California Insurance Fraud Prevention Act

California is one of only two states in the country with a *qui tam* statute that addresses fraud committed against private insurers. The California Insurance Frauds Prevention Act (“IFPA”), located under Section 1871.7 of the California Insurance Code, allows members of the public to file private *qui tam* suits against anyone who commits insurance fraud in the state. CPM has brought many successful whistleblower cases under the IFPA, working with government prosecutors from the California Department of Insurance.

The IFPA is designed to combat fraud committed against insurers by individuals, organizations and companies, and particularly fraud concerning health, automotive, and worker’s compensation insurance. The IFPA provides for fines against fraudsters ranging from $5,000 to $10,000 **per violation** in addition to damages of three times the amount of money the fraud cost its victims. Examples of insurance fraud covered by the IFPA include:

- Fraudulent billing or overbilling of health insurance companies by hospitals and medical specialists;
- Billing of auto insurance providers by auto repair shops for services not provided and/or parts not installed;
- Underreporting of total people employed by employers attempting to lower workers’ compensation insurance rates;
- Submitting multiple insurance claims for the same service rendered or part replaced; and
- Employing “runners, steerers or cappers” to recruit patients or clients (a/k/a providing kickbacks).

Similar to the *qui tam* provision of state and federal false claims acts, the IFPA allows individuals to sue those who commit insurance fraud covered by California law. However, unlike with non-insurance-related false claims *qui tam* actions, **under the IFPA it is not necessary that the**

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government suffer harm as a result of the fraud. This is due to the fact that insurance fraud usually harms a large number of people, as insurance companies frequently cite insurance fraud losses in raising rates for policyholders. (For example, the Act states that healthcare insurance fraud likely increases national healthcare costs by "billions of dollars annually.") Thus, individuals who sue fraudulent actors under the IFPA are acting on behalf of themselves and every one of their fellow policyholders and for the State of California.

In an IFPA *qui tam* action, "any interested person" or insurer files a civil suit in the name of the State of California. The complaint and all related evidence are filed under seal with the relevant superior court and served to the local district attorney and the state insurance commissioner, who have 60 days to decide whether or not to intervene in the case. (Either official may, however, file to extend this deadline if they can show "good cause" to do so.) If either the district attorney or the commissioner decides to intervene, government attorneys may take over and lead the prosecution, or they may allow the relator to continue to do so and serve in a supportive role. In this scenario, the relator would be entitled to collect **between 30 and 40 percent of all subsequent recoveries** from the defendant, even if the case settles before final judgment. The state will calculate the "total recovery" using the total assets remaining after it has reimbursed both the relator and itself for reasonable attorneys' fees, costs and expenses incurred during the case. Conversely, if the government declines to intervene, the relator would have the option of proceeding with the case alone, and would be entitled to **between 40 and 50 percent of any eventual recovery.** Additionally, if the court determines that the relator's case is "based primarily" on information that was already publicly available–for example, legislative or administrative reports, news articles, or public hearings–the relator would stand to receive only **a maximum of 10 percent of the eventual recovery.**

In all three scenarios, the relator's reward will vary "depending upon the extent to which the person substantially contributed to the prosecution of the action." However, parties who "planned and initiated" the underlying violation are barred from collecting rewards for filing *qui tam* actions under the IFPA. Regardless of their involvement in the reported violation, prospective relators who file "clearly frivolous" or vexatious claims, or claims "brought primarily for purposes of harassment," may be ordered to reimburse the defendant for reasonable attorneys' fees and expenses.

The IFPA also broadly protects employees from retaliation for filing or even supporting an IFPA *qui tam* action: the Act states that employees suffering retaliation for their involvement in reporting insurance fraud "shall be entitled to all relief necessary to make the employee whole." Specifically, the IFPA requires that the employee reinstate the employee with the same seniority the employee would have had if not for suffering the retaliation, pay the employee twice the amount of backpay he or she is due, plus interest, and compensate the employee "for any special damages sustained as a result of the discrimination," including attorneys' fees and reasonable litigation costs. Employees who suffer discrimination as a result of their

involvement in an IFPA action and wish to pursue damages for their injuries must file suit within three years of when they discover "the facts constituting the grounds" for the action or within eight years of the retaliatory act.

For more information about the California Insurance Fraud Prevention Act, about the Act's *qui tam* process and how it works, or to report an apparent violation of the Act and discuss your legal options, please follow up with Justin Berger or Nazy Fahimi.

- Email Justin
- Email Nazy
- Call Justin or Nazy at (650) 697-6000.

News

Whistleblower Lawsuits filed under California, Illinois insurer fraud laws may increase
Modern Healthcare, 02.17.2016

Public Radio Airs Story on CPM's Counterfeit Screws Litigation
The Center for Investigative Reporting, 03.09.2015

FAQs

HOW DOES THE CALIFORNIA INSURANCE FRAUD PREVENTION ACT DIFFER FROM THE FALSE CLAIMS ACT?

The False Claims Act ("FCA") is a Civil War-era Federal statute enacted to protect the public treasury from fraud. The FCA prohibits knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval or knowingly making, using, or causing to be made or used, a false record or statement material to a false for fraudulent claim. 31 U.S.C. § 3729(a)(1)(A), (B).

The California Insurance Fraud Prevention Act ("CIFPA"), Ins. Code §§ 1871, et seq., is a state anti-fraud statute applicable to all types of insurance fraud. The CIFPA was enacted to protect the public from harm caused by insurance fraud, including increased premiums. See Cal. Ins. Code §1871.

Both the FCA and CIFPA rely on "whistleblowers" coming forward to expose fraud. The statutes are both broad reaching, designed to prevent and punish fraud through imposing significant penalties and providing for recovery of damages, attorneys' fees and costs, and a share of the penalties imposed by the successful whistleblower. Both the FCA and CIFP provide government investigators with the knowledge and additional resources whistleblowers and their attorneys bring to these complex fraud cases.

Fraud schemes covered by both statutes often include schemes involving healthcare bills, including inflating the amount owed under a contract, billing insurance providers for services not performed, and paying kickbacks to doctors to get them to prescribe certain drugs or laboratory tests.

While the FCA and CIFPA are similar, they have some differences.

Goals of the Statutes

"[T]he goal of the FCA is to recover funds fraudulently obtained directly from the government." *California v. AbbVie Inc.*, 390 F.Supp.3d 1176, 1180 (N. D. Cal. 2019). The government is the direct and only victim. *Id.*

The goal of the CIFPA is to detect and prevent insurance fraud in a variety of forms. Cal. Ins. Code § 1871. The insurers who pay out on fraudulent claims or coverage and the insureds who pay inflated premiums to cover the cost of the fraud are the direct victims. *California v. AbbVie Inc.*, 390 F.Supp.3d 1176, 1180 (N. D. Cal. 2019); see also *People ex rel. Allstate Ins. Co. v. Weitzman*, 107 Cal.App.4th 534, 561-2 (2003).

What type of claims are brought and who investigates and pursues them?

Under both the FCA and CIFPA, the relator or whistleblower files claims on behalf of the government.

Under the FCA, claims are brought for submission of false claims to the government. The U.S. Government, if it elects to intervene, prosecutes the claims on behalf of the government with the relator.

Under the CIFPA, claims are brought for submission of fraudulent claims to an insurance company. The California Insurance Commissioner and/or the local district attorney prosecute the claims on behalf of the state with the relator, if they elect to intervene. The Department of Insurance ("DOI") should be the lead. Cal. Ins. Code § 1871.7(d).

Pre-filing procedure and investigation period

Claims brought under both the FCA and the CIFPA must be initially filed under seal and served with "a written disclosure of substantially all materials evidence and information the person possesses," or "Relator's Statement." 31 U.S.C. § 3730(b)(2); Cal. Ins. Code § 1871.7(e)(2). Under both statutory schemes, the government then has 60 days–plus any extensions–to investigate the whistleblower's claims and decide whether it will intervene in the case. 31 U.S.C. § 3730(b)(2)-(3); Cal. Ins. Code § 1871.7(e)(2)-(3).

Under the FCA, the sealed complaint and relator's statement must be personally served on (1) the Attorney General at the Department of Justice in Washington, D.C. and (2) the local AUSA's office where the complaint is filed. See 31 U.S.C. § 3730(b)(2).

Under the CIFPA, the sealed complaint and relator's statement must be personally served on (1) the California Department of Insurance ("DOI") in Sacramento and (2) the District Attorney and Insurance Fraud Unit of the county where the defendant is located (e.g., Santa Clara County's DA's Office and Insurance Fraud Units for a defendant based in San Jose). Cal. Ins. Code § 1871.7(e)(2).

Penalties and opportunity for reduction of damages

Under both the FCA and CIFPA, damages may be trebled, and civil penalties are triggered on each false claim submitted. 31 U.S.C. § 3729(a); Cal. Ins. Code § 1871.7(b). The civil penalty ranges are different between the statutes as is the possibility for reducing damages.

Civil Penalties

Under the FCA, the civil penalty range adjusts with the Federal Civil Penalties Inflation Adjustment Act of 1990.

Under the CIFPA, civil penalties are set at a minimum of $5,000 and a maximum of $10,000 for each fraudulent claim. Cal. Ins. Code § 1871.7(b). There is no adjustment included in the statute for the penalties to keep pace with inflation.

Calculating and Reducing Damages

Under the FCA, the governments damages are trebled. 31 U.S.C. § 3729(a). The FCA also allows for reduction of damages if the defendant voluntarily discloses information to the government and cooperates with the government's investigation. See 31 U.S.C. § 3729(a)(2).

Under the CIFPA, damages are trebled, and based on "the amount of each claim for compensation," Cal. Ins. Code § 1871.7(b), and there is no requirement the claim was actually paid. There is no provision in the CIFPA for reducing damages.

Whistleblower's reward

Like the FCA, a whistleblower's recovery in a CIFPA action varies.

Under the FCA, if the government intervenes in the action, the relator is entitled to 15 percent to 25 percent as a reward. 31 U.S.C. § 3730(d)(1).

Under the CIFPA, either the California Insurance Commissioner or the local district attorney may elect to intervene. If the California Insurance Commissioner intervenes in the action, the Commissioner and the whistleblower may stipulate to the whistleblower's reward pending successful resolution of the matter

either by judgement or settlement. If there is no stipulation, then the court determines the whistleblower's award, upon motion by either the Commissioner or the whistleblower. The whistleblower is entitled to between 30 percent to 40 percent of the recovery as a reward, after recovery of their attorney's fees and costs, any moneys the whistleblowing entity paid to the defendant (if the whistleblower is an insurer), and the Commissioner's recovery of his or her attorney's fees and costs. Cal. Ins. Code § 1871.7(g)(1)(A)(iii). If the local district attorney intervenes in the action, then the whistleblower is entitled to 30 percent to 40 percent of the recovery as a reward. Cal. Ins. Code §1871.7(g)(1)(A)(i).

Under the FCA, if the government declines to intervene in the action, the relator is entitled to 25 percent to 30 percent as a reward. 31 U.S.C. § 3730(d)(2).

Under the CIFPA, if the California Insurance Commissioner or the local district attorney decline to intervene in the action, then the whistleblower is entitled to 40 percent to 50 percent of the recovery as a reward in addition to recovering their reasonable attorney's fees and costs. Cal. Ins. Code §1871.7(g)(2)(A).

CPM is currently prosecuting and investigating several healthcare fraud schemes under the FCA and CIFPA on behalf of whistleblowers. If you are aware of any information about such practices, please contact us.