they deliver it immediately; these other vendors may charge less but do we want to risk shutting down the production line if they don't come through?" At this point, the employer is clearly aware of its injury, i.e., is aware that the employer is paying higher than market prices to the bribing vendor, so under the simple "discovery of injury"

rule, RICO's statute of limitations could begin to run. On the other hand, however, the employer is completely unaware of the pattern of racketeering activity; the employee receiving the bribes has provided a reasonable (although untrue) explanation for paying the higher prices. In truth, the employer is paying the vendor's higher prices because the employee is being bribed. Without knowledge of this truth, the employer lacks knowledge of the facts necessary to allege a pattern of racketeering.

In recognition of the unique nature of RICO's pattern of racketeering activity requirement, the United States Court of Appeals for the Eleventh Circuit undertook an effort to formulate a completely original accrual rule for civil RICO claims. In *Bivens Gardens Office Bldg., Inc. v. Barnett Bank of Florida, Inc.*, 906 F.2d 1546 (11th Cir. 1990), *cert. denied*, 500 U.S. 910 (1991), the Eleventh Circuit agreed with the *Keystone* court in that the simple "discovery of injury" rule failed "to recognize that an injury to a plaintiff from a single predicate act does not evolve into a RICO injury until a 'pattern' of racketeering activity has developed." *Id.* at 1553. The Eleventh Circuit, however, was also critical of *Keystone's* "last predicate act" rule because it enabled a plaintiff to sit back and wait for a defendant's last predicate act before filing an action, even though the plaintiff could be wholly aware of its injury and the defendant's pattern of racketeering activity for decades before bringing its claim. Rather than adopting either the "discovery of injury" rule or the "last predicate act" rule, the Eleventh Circuit developed and adopted the "discovery of injury and pattern" rule:

. . . with respect to each independent injury to the plaintiff, a civil RICO cause of action begins to accrue as soon as the plaintiff discovers, or reasonably should have discovered, both the existence and source of his injury and that the injury is part of a pattern.

Id. at 1554-55. Thus, with regard to our bribery scenario, under the "discovery of injury and pattern" rule, the employer's RICO claim would not have accrued merely upon his discovery that the vendor

was being paid above-market prices. The accrual of the employer's RICO claim would have been postponed until he discovered or reasonably should have discovered the bribe scheme. Once the bribe scheme was discovered, however, the employer would have only four years to file his claim. Whereas under the "last predicate act" rule, the employer could theoretically sit back after discovering the bribe scheme and allow it to continue for several more decades, knowing that his civil RICO claim would be timely so long as it was brought within four years of the last act of bribery. The Eleventh Circuit's remedy seemed to be a reasonable solution to the unique accrual issues presented by civil RICO claims.

2. *The Supreme Court's Effort to Resolve the Conflict*

Given that *Keystone's* "last predicate act" rule indefinitely allowed a plaintiff to sit on its rights and refrain from bringing a cause of action for so long as the defendant engaged in acts of racketeering, the rule was never adopted outside of the Third Circuit. The Second Circuit's "discovery of injury" rule and the Eleventh Circuit's "discovery of injury and pattern" rule, however, were adopted by almost an even number of federal circuit courts of appeal. The United States Supreme Court was thus required to step-in and resolve the conflict.

In *Klehr v. A.O. Smith Corp.*, 521 U.S. 179 (1984), the United States Supreme Court undertook its first effort to bring uniformity to civil RICO's accrual standard. Under the facts of *Klehr*, however, the plaintiff's action was timely under either the "discovery of injury" or "discovery of injury and pattern" rules. Thus, in the *Klehr* decision, the Supreme Court merely rejected "last predicate act" rule, stating:

We conclude that the Third Circuit's rule is not a proper interpretation of the law. We have two basic reasons. First, . . . the last predicate act rule creates a limitations period that is longer than Congress could have contemplated. Because a series of predicate acts . . . can continue indefinitely, such an interpretation,

in principle, lengthens the limitations period dramatically. It thereby conflicts with a basic objective - repose - that underlies limitations periods. [Citation omitted.] Indeed, the rule would permit plaintiffs who know of the defendant's pattern of activity simply to wait, "sleeping on their rights," . . . as the pattern continues and treble damages accumulate, perhaps bringing suit only long after the "memories of witnesses have faded or evidence is lost." [Citation omitted.] We cannot find in civil RICO a compensatory objective that would warrant so significant an extension of the limitations period, and civil RICO's further purpose, encouraging potential plaintiffs diligently to investigate [citation omitted], suggests to the contrary.

Second, the Third Circuit rule is inconsistent with the ordinary Clayton Act rule, applicable in private antitrust treble damage actions, under which "a cause of action accrues and the statute begins to run when a defendant commits an act that injures a plaintiff's business." [Citation omitted.] . . . We do not say that a pure injury accrual rule always applies without modification in the civil RICO setting in the same way that it applies in traditional antitrust cases.

Id. at 187-88. In *Klehr*, the Supreme Court went no further than to reject the "last predicate act" rule and left for future consideration the issue of whether the "discovery of injury" rule or "discovery of injury and pattern" rule was more appropriate.

As noted above, the majority in *Klehr* noted that the Clayton Act's accrual rule focused on the time of injury. The Clayton Act's outlook on accrual was important because Congress essentially borrowed RICO's civil remedy provision from the Clayton Act. The Clayton Act, however, does not postpone accrual until discovery of injury, rather a claim accrues upon injury - regardless of whether a plaintiff is aware of the injury. Given the nature of antitrust injuries, however, it is rare that a plaintiff is not immediately aware of the injury giving rise to an antitrust claim. The majority never suggested that a pure injury accrual rule should be applied to civil RICO claims. In his dissent, Justice Scalia

argued that if the Supreme Court was going to borrow the Clayton Act's statute of limitations (a decision that Justice Scalia disagreed with, believing it was appropriate for Congress, not the courts, to remedy RICO's missing statute of limitation problem), then it was only logical that the Clayton Act's accrual rule should also be applied. Although the Clayton Act's accrual rule presents a fourth alternative, none of the circuit courts have applied the Clayton Act's accrual rule despite Justice Scalia's persuasive dissent in *Klehr*.

The Supreme Court next considered civil RICO's accrual rule in *Rotella v. Wood*, 528 U.S. 549 (2000). The Supreme Court used the opportunity to reject the "discovery of injury and pattern" rule:

> Federal courts, to be sure, generally apply a discovery accrual rule when a statute is silent on the issue, as civil RICO is here. [Citation omitted.] But in applying a discovery accrual rule, we have been at pains to explain that discovery of injury, not discovery of the other elements of the claim [e.g., pattern], is what starts the clock.
>
> * * * *
>
> In sum, any accrual rule softened by a pattern discovery feature would undercut every single policy we have mentioned. By tying the start of the limitations period to a plaintiff's reasonable discovery of a pattern rather than the point of injury or its reasonable discovery, the rule would extend the potential limitations period for most civil RICO cases well beyond the time when a plaintiff's cause of action is complete . . . .

Id. at 555, 559. Theoretically, the Clayton Act's injury accrual rule continues to remain an accrual option in the wake of the *Klehr* and *Rotella* decisions, but no circuit court has ever embraced it. Rather, *Rotella* has effectively resolved the conflicting accrual rules among the circuit courts in favor of the "discovery of injury" accrual rule.

C. Tolling Principles

Superficially, the "discovery of injury and pattern" rule was revolutionary because it tied accrual to something other than a plaintiff's discovery of injury. In their practical applications, however, equitable tolling principles largely eviscerated any

material distinction between the "discovery of injury" and "discovery of injury and pattern" rules. As the Supreme Court noted in *Rotella*:

In rejecting pattern discovery as a rule, we do not unsettle the understanding that federal statutes of limitations are generally subject to equitable principles of tolling [citation omitted], and where a pattern remains obscure in the face of a plaintiff's diligence in seeking to identify it, equitable tolling may be one answer to the plaintiff's difficulty. . . . [Citation omitted.] The virtue of relying on equitable tolling lies in the very nature of such tolling as the exception, not the rule.

Id. at 560-61. Unlike accrual, that postpones the running of the statute of limitations until discovery of injury, a tolling doctrine, such as fraudulent concealment or duress, suspends the statute of limitations after it has begun to run. In a RICO claim based upon acts of extortion, the victim's RICO claim usually accrues the first time the plaintiff pays money in response to an unlawful threat. By paying money in response to an unlawful threat, the plaintiff is clearly aware of his injury and extortion usually presents threats of indefinite duration (i.e., open-ended patterns of racketeering). For example, the threat pay me $1000 per week or I'll break your legs, is an open-ended pattern based on a threat of indefinite duration. As soon as the plaintiff fails to pay $1000 per week, his legs will be broken regardless of whether that failure to pay occurs next week or in ten years. Thus, the statute of limitations begins to run as soon as the victim makes the first extorted payment. Suppose further, however, that after a year, the victim threatens to sue or report the extortion to the police, and the defendant replies: "if you report me or sue me, I'll kill your whole family." Under these circumstances, the four-year limitations period likely would have run for the first year of the scheme, but would have been tolled or suspended thereafter based on the defendant's additional threat to kill the victim's family if the victim brought a claim or filed a report. If the defendant were later arrested and jailed on unrelated charges, and the duress was then removed, the statute of limitations

would restart, and the plaintiff would have only three years from the defendant's imprisonment to bring his civil RICO claim.

The tolling doctrine of fraudulent concealment combined with the "discovery of injury" rule essentially reaches the same result as the "discovery of injury and pattern" rule. Under fraudulent concealment, the running of the statute of limitations is tolled when a defendant engages in some misleading, deceptive or otherwise contrived action or scheme, in the course of committing the wrong, that is designed to mask the existence of a cause of action. *Riddell v. Riddell Washington Corp.*, 866 F.2d 1480, 1491 (D.C. Cir. 1989). A defendant could affirmatively conceal a cause of action by creating false invoices, two sets of books, or by simply lying. In short, for fraudulent concealment to apply, the defendant must simply do something of an affirmative nature designed to prevent discovery of the cause of action. Even if there is an affirmative act of fraudulent concealment, however, the running of the statute of limitations will not be tolled if the defendant can establish that the cause of action could have been discovered if the plaintiff had exercised reasonable diligence. *Id.* In *Klehr*, the Supreme Court affirmed the principle that a civil RICO plaintiff cannot take advantage of the doctrine of fraudulent concealment unless the plaintiff has exercised reasonable diligence in discovering the claim. 521 U.S. at 195-96.

Thus, assuming the plaintiff exercises reasonable diligence, the statute of limitations will be tolled (even if the plaintiff is aware of its injury but is unaware that the injury is the result of a pattern of racketeering activity) if the defendant engaged in some affirmative act to conceal the existence of the scheme to defraud. In the context of civil RICO claims based on schemes to defraud, seldom is a scheme to defraud committed in an open and notorious manner. To be effective, schemes to defraud must generally be concealed from the victim, so the doctrine of fraudulent concealment frequently postpones the statute of limitations under such circumstances.

D. <u>New and Independent Injuries</u>

Although the "discovery of injury" rule stated in the *Bankers' Trust* opinion has become the prevailing accrual standard, the *Bankers' Trust* opinion also stood for the proposition that "a plaintiff may sue for any injury he discovers or should have discovered within the four years of commencement of the suit, regardless of when the RICO violation causing such injury occurred." 859 F.2d at 1103. In short, the Second Circuit was opposed to the notion that the statute of limitations could bar a claim based on an injury that had not yet occurred or had occurred within the four-year limitation period. Accordingly, the *Bankers' Trust* decision guaranteed that the plaintiff could always recover for any injuries that occurred within four years of filing the claim.

Although not as problematic as the "last predicate act" rule, that allowed plaintiffs to bring suit within four years of the defendant's last predicate act and recover for all injuries that were ever caused by the pattern of racketeering activity, *Bankers' Trust's* four-year free ticket also ran contrary to the plaintiff's obligation to pursue its action with diligence.

To avoid a four-year free ticket and to obligate a plaintiff to act with diligence, most circuit courts have adopted the principle that civil RICO's statute of limitations is restarted only when the plaintiff experiences a "new and independent" injury. For example, in *Glessner v. Kenny*, 952 F.2d 702 (3d Cir. 1991), the plaintiffs alleged that the defendant engaged in a scheme of fraudulent advertisements that caused them to purchase the defendant's defective furnace. Plaintiff's argued that they were injured when they purchased the furnace and that they were further injured when they had to buy replacement furnaces. Plaintiff's purchases of defendant's defective furnace were beyond the four-year limitations period and, thus, were barred, but plaintiffs argued that they were nonetheless entitled to recover for the expense of replacing the furnaces. The court disagreed:

. . . if Glessner's only injury was limited to servicing his "blue flame" unit, the fact that he continued to service his unit after June, 1984 [the suit was filed in June 1988] could not be considered a

"further injury" sufficient to revive the RICO cause of action. We do not regard the need ultimately to replace the unit to be a "separate" or "independent" type of injury [necessary to restart the statute of limitations] . . . . While the cost of replacement of the unit may be an element of damage, the mere continuation of damages into a later period will not serve to extend the statute of limitations.

Id. at 708. To constitute a new and independent injury sufficient to restart the statute of limitations with regard to those injuries, the new and independent injuries must be caused by a new pattern of racketeering.

As in *Glessner*, the *Klehr* plaintiff's initial injury occurred when they purchased an allegedly defective silo. The plaintiffs thereafter experienced on-going injuries as a result of the alleged herd health problems that were caused whenever the silo was used. As explained by the Eighth Circuit in *Klehr*, the plaintiff's injuries were not new and independent:

. . . [The plaintiff's] injuries are all [part] of . . . one cognizable pattern of conduct - [the defendant's] alleged misrepresentations regarding the [product]. We believe that these separate, discrete "injuries" that the [plaintiffs] identify are more appropriately categorized as one single, continuous injury that was sustained sometime in the 1970s [when the product was purchased] and for which the limitations period [expired long before the plaintiffs filed their complaint] . . . .

Id. at 239. Thus, in both *Glessner* and *Klehr*, the courts held that the plaintiffs' damage claims were entirely barred by the statute of limitations even though injuries continued to occur within the limitations period. The injuries occurring within the limitations period were simply a continuation of the same injury that was sustained by the plaintiffs when they bought the allegedly defective products.

VII. CONCLUSION: KEY CONCEPTS OF RICO JURISPRUDENCE

There are 17 key concepts of RICO jurisprudence. Before bringing any civil RICO action or before responding to any civil RICO complaint, a practitioner or party should understand and be able to apply all of these concepts:

1. RICO encompasses both legitimate and illegitimate enterprises. *United States v. Turkette*, 452 U.S. 576 (1981).
2. Under RICO, section 1962(c), there must be a distinction between the RICO "person" and the RICO "enterprise." An individual cannot "associate" with himself. This is known as the person / enterprise distinction. *River City Markets, Inc. v. Fleming Foods West, Inc.*, 960 F.2d 1458 (9th Cir. 1992).
3. With regard to the person / enterprise distinction, one can associate with a group of which he is a member while the member and the group remain distinct. *Riverwoods Chappaqua Corp. v. Marine Midland Bank, N.A.*, 30 F.3d 339 (3d Cir. 1995).
4. RICO's person / enterprise distinction is NOT met by alleging that a corporation associated with its own employees, agents, subdivisions or affiliates. *Riverwoods Chappaqua Corp. v. Marine Midland Bank, N.A.*, 30 F.3d 339 (3d Cir. 1995).
5. Under RICO, section 1962(c), there also must be a distinction between the enterprise and the racketeering activity; in other words, members of an enterprise must be linked by more than their participation in the same pattern of racketeering activity. This is known as the racketeering activity / enterprise distinction. *McDonough v. National Home Ins. Co.*, 108 F.3d 174 (8th Cir. 1997).
6. A RICO enterprise need not be economically motivated. *National Organization for Women, Inc. v. Scheidler*, 510 U.S. 249 (1993).

7. To be liable under section 1962(c), a person must participate in the operation or management of the enterprise itself. *Reves v. Ernst & Young*, 507 U.S. 170 (1993).
8. Since 1995, a civil RICO claim cannot be based upon allegations of a securities fraud violation; a defendant must be criminally convicted of securities fraud before he can be subject to civil liability on the basis of securities fraud violations. 18 U.S.C. § 1964(c).
9. A RICO claim can be predicated on mail and wire fraud alone but should not be so predicated. RICOAct.com.
10. The factors of continuity plus relationship combine to produce a pattern. *H.J. Inc. v. Northwestern Bell Tele. Co.*, 492 U.S. 299 (1989).
11. A close-ended pattern must generally last one year. *Grimmett v. Brown*, 75 F.3d 506 (9th Cir. 1996).
12. A plaintiff has standing only to the extent that she has been injured in her business or property "by reason of" the conduct constituting the violation; a defendant who violates section 1962(c) is not liable for treble damages to everyone she might have injured by other conduct (e.g., breach of contract or negligence) nor is the defendant liable to those who have not been injured. *Sedima, S.P.R.L. v. Imrex Co., Inc.*, 473 U.S. 479 (1985); *Holmes v. Securities Investor Protection Corp.*, 503 U.S. 258 (1992).
13. Always bring a section 1962(d) claim; never bring a section 1962(a) or (b) claim without a 1962(c) claim. RICOAct.com
14. A RICO claim must be brought within 4 years of accrual. *Agency Holding Corp. v. Malley-Duff Associates, Inc.* 483 U.S. 143 (1987).
15. Aa RICO claim accrues and the statute of limitations begins to run when the victim discovers or reasonably should have discovered its injury. *Klehr v.*

A.O. Smith Corp., 521 U.S. 179 (1997); Rotella v. Wood, 528 U.S. 549 (2000).

16. A plaintiff can bring a federal civil RICO claim in either state or federal court. *Tafflin v. Levitt*, 493 U.S. 455 (1990).

17. If agreed to by the parties, RICO claims may be arbitrated. *Shearson / American Express, Inc. v. McMahon*, 482 U.S. 220 (1987).

Creating Fraud Awareness

Enron, WorldCom, Adeiphia, Tyco.. .these names depict images of executives in handcuffs and represent bankruptcies and billions of dollars lost by investors, retirees, and lenders. Sherron Watkins, speaking at the $_{13}$th Annual Fraud Conference and Trade Show of the Association of Certified Fraud Examiners, stated that, "In less than two years, investors lost more than $60 billion in the value of their shares in Enron, and the company filed bankruptcy without ever disclosing a poor quarter relative to recurring earnings." At WorldCom, financial officers and their subordinates reclassified more than $3.8 billion of lease expense for communications lines owned by third parties from the income statement to the fixed assets section of the balance sheet in order to maintain higher stock prices.[2] Adeiphia founder John J. Rigas and his two sons have been accused of using the company's funds as their personal piggy bank, using more than $250 million in Adeiphia funds to pay personal margin calls, diverting additional funds to build a golf course on their privately owned property, and using corporate apartments and jets for personal use without reimbursing the company—all while Adeiphia carried more than $2.3 billion in "off balance sheet debt."[3] Tyco's CEO, CFO, and general counsel have been charged with fraud for receiving millions of dollars in low- or no-interest loans for personal purposes without disclosure to investors; further, they have failed to disclose related party transactions and executive compensation arising from the forgiveness of loans in their financial statements.[4]

These are the cases that have drawn wide-spread attention because of the billions of dollars involved. However, these are not isolated incidents. In March, 2002, a shareholder suit was revived against A.T. Cross Corp., makers of Cross pens, for fraudulently

overstating revenues.[5] Also, the former CFO of Media Vision Technology, Inc., was found guilty in August, 2002, of five counts of fraud for lying to investors and financial analysts about numerous schemes at the company that were employed to overstate the company's financial position, including falsifying inventories, misdating transactions, and recording nonexistent products. Interestingly, a trial for the same charges against the CFO had resulted in a hung jury a year earlier.[6]

The nation's largest accounting firms have come under investigation by the Securities and Exchange Commission for their roles in the aforementioned and other accounting scandals. Additionally, federal prosecutors brought charges against Arthur Andersen LLP and are investigating Price Waterhouse Coopers for conspiring with management of public companies to defraud investors.[7] The conviction of Arthur Andersen LLP for obstruction of justice for shredding documents and doctoring Enron related statements is unprecedented.

Impact on the US Economy

The recent spate of billion dollar bankruptcies and accounting scandals is having

an impact on the nation's economy. The July 18, 2002, press release of The Conference Board stated, in part, that:

Stock prices and consumer expectations are the primary components that are preventing the leading index from continuing its positive trend in June. The recent wave of questionable corporate practices and the lack of measures aimed at addressing them have contributed to the weakness in these two components.

Additionally, The National Economic Review for the second quarter 2002 reported that "concerns regarding financial reporting, a weak labor market, and waning business conditions have eroded

consumer confidence. . . While (June) confidence is still higher than it was at the start of the year, consumers' assessment of current conditions and their expectations for the next six months declined."

Changes in the Regulatory Environment

In response to huge investor losses, legislation known as the Sarbancs-Oxley Act of 2002 was signed into law on July 30, 2002, by President Bush. This law requires that a public company's CEO and CFO prepare a statement to accompany the audit report that certifies the "appropriateness of the financial statements and disclosures contained in the periodic report, and that those financial statements and disclosures fairly present, in all material respects, the operations and financial condition of the issuer." Further, each annual report is now to contain an "internal control report" which shall 1) state management's responsibility for establishing and maintaining adequate internal control structure and procedures to insure that the financial statements are materially correct; and 2) contain an assessment of the effectiveness of the internal control structure and procedures. Certifying officers are now subject to the risk of fines, prison, or both.[8]

The law also established the public watchdog Public Company Accounting Oversight Board, which is to include two CPAs and three "financially literate" individuals who are not and have never been accountants. The Securities and Exchange Commission, the chairman of the Federal Reserve Board, and the Secretary of the US Treasury are jointly responsible for appointment of the Oversight Board's members.[9] Further, the law increased the number of offenses that qualify as corporate crime and stiffened the penalties for the same. Accordingly, it is likely that there will be increasing prosecution of white-collar criminals.[10]

Private and Small Business is not Exempt

The foregoing discussion has been centered around companies with publicly traded shares of stocks. Privately-owned companies, however, are no less susceptible tofraudulent activities of managers and employees, and related losses may subject companies to significant business risk. A study was conducted in June 2002 by Ernst & Young, LLP, to measure the attitudes of American workers about workplace fraud. Survey results suggest that one-in-five American workers are personally aware of fraud in their workplace, 80% would be willing to turn in a co-worker they believed to be committing fraud, but only 43% actually have. The surveyed workers estimate that employers lose as much as 20% of gross revenues to fraud, and the specific acts cited include theft of office items, claiming extra hours worked, inflating expense accounts, and taking kickbacks from suppliers. One-in-ten surveyed employees believed that fraud was increasing in their workplace."

The Association of Certified Fraud Examiners ("ACFE") also reports that small businesses are especially prone to misappropriation of assets, which accounts for 80% of all fraud cases, and experience fraud losses at a frequency of nearly 100 times that of larger businesses.'[2] Factors cited by Camico Insurance that would lend support to this claim include the following: 1) fraud is relatively easy to perpetrate and conceal, and the widespread use of computers has made it easier in many ways; 2) only about 20% of known fraud cases are discovered by methods such as audits and management oversight; and 3) small businesses frequently do not have enough employees for segregation of duties, which means there are fewer checks and balances to detect a fraud perpetrator's activities.'[3]

Schemes

Based on a study of 971 fraud cases in 2002, the ACFE found that the most
common types of workplace fraud, their relative frequency, and median costs to the companies the frauds were perpetrated against are as follows:'[4]

Fraudulent Act	Relative Frequency	Median Cost to Companies
Billing schemes	*25.2%*	$ 160,000
Skimming	24.7%	70,000
Check tampering	16.7%	140,000
Corruption schemes	12.8%	530,000
Expense reimbursements	12.2%	60,000
Payroll schemes	9.8%	140,000
Non-cash misappropriations	9.0%	200,000
Cash larceny	6.9%	25,000
Fraudulent financial statements	*5.1%*	4,250,000
Register disbursement	1.7%	18,000

A Fraud Primer

According to Merriam-Webster's Dictionary of Law © 1996, the definition of fraud is:

Any act, expression, omission, or concealment calculated to deceive another to his or her disadvantage, specifically, a misrepresentation or concealment with reference to some fact material to a transaction that is made with knowledge of its falsity or in reckless disregard of its truth or falsity and with the intent to deceive another and that is reasonably relied on by the other who is injured thereby.

Thus, incompetence and poor management do not constitute fraud. The intent to deceive for one's personal gain coupled with injury to

the party who reasonably relied on the truthfulness of the facts material to the transaction are paramount elements of fraud.

There are three types of workplace fraud, 1) management fraud, 2) occupational or transactional fraud, and 3) corruption.

Management Fraud

Management fraud is perpetrated at the top level of companies and, as shown
above, is the most costly fraudulent act. It involves the deliberate misstatement of financial statements to reflect financial performance that is better than economic reality. In an article entitled "The three Cs of fraudulent financial reporting," Zabihollah Rezaee states that:

> Assessing an organization's conditions, corporate structure, and the choices it makes can help reveal the motivations, opportunities, and rationalizations behind the commission of financial statement fraud.

The definitions provided for the three Cs follow:

The motivations and pressure to engage in financial statement fraud are the CONDITIONS. Pressures on corporations to meet analysts' earnings forecasts play an important role in the commission of this type of fraud. In recent corporate cases, executives deliberately committed illegal actions to mislead users of financial statements — investors and creditors — about their poor or less-than-favorable financial performance.

Note: Although the author is addressing management in publicly-traded companies, the same motivations and pressures have been found in closely-held businesses, where the motivation and pressure are derived from the financial expectations of business owners and lenders.

An organization's CORPORATE STRUCTURE can create an environment that increases the likelihood that fraudulent financial reporting will occur. Given that management usually is the perpetrator of this type of fraud, it is not surprising that most incidences occur in an environment characterized by irresponsible and ineffective corporate governance.

Management must make CHOICEs between using ethical business strategies to achieve continuous improvements in both quality and quantity of earnings and engaging in illegitimate earnings management schemes to show earnings stability or growth. Management may choose to engage in financial statement fraud when:
1) its personal wealth is closely associated with the company's performance; 2) management is willing to take personal risk for corporate benefit; 3) opportunities for the commission of financial statement fraud are present; 4) there is a substantial internal and external pressure either to create or maximize shareholder value; and *5)* the probability of the fraud being detected is perceived to be very low.

The author states further that "the presence of any one of the 3 Cs can signal the possibility of fraud, whereas the combination of two or more factors at any one time increases the likelihood that fraud has occurred."[5]

Misstatements of the financial statements may occur in the balance sheet, the income statement, or both, and the following areas are subject to the most frequent abuses: revenue measurement and recognition, provisions for uncertain future costs, asset valuation, and related-party transactions."[6]

<u>Revenue measurement and recognition</u>: For most businesses, sales are recorded at the time of delivery of a product or completion of a

service (recognition), and the amount recorded for the sale is the agreed-upon price of the item or service (measurement). Sometimes judgment is required to determine whether a sales transaction actually existed. For instance, the SEC filed charges against three former executives of Home store, Inc., for arranging fraudulent "round-trip" barter transactions involving online advertising. The scheme was to pay inflated amounts to vendors who used the proceeds to buy advertising from two media companies who then bought on-line advertising from Home store, Inc. The effect was that Home store recognized its own cash as ~ More often, however, judgment regarding recognition is necessary when performance required to earn the revenue extends across multiple accounting periods, i.e., contracts, warranties, preseason ticket sales, and subscriptions.

Judgment regarding measurement is necessary when the probability of collecting all of the payments is in doubt at the time of completion of the transaction or when one company acts as an intermediary between the buyer and seller. As an example of the latter, many of the dot.com companies reported billions of dollars of sales revenues during the 1 990s, when in fact, they were intermediaries between buyers and sellers, and their true revenues were commissions amounting to only *3-5%* of the total revenues reported.

Provisions for Uncertain Future Costs: Companies are required to make provisions for expenses such as bad debt, inventory obsolescence, depreciation and amortization of assets, product returns, discounts, and contingent liabilities whether or not the amounts are measurable with certainty. These provisions are intended to present to the readers of the financial information the true economic position of a company. These allowances, however, can be seriously over- or understated when "earnings management" is occurring. Managing earnings is done with the intention of "smoothing" the earnings stream. Provisions are

overstated to hide excess income in boom times and understated to hide losses in economic downturns. According to Makar, Alam, and Pearson, earnings management exists when the question is "How can we best report desired results?" rather than "How can we best report economic reality?"[8]

Asset Valuation: "On the most basic level, an asset is something that has current or intrinsic value, like cash, or that can be used to generate future revenues."[19] Fixed and intangible assets are areas of the balance sheet that are susceptible to being over or understated for fraudulent purposes with the goal of either inflating asset values or managing earnings by increasing or reducing expenses recorded for depreciation and amortization. Assets of concern are fixed assets, including buildings, machinery and equipment, furniture, and vehicles, and intangible assets, including goodwill, patents, trademarks, copyrights, and capitalized research and development costs. Accounting rules require that companies record fixed and intangible assets at historical cost and reduce that value by way of depreciation or amortization over their expected useful lives. There are numerous accounting alternatives for recording depreciation and amortization, however, and those alternatives leave room for interpretation about "useful life" which is the period of time that will elapse before the asset is no longer useful in generating future revenues. The election of one method over another is not fraud *unless* there is intent on the part of management to overstate the value of the company's assets or to over- or understate the company's earnings.

Related Party Transactions: Disclosure of related party transactions varies with the regulatory environment and company policies. Related parties may include parent or subsidiary companies, company management, shareholders, directors, lenders, vendors, and customers. The potential exists for management to hide unreported or diverted profits, to hide evidence of earnings management, and to avoid disclosure of the enrichment of a

subgroup of managers or shareholders. As previously cited, it is alleged that Tyco's CEO, CFO, and general counsel received millions of dollars in low- or no-interest loans for personal purposes without disclosure to investors and failed to disclose related party transactions and executive compensation arising from the forgiveness of loans in their financial statements. Enron shifted significant amounts of debt to related companies whose financial results did not have to be included in the consolidated financial statements to improve the company's balance sheet.

According to Sherron Watkins of Enron,[2°]

The recent, numerous accounting scandals suggest that companies believe that, similar to interpreting the tax code as liberally as possible to minimize the company's tax liabilities, accounting rules should be applied that present the company's financial results in the most favorable light possible, whether or not those financial statements materially represent the financial condition of the company or its operations.

In determining whether the presentation of a suspect company's financial statements is a liberal interpretation of accounting principles or fraud, it is necessary to revisit the definition of fraud. If management's intent is to mislead creditors, investors, and shareholders, whether for personal benefit or to avoid loss of market share, and if the readers of the financial statements rely on the material correctness of those statements to their detriment, then management fraud has occurred.

Occupational Fraud

Returning to the table showing the results of the ACFE's study of 971 fraud cases in 2002, the following fraudulent acts are

commonly referred to as “occupational” or “transactional” fraud and involve asset misappropriation:

Fraudulent Act	Relative Frequency	Median Cost to Companies
Billing schemes	*25.2%*	$160,000
Skimming	24.7%	70,000
Check tampering	16.7%	140,000
Expense reimbursements	12.2%	60,000
Payroll schemes	9.8%	140,000
Non-cash misappropriations	9.0%	200,000
Cash larceny	6.9%	25,000
Register disbursements	1.7%	18,000

While these acts may be committed by management, they are more often committed by employees. It is, therefore, helpful to gain insight into the reasons employees commit fraud. Two separate but related theories regarding the motivation to commit fraud have been developed.[2]’ The first is based on a 20-year-old study of 12,000 employees wherein it was found that nearly 90% of those employees engaged in “workplace deviance.” This deviance included acts such as failing to perform delegated tasks, workplace slowdowns, sick time abuses, and pilferage. Further, one-third of the employees had stolen money or merchandise from the job. Researchers Hollinger and Clark linked the tendency to engage in fraudulent acts with job dissatisfaction. It has been theorized that dissatisfied employees (particularly those who believe that they are not being paid what they perceive they are worth) seek “wages in kind” and will steal to “balance the scales.”

The second theory is related to financial pressures. Donald R. Cressey, a criminologist, interviewed 200 incarcerated embezzlers in the late 1940s. He found that the majority had committed fraud to meet their financial obligations. However, Cressey also identified two other factors that had to exist for the fraudulent acts

to occur: each perpetrator had perceived an opportunity to commit and conceal their crimes, and each was able to rationalize their offense as something other than criminal activity. Cressey's findings are represented graphically in what has become know as the "Fraud Triangle," as follows:

Opportunity
Pressure ▲Rationalization

Given some understanding of the motives to commit fraud, it is time to turn to various methodologies used to perpetrate fraud.

Billing Schemes: In billing schemes, a company pays invoices an employee fraudulently submits to obtain payments he or she is not entitled to receive.[22] There are four major types of these schemes:

Shell company schemes: Using this scheme, an employee will set up a fictitious company and use that company's name to bill for goods or services the employer has not received. Upon receipt of payment, the employee will deposit the funds into a bank account that has been established in the name of the fictitious company, then withdraw the funds for his or her personal use.

Pass-through schemes: A shell company established by the employee will purchase goods or services, mark up the cost, then sell those goods and services to the employer. The funds derived from the mark-up are then converted to the employee's personal use.

Pay-and-return schemes: In this scheme, an employee will purposely cause a duplicate payment to a legitimate vendor, then

request a refund of the overpayment. When the overpayment is received, the employee embezzles the money.

Personal-purchase schemes: Employees order merchandise for their personal use and charge it to the company. Sometimes the employee will keep the merchandise; other times, he or she will return it for a cash refund.

Skimming: Skimming occurs when employees steal incoming funds.[23] The term comes from the fact that the money is "taken off the top." The three principal skimming targets are revenues, refunds, and accounts receivable, with revenue skimming being the most popular method. Any employee that comes in contact with cash should be suspected when skimming has occurred; this includes top management who has the opportunity to override internal controls. When skimming occurs, regardless of the method, the accounting effect will be a decrease in revenues without a corresponding decrease in the costs incurred to generate those revenues.

Check tampering: Although embezzlers would prefer to deal with cash, businesses without high volumes of cash may necessitate the altering of checks. Check tampering is affected by one of the following methods:

Forged maker: The employee forges the signature of the person with check-signing authority. To accomplish this, the employee must have access to blank or unsigned checks.

Forged endorsement: The employee intercepts a company check that is
payable to another party, endorses the check using the payee name, and, if necessary, provides a second endorsement. To conceal this act, the employee will remove the original document from the bank statement, erase the second endorsement, or simply destroy the

document. He or she will also re-enter the original invoice for payment to the original vendor, often arranging for payment by a manual check.

Altered payee: The employee inserts his or her name, the name of an accomplice, or the name of a fictitious entity on the payee line, and converts the check for personal use.

Altered payment amount: A check legitimately issued to the employee is altered to increase the amount of the payment to the employee.

Returning to the discussion of why employees steal, the opportunity to commit and conceal the act limits the list of "usual suspects" for this type of embezzlement. in most instances, the perpetrator will have access to the incoming bank statements and can, thereby, remove all incriminating evidence.

Payroll Schemes: The most common payroll schemes include the following:

Ghost employees: In this scheme, payroll checks are issued to a party (real or fictitious) who does not work for the employer. When the party is a real person, he/she is generally a friend or relative of the fraud perpetrator. This fraud is similar to the billing scheme fraud previously discussed, but rather than paying a fictitious invoice, false payroll information is created for the ghost employee.

Falsified hours and/or rate of pay: The perpetrator of this scheme either submits un-worked hours for pay or is able to increase his/her rate of pay.

Commission schemes:Commissions are used as an incentive for performance, most frequently related to obtaining sales. As with falsified hours and/or rate of pay, the perpetrator of this fraud submits sales he/she did not make or is able increase the commission rate.

During slow periods of a business cycle, management may promise extra incentives to anyone who generates additional sales during a given month. Analytical review of actual results for the month *and* for the months preceding and following that month, however, is important before such incentives are offered in the future. It is often found that sales in the month prior will drop from historical levels, and returns in the month following will increase. This suggests that fraudulent employees hold orders from the prior month for submission during the "bonus" month, and are able to persuade customers to overbuy knowing that they can return product in the next month.

Non-cash misappropriations: These schemes involve the theft of corporate assets other than cash. Many corporate assets are misused, including company vehicles, computers, supplies, and other office equipment, and many of these acts arc fraudulent, but cost to employers is relatively small. Theft of a company's assets, however, usually occurs by one of four methods: larceny, asset requisition and transfer schemes, purchasing and receiving schemes, and false shipment schemes.

Larceny: Larceny is the outright theft of company assets without any effort at concealment by the perpetrator.

Asset requisition and transfer schemes: Fraud perpetrators utilizing this scheme gain control of a company asset for delivery to another location. In the transfer, the asset disappears.

Purchasing and receiving schemes: When perpetrating this scheme, the fraudster may remove items from an incoming shipment, marking receiving records as though the item count was short. To conceal this scheme, the receiver may send one, unedited copy of the invoice to accounts payable so that the vendor receives full payment for the shipment and an edited copy to be entered into the inventory system.

False shipment schemes: Perpetrators of this fraud will record a nonexistent sale (usually to a fictitious party or an accomplice) and steal the products "sold."

The foregoing schemes involve theft by employees, but vendors and contractors may also deliver defective services, merchandise, and/or invoices. Defective deliveries include short-counting an order, substituting inferior goods or materials, and/or pricing items higher than a previously negotiated price.

Register disbursements: These simple schemes generally involve employees removing money from the register and substituting a fraudulent document such as a void or refund slip to conceal the theft.[24]

Corruption

The last of the workplace frauds is corruption. Although the relative frequency of these frauds, according to the ACFE, was only 12.8%, the median cost of these frauds to companies was $530,000; accordingly, the median cost of these frauds was second only to company losses arising from fraudulent financial statement schemes.

Corruption schemes: These schemes include bribery, kickbacks, contract rigging, extortion, and payment and receipt of illegal gratuities. Numerous high-profile governmental cases have made

most people aware of bribery, kickbacks, extortion, and payment and receipt of illegal gratuities. Therefore, this discussion will be limited to contract rigging schemes.

Contract rigging generally involves a two-phase process: obtaining the contract, then defrauding the victim. During the bidding process, if the contractor has an accomplice within the contracting firm, the process of obtaining the contract is made easier; accomplices can often be enticed to divulge information about competing contracts by promises of a kickback from the profits of the awarded contract. Absent an accomplice, however, the contractor may prepare his/her bid based, not on the basis of what it will cost to perform the contract, but below the price the contractor anticipates other bidders will quote. The dishonest contractor knows there are many ways to make up the profits if he/she can just obtain the contract. Most schemes[25] arise from change orders to the contract and include the following:

Bidding a low price on contract items that they are relatively certain will be eliminated during the term of the contract while bidding a higher price on items they are relatively certain will remain.

Deferring work on contract items they know will be changed, then falsely claiming to have invested substantial sums in time and material, for which they are entitled to be reimbursed.

Substituting cheaper materials than those specified by the contract.

Timing of the change orders is critical for the fraud perpetrator, as there must be substantial work-in-progress so that the contracting entity has no option other than to pay the additional cost.

Deterrence

According to Joseph T. Wells, all crime is a combination of motive and opportunity.[26] As previously discussed, motives to commit fraudulent acts have been found to arise from job dissatisfaction and/or financial pressure. To reduce these motivations, owners and managers should: 1) provide an ethical work environment and lead by demonstrating ethical behavior in all business activities; 2) treat employees well; and 3) listen to and address employees' complaints and problems, particularly when they are expressing dissatisfaction with their jobs or discussing financial difficulties. A wary eye for changes in lifestyle with no apparent explanation may also help the business owner or manager spot fraud before the acts become very costly.

To reduce employees' perceptions of opportunities to commit fraud, the best message owners and managers can send is that "someone is watching." . If possible, engage an outside accountant to come in periodically to examine the books and records Add a corporate fraud policy to the company's documents, and provide a copy of that policy to every employee. Also, discuss the consequences of violating the fraud policy (i.e., termination or prosecution). Be willing to prosecute known offenders.

There may be no way to prevent all acts of fraud. This is particularly true when there is collusion between employees. Accordingly, to safeguard corporate assets, institute training programs to educate employees about fraud prevention in their areas of responsibility, and evaluate internal controls regularly to assess their effectiveness.

The most important internal control to implement is segregation of duties — designing job functions in such a way that an employee cannot easily perpetrate and conceal the fraud. This is often

difficult to accomplish when a company is staffed leanly, but is of vital importance. For instance, if an employee has a check-writing function, do not allow that employee to reconcile bank statements. If necessary, have the statements delivered to your home. Do not allow payroll personnel to add employees to the payroll system, adjust pay rates, record hours, pay the employees, *and* reconcile the payroll checking account.

If at all possible, use a single system to record all business transactions. If a sale is made, either cash or accounts receivable should be simultaneously adjusted, inventory should be reduced, and cost of goods sold should increase. When multiple systems are used, transactions can easily fall through the cracks.

Finally, if the business cannot justify the expense of an audit, prepare and read financial statements monthly. Learn to identify unusual trends that may signal a problem. If financially possible, employ external accountants to periodically examine records for irregularities. An alternative to an audit is a "Review" wherein analytical procedures are applied that can identify unusual trends and irregularities. The "Review" is significantly less costly than an audit. Work with the accountant to identify potential problem areas, and consider any suggestions for reducing risk of loss from those areas. Also, provide a means for employees to anonymously report known or suspected fraud (i.e., an ethics hotline).

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