Kentucky Court of Appeals

No. 2022-CA-1431

On Appeal from the Greenup Circuit Court,
No. 18-CI-00348

CSX TRANSPORTATION, INC. APPELLANT

v.

DANIEL J. CAREY, *et al.* APPELLEES

BRIEF OF *AMICI CURIAE*
AMERICAN TORT REFORM ASSOCIATION,
AMERICAN PROPERTY CASUALTY INSURANCE ASSOCIATION,
NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES, AND COALITION FOR LITIGATION JUSTICE, INC.

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Certificate of Service

In accordance with RAP 30(B), on September 8, 2023, the undersigned filed this brief with the Court's electronic filing system which caused a copy to be served on all counsel of record. The undersigned also served copies of the brief via U.S. Mail on Stephen G. Amato, 201 East Main Street, Suite 900, Lexington, KY 40507 and the Hon. John F. Vincent, Special Judge, 2805 Louisa Street, Catlettsburg, KY 41129.

/s/ Michael D. Risley
Michael D. Risley

STATEMENT OF POINTS AND AUTHORITIES

INTRODUCTION

The ability of parties to report questionable trends in claims activity is critical to maintaining the integrity of the civil justice system. While this case arises in the context of suspicious pattern of claims for railroad disability benefits, as this brief will show, businesses have detected potential fraud and abuse in a wide range of contexts. Mass tort litigation is especially prone to abuse, as has occurred in asbestos and silica litigation. In addition, soft-tissue injuries, the kind of injuries that raised questions in this case, are also particularly susceptible to exaggeration and fraud, as shown in auto accident and workers' compensation claims. There are many examples of businesses and their insurers reporting suspicious trends, some of which have ultimately resulted in loss of medical licenses, attorney disciplinary action, and even criminal convictions. Unless reversed, the outcome of this case will chill the willingness of businesses to report potential misconduct in the future.

Here, CSX Transportation identified an unprecedented spike in disability claims—certified by just two chiropractors—that coincided with a furlough announcement and would have entitled the claimants to health and welfare benefits for up to two years while other employees would receive such benefits for only four months. According to CSX's review, these Certification of Ongoing Illness or Injury ("COII") forms asserted hard-to-verify minor musculoskeletal injuries, such as sprains, back pain, and muscle spasms, sustained while the employee was off duty. CSX brought this suspicious

pattern to the attention of appropriate regulatory and licensing authorities, as well as affected insurers. Yet, as a result of the trial court's pre-trial rulings and erroneous jury instructions, a jury found CSX liable for defamation and tortious interference with business expectancies.

If upheld, the staggering judgment in this case—including $1.4 million in compensatory damages and $21.4 million in punitive damages—threatens those who report suspicious claims activity with substantial liability. It will discourage businesses from taking steps that protect the integrity of the civil justice system. The Court should reverse the judgment to ensure proper application of the qualified privilege, which is essential to exposing fraud and abuse not only in the railroad employee benefit context, but also in the broader tort system.

PURPOSE AND INTEREST OF *AMICI CURIAE*

Amici curiae are organizations whose members have an interest in exposing suspected fraud and abuse in litigation and preserving the ability of others to report suspicious claims activity, which is directly implicated in this action.

The American Tort Reform Association (ATRA) is a broad-based coalition of businesses, corporations, municipalities, associations, and professional firms that have pooled their resources to promote the goal of ensuring fairness, balance, and predictability in civil litigation. ATRA has filed

amicus curiae briefs in cases before state and federal courts, which have addressed important liability issues.

The American Property Casualty Insurance Association (APCIA) is the primary national trade association for home, auto, and business insurers. APCIA promotes and protects the viability of private competition for the benefit of consumers and insurers, with a legacy dating back 150 years. APCIA's member companies represent 63% of the U.S. property-casualty insurance market and nearly 68% of Kentucky's market. On issues of importance to the insurance industry and marketplace, APCIA advocates sound and progressive public policies on behalf of its members in legislative and regulatory forums at the federal and state levels and submits amicus curiae briefs in significant cases before federal and state courts.

The National Association of Mutual Insurance Companies (NAMIC) consists of more than 1,500 member companies, including seven of the top 10 property/casualty insurers in the United States. The association supports local and regional mutual insurance companies on main streets across America as well as many of the country's largest national insurers. NAMIC member companies write $391 billion in annual premiums and represent 68% of homeowners, 56% of automobile, and 31% of the business insurance markets. Through its advocacy programs NAMIC promotes public policy solutions that benefit member companies and the policyholders they serve and fosters greater

understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.

The Coalition for Litigation Justice, Inc. is a nonprofit association formed by insurers in 2000 to address and improve the litigation environment for asbestos and other toxic tort claims.[1] The Coalition files *amicus* briefs in cases that may have a significant impact on the litigation environment. The Coalition has filed nearly 200 *amicus curiae* briefs.

ARGUMENT

I. In a Wide Range of Cases, Identification of Suspicious Claims Activity Has Led to Investigations That Have Revealed Fraud

The ability and willingness of businesses and their insurers to report suspicious trends in claims activity is critical to maintaining the integrity of the civil justice system as well as other injury compensation programs. As discussed below, investigations into surges of unexplained spikes in claims have exposed fraud and abuse in asbestos and silica litigation. The risk of fraud and abuse is particularly high in mass tort litigation, in which meritless claims may be hidden among thousands of lawsuits generated through television commercials and social media ads. In addition, soft-tissue injuries, such as those that gave rise to suspicion here, have proven particularly susceptible to exaggeration or fraud.

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[1] The Coalition includes Century Indemnity Company; Allianz Reinsurance America, Inc.; Great American Insurance Company; Nationwide Indemnity Company; Resolute Management, Inc., a third-party administrator for numerous insurers; and TIG Insurance Company.

A. Fraud and Manipulation in Silica and Asbestos Litigation

An unexplained surge of silica and asbestos claims ultimately revealed that attorneys, with the assistance of a few healthcare professionals, sought compensation on behalf of clients based on unsupported medical diagnoses. This experience demonstrates the importance of permitting those who identify suspicious claims activity to report it to licensing and other authorities without fear of liability.

Silica lawsuits surged between 2000 and 2004. *In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d 563, 571-73 (S.D. Tex. 2005). An analysis revealed that just twelve doctors, who were affiliated with a handful of law firms and mobile x-ray screening companies and did not work in the same city or state as the plaintiffs, diagnosed thousands of plaintiffs with silicosis. *Id.* at 580. The most prolific diagnosing physician, Dr. Ray Harron, later admitted that he had allowed untrained employees to produce form letters of diagnoses and stamp his name on them, and provided blank, pre-signed forms to a screening company. *Id.* at 601, 605. The radiologist had even diagnosed some plaintiffs as suffering from both asbestosis and silicosis, on separate reports, based on a single x-ray, for purposes of litigation. *See id.* at 605-06. After examining this and other evidence proffered by the defendants, the district court overseeing federal silica litigation concluded that "these diagnoses were driven by neither health nor justice." *Id.* at 632. Rather, "they were manufactured for money." *Id.* at 635.

Further investigation revealed that Dr. Harron reportedly diagnosed 75,000 potential asbestos victims for lawsuits at a rate of 150 x-rays per day for $125 each. *See* Jonathan D. Glater, *Reading X-Rays in Asbestos Suits Enriched Doctor*, N.Y. Times, Nov. 29, 2005. As a result of the exposure of this misconduct, Dr. Harron lost or surrendered his medical licenses in at least six states. *See* Editorial, *The Silicosis Abdication*, Wall St. J., Apr. 7, 2009. CSX Transportation, the Defendant here, later obtained a $1.3 million verdict under the Racketeer Influenced and Corrupt Organizations Act ("RICO") against two attorneys who allegedly conspired with Dr. Harron to fabricate asbestos claims against it. *See CSX Transp. Inc. v. Peirce*, 2013 WL 5375950 (N.D. W. Va. Sept. 25, 2013). There, the jury rejected a counterclaim against CSX alleging fraud based on its representations during the litigation. *See id.* While the case was on appeal, the attorneys and estate of the radiologist agreed to pay CSX $7.3 million, satisfying the judgment and paying the railroad's attorney's fees and costs. *See* Peter Vieth, *$7.3M Asbestos Fraud Settlement Ends 4th Circuit Appeal*, Va. Lawyers Weekly, Nov. 6, 2014. CSX's courage in tackling fraudulent claims was applauded by civil justice advocates, including *amici*. *See* Paul M. Barrett, *After CSX Settlement, More Trial Lawyers Will Be Sued Under RICO*, Bloomberg, Nov. 10, 2014.[2]

[2] Soon after, a company that had produced and sold gaskets, Garlock Sealing Technologies, found that personal injury law firms would routinely delay filing claims with asbestos trusts alleging that bankrupt companies exposed their clients to asbestos, so that the remaining solvent defendants in tort litigation would not have access to that information. *In re Garlock Sealing Techs., LLC*,

More recently, BNSF Railway took action after finding that a single physician, working with a small, federally funded clinic in Montana, certified thousands of residents as having contracted asbestos-related diseases. *See* Matthew Brown & Amy Beth Hanson, *Health Clinic in Montana Superfund Town Faces Penalties for False Asbestos Claims*, Wash. Post, June 29, 2023. In that instance, the doctor – a pediatrician – allegedly provided certifications to support patient claims for Medicare and other benefits without confirming their diagnoses though an x-ray. *See id.* Those diagnoses were also used to support numerous asbestos lawsuits against the railroad and other entities. *See id.* The doctor involved claimed that he was able to spot early warning signs of asbestosis that radiologists would miss. *See id.* Ultimately, BNSF's investigation of this surge of claims led it to bring a claim under the False Claims Act. *See id.* While the federal government declined to intervene in the case, the trial resulted in a $1 million jury verdict in favor of BNSF. *See id.*

Businesses, such as CSX and BNSF, should not be threatened with liability for investigating and reporting suspicious claims activity in good faith.

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504 B.R. 71, 82, 84 (W.D.N.C. Bankr. 2014). When plaintiffs sued Garlock in the tort system, evidence of plaintiffs' exposure to asbestos products made by others often "disappeared." *Id*. at 84-86. Garlock showed that several law firms had engaged in widespread "suppression of evidence" that had profoundly impacted the company's trials. *See id.* at 82, 86. While not reaching the propriety of this practice, the court concluded that Garlock had unfairly paid inflated settlements for decades because of this manipulation. *See id.* at 86-87.

B. The Risk of Fraud is Particularly High in Mass Tort Litigation

As examples in the asbestos and silica litigation context show, the risk of fraud and abuse is particularly high in mass tort litigation, where illegitimate cases may be hidden among viable claims. Widespread fraud, sometimes supported by questionable diagnoses, has occurred in other mass torts. As defendants and their insurers increasingly operate in an environment in which lawsuit advertisements quickly generate thousands of claims with little screening, Kentucky law should not discourage or punish those who, in good faith, request an investigation of suspicious claims.

A well-known example of questionable diagnoses occurred in the fen-phen litigation in the early 2000s. That litigation involved thousands of plaintiffs who claimed to have sustained heart valve damage after taking a diet-drug combination. A single physician reviewed approximately 10,000 echocardiograms over a ten-month period – 300 to 500 per week – as part of her engagement with a consortium of law firms active in the litigation. *In re Diet Drugs (Phentermine, Fenfluramine, Dexfenfluramine) Prods. Liab. Litig.*, 236 F. Supp. 2d 445, 455 n.11 (E.D. Pa. 2002). The federal judge overseeing the litigation found the cardiologist had "a mass production operation that would have been the envy of Henry Ford." *Id.* at 457. Later, the trust established under a nationwide settlement to pay class members' claims alleged that the doctor's unsupported diagnoses had defrauded the trust, depleting funds

available for legitimate claims. *See* Nora Freeman Engstrom, *Retaliatory RICO and the Puzzle of Fraudulent Claiming*, 115 Mich. L. Rev. 639, 657 n.61 (2017).

In the years following the fen-phen litigation, mass tort litigation has surged. *See* Daniel S. Wittenburg, *Multidistrict Litigation: Dominating the Federal Docket*, A.B.A. J., Feb. 19, 2020 (noting that, for the first time in its fifty-year history, multidistrict litigation exceeded 50% of the federal civil caseload in 2018). A federal judge has observed that mass tort dockets are often "fueled" through "an onslaught of lawyer television solicitations," with cases insufficiently screened and filed en masse.[3] *In re Mentor Corp. ObTape Transobturator Sling Prods. Liab. Litig.*, 2016 WL 4705827, at *2 n.2 (M.D. Ga. Sept. 7, 2016). Prospective plaintiffs are bundled and sold to law firms as a commodity. *See* Sara Randazzo & Jacob Bunge, *Inside the Mass-Tort Machine That Powers Thousands of Roundup Lawsuits*, Wall St. J., Nov. 25,

[3] In recent years, there has been a significant rise in lawsuit advertising, a substantial portion of which targets pharmaceuticals, medical devices, and consumer products. *See* Cary Silverman, *Bad for Your Health: Lawsuit Advertising Implications and Solutions*, at 6 (U.S. Chamber Inst. for Legal Reform, Oct. 2017) (documenting an increase in legal service television advertising from approximately $250 million in 2006 to $1 billion in 2017); *see also* Am. Tort Reform Ass'n, *Legal Services Advertising in the United States 2017-2021*, at 4 (2022) (finding that between $1.2 billion and $1.5 billion was spent each year on legal service ads nationwide between 2017 and 2021); Vickie Yates Brown Glisson, Op-ed, *The Tort System is Harming Business, Public Health. Let's Fix It*, Louisville Bus. First, Oct. 7, 2022 (former Kentucky Secretary of the Cabinet for Health and Family Services, raising concern with this trend). Plaintiffs' lawyers and companies that specialize in generating mass tort claims have, in several instances, invested over $100 million dollars into television advertising and social media to gather claims for a *single* litigation. *See* Roy Strom, *Camp Lejeune Ads Surge Amid 'Wild West' of Legal Finance, Tech,* Bloomberg L., Jan. 30, 2023.

2019. Many of the cases "probably should never have been brought in the first place." *In re Mentor Corp*., 2016 WL 4705827, at *1. The goal of some attorneys is to overwhelm the defendant and the civil justice system with cases, thereby avoiding a careful look at whether cases have individual merit and, instead, pressure a global settlement. *See id.* In fact, a Federal Advisory Committee on Civil Rules report estimated 20% to 30% of claims in federal multidistrict litigation are "unsupportable" and that, in some litigations, that figure "may be as high as 40% or 50%." Advisory Committee on Civil Rules, Agenda Book, Nov. 1, 2018, at 142.

In this atmosphere, there is a significant danger that some attorneys will knowingly file meritless claims or purposefully avoid investigating whether claims are supported by facts and law before filing them. Whether or not such practices ultimately rise to the level of fraud, in this environment, it is imperative that defendants have the freedom to flag questionable trends in claims activity without fear of liability.

In some cases, there have been allegations that enterprises involved in generating mass tort litigation have referred potential plaintiffs to medical clinics that were willing to perform unnecessary surgeries to boost the settlement value of their cases. According to a *New York Times* exposé, doctors and medical clinics that participated in generating pelvic mesh litigation could make $14,000 a day. *See* Matthew Goldstein & Jessica Silver-Greenberg, *How Profiteers Lure Women Into Often-Unneeded Surgery*, N.Y. Times, Apr. 14,

2018. The companies that financed these surgeries would be paid out of the plaintiffs' settlements. *See id.; see also* Alison Frankel & Jessica Dye, *The Lien Machine: New Breed of Investor Profits by Financing Surgeries for Desperate Women Patients*, Reuters, Aug. 15, 2015 (reporting that medical device manufacturers had launched investigations into a suspected "scheme to recruit doctors willing to overstate women's injuries from implants, thereby driving up awards").

Suspicious claims activity in mass tort litigation is not limited to product liability claims. It occurred, for example, in litigation stemming from the Deepwater Horizon oil spill in 2010. In that litigation, the court appointed former FBI director Louis Freeh to investigate ethical violations or other misconduct in the settlement program resulting from the environmental contamination, which led to the disqualification of at least two attorneys from further participation in the program. *See In re: Deepwater Horizon*, 824 F.3d 571 (5th Cir. 2016). In addition, two individuals were convicted for their roles in obtaining and using the social security numbers of thousands of people without their consent to create "clients." *See United States v. Warren*, 728 F. App'x 249 (5th Cir. 2018). In exchange for a $10 million fee, these individuals sent information for the supposed clients to a prominent plaintiffs' attorney, who then filed claims on their behalf in a multi-district case. When the settlement proceeded, just 786 clients came forward out of 40,000 submitted claims. The Fifth Circuit upheld the conviction.

Most recently, insurers have questioned the number of claims filed in the Boy Scouts bankruptcy case seeking a portion of a $2.4 billion plan, which vastly exceeded expectations. *See* Opening Brief of Certain Insurers, *In re Boy Scouts of Am. & Del. BSA, LLC*, No. 1:22-cv-01237-RGA (D. Del. Nov. 7, 2022). After the Boy Scouts filed for bankruptcy as a result of childhood sexual abuse claims, the number of claims spiked from 275 pending lawsuits and 1,400 additional known potential claims to more than 82,000 claimants – a 6,000% increase, according to insurers. *Id.* at 17-18. The insurers alleged that the "explosion" of claims resulted from a massive and misleading advertising campaign by plaintiffs' lawyers, and claimed "bad faith, collusion, and outright fraud." *Id.* at 5. They pointed to significant differences in the new claims from BSA's historical claims and thousands of proof of claim forms filed by attorneys with missing or inaccurate information. *Id.* at 20-21. Ultimately, the bankruptcy court approved the plan, despite the objections, and the Third Circuit denied a request for a stay pending appeal. *See In re Boy Scouts of Am. & Del. BSA, LLC*, 2023 WL 2662992 (D. Del. Mar. 28, 2023), *stay denied*, No. 23-1664 (3d Cir. Apr. 19, 2023).

Imposing liability for defamation in this case could deter businesses and their insurers from investigating and reporting suspicious activity in mass tort litigation, as has occurred in these and other instances, and may become even more prevalent in the future.

C. Soft-Tissue Injuries are Particularly Susceptible to Fraud

Claims alleging soft-tissue injures or musculoskeletal conditions (e.g., sprains, strains, back pain, muscle spasms, or bruises), like those for which benefits were sought in the instant case, "are particularly beset" by fraud. *See* Nora Freeman Engstrom, *Retaliatory RICO and the Puzzle of Fraudulent Claiming*, 115 Mich. L. Rev. 639, 660 (2017). These cases present challenges in verifying the injury and determining whether it was caused by the defendant's conduct. *See id.* at 661-62. Such hard-to-discern injuries may be pre-existing, substantially exaggerated, or wholly fabricated. *Id*. at 652-53.

Experience shows that, in some instances, attorneys, healthcare professionals, and others have gone so far as to stage accidents, provide unnecessary treatment, or inflate medical bills for soft-tissue injuries. For example, in 2018, attorneys representing insurance companies flagged a steep rise in commercial vehicle accidents, primarily on a particular stretch of highway in the New Orleans area. John Simerman, *In Scheme to Crash Cars Into Big Rigs, New Orleans Lawyer Danny Keating Jr. Pleads Guilty*, Times-Picayune, June 17, 2021. That trend sparked a federal investigation, dubbed "Operation Sideswipe." *See id.* The investigation revealed a scheme in which a driver ("the slammer") would intentionally collide with a tractor trailer and jump into a getaway vehicle, after which the remaining passengers would feign injury. The participants would then demand compensation for the bogus accident. At least 43 defendants, including an attorney, have been convicted in this widespread scheme. *See* U.S. Dep't of Justice, News Release, *Gibson*

Woman Pleads Guilty in Staged Automobile Collision Scheme, Nov. 30, 2022; Simerman, *supra.*

Healthcare providers have been implicated in similar schemes. In Florida, two physical therapists and five others were arrested in connection with an auto insurance fraud ring. *Physical Therapists, Others Charged in Miami PIP Fraud Scheme*, Ins. J., Apr. 18, 2022. After staging accidents, "victims" were taken to physical therapy clinics, paid to register as patients, and instructed to complain of certain types of injuries, for which the clinics billed insurers. *See id.* Earlier, a Florida attorney pleaded guilty for his role in a group of clinic owners, chiropractors, and attorneys who collected at least $23 million in fraudulent auto insurance claims. *See* Paula McMahon, *Attorney Owes $1.8 Million for Role in Auto Insurance Fraud at Chiropractor Clinics*, Sun Sentinel, Apr. 16, 2018. In that instance, individuals involved in actual car accidents were steered to corrupt clinics, which conducted unnecessary and excessive treatment and then demanded money from insurers. These types of fraudulent claims continue. *See, e.g., Man Confessed to Staged Crash But Alleged Conspirators Went to PIP Clinics Anyway*, Claims J., Jan. 17, 2023.

The practice of personal injury lawyers referring clients to medical clinics that would provide unnecessary treatment such as extended rehabilitation services, or inflate rates to drive up settlement demands and judgments, has become so prevalent that one state legislature recently required disclosure of such arrangements and provided for their admissibility

in litigation as evidence of bias. Ch. 2023-15, § 6 (Fla. 2023) (H.B. 837) (to be codified at Fla. Stat. Ann. § 768.0427(3)(e)).

Fraudulent or exaggerated claims occur not only in the tort system, but also in healthcare reimbursements sought from employer health plans or workers' compensation systems. For example, a New Jersey doctor recently admitted to submitting reimbursement claims for medical treatments for Amtrak workers that were either unnecessary or not provided. *See* Ryan Harroff, *NJ Doctor Admits to Defrauding Amtrak's Health Care Plan*, Law360, Apr. 27, 2023. In California, medical imaging companies paid physicians bribes and kickbacks in exchange for the referral of workers' compensation patients, then charged the state's workers' compensation system for hundreds of millions of dollars of medically unnecessary MRIs. *See* Hailey Konnath, *Medical Imaging CEO Gets 5 Years in Prison for $250M Fraud*, Law360, Jan. 28, 2022. In Eastern Kentucky, an attorney who promoted himself on billboards as the state's only social security disability specialist, Eric C. Conn, recruited four doctors to complete 15-minute evaluations of his clients—seeing up to 35 clients in a day. *See generally* Chelise L. Conn Greer, Note, Less *Due Process than Terrorists: An Analysis of the Eric C. Conn Fiasco*, 107 Ky. L.J. 149, 152-53 (2018). His favored, well-paid doctors signed pre-printed forms that lacked only the client's names and social security number. *See id.* Conn submitted these forms in support of hundreds of his client's social security disability benefit applications—whether they met the criteria for a "severe

impairment" or not. *See id.* In that instance, former Social Security Administration workers blew the whistle on the scheme, which included a bribed administrative law judge who rubber-stamped the fraudulent applications. *See* Garrett Wymer, *Eric Conn Sentenced 15 Additional Years in Prison, Owes Millions in Restitution*, WKYT, Sept. 7, 2018.

The potential for fraudulent or exaggerated claims related to soft-tissue injuries is present in U.S. Railroad Retirement Board (RRB) disability programs. In 2019, the RRB's Inspector General found that the Board's disability programs did not effectively consider fraud risk indicators. *See* U.S. R.R. Retirement Bd., Office of Inspector General, *The Railroad Retirement Board Disability Programs Do Not Effectively Consider Fraud Risk Indicators in the Disability Decision Process*, Rep. No. 19-16 (Sept. 27, 2019). The very first indicator of potential fraud and abuse that the auditor retained by the Inspector General identified were applications for benefits that consisted of "medical conditions that were difficult to objectively diagnose (including decisions based on pain)." *Id*. at 3. Based on this audit, the Inspector General recommended that the RRB's Office of Programs/Disability Benefits Division use this and other fraud risk factors to score applications for those that are at higher risk of fraud or abuse and establish additional supervisory review for those claims. *Id.* at 4. CSX should not be faulted for bringing this very type of suspicious activity to the RRB's attention.

II. Failing to Apply the Qualified Privilege Here Will Deter Individuals, Employers, and Insurers from Reporting Suspicious Claims Activity

As the diverse range of examples above shows, often where there is smoke, there is fire. Employers and their insurers are keenly aware of the potential for fraud and must be vigilant in reviewing submitted claims. When they identify questionable claims activity or suspicious trends, it is critical that Kentucky defamation law not discourage them from reporting such findings to the appropriate authorities and others who share a common interest in investigating and responding to the potential abuse. The qualified privilege exists for this very purpose. Here, there were flames. *See Adkins v. CSX Transp., Inc.*, 2023 WL 4035811 (4th Cir. June 16, 2023) (discussed *infra*). But even when there is smoke and, upon closer investigation, no fire, those who report suspicions of misconduct should have a privilege that shields them from liability for defamation claims.

Kentucky law has long recognized the important public policy served by protecting those who report suspicious activities to proper authorities for investigation. As the Court recognized in *Grimes v. Coyle*, "[t]he public interest requires that such communications should be made, that offenders may be detected, and the citizen should not be deterred from making them by a fear of legal responsibility." 45 Ky. (6 B. Monroe) 301, 305 (1845); *see also Weinstein v. Rhorer*, 42 S.W.2d 892, 894 (Ky. 1931) (recognizing a rule in slander cases that a communication is privileged "when it is made by a party who has an

interest to another party having a corresponding interest and made in good faith without actual malice").

Some states have specifically codified a qualified privilege in the context of reporting suspected fraud in insurance or workers' compensation claims to the state insurance department or attorney general, *see, e.g.*, Okla. Stat. § 36-363(B), or reporting to a medical licensing board information that appears to show that a physician has engaged in unprofessional conduct, *see, e.g.*, Ariz. Rev. Stat. § 32-1451(A). Kentucky common law reflects these principles, providing defendants with the "necessary latitude to communicate freely" while demanding that plaintiffs affirmatively prove both falsity and actual malice, meaning "malevolence or ill will." *Toler v. Sud-Chemie, Inc.*, 458 S.W.3d 276, 283-85 (Ky. 2014), as corrected (Apr. 7, 2015). As the Kentucky Supreme Court recognized, "society benefits when employers, or others who share common interests, are permitted to discuss matters [such as allegations of misconduct] freely, even if those discussions are found to be based on erroneous beliefs or misinformation." *Id.* at 286.

Here, as Defendants explain in their briefs, the company received an unexplainable, unprecedented influx of Certifications of Ongoing Illness or Injury forms from two chiropractors that took dozens of its employees off work. This unusual spike was particularly suspicious because it coincided with CSX's announcement of a furlough in that area. Employees on disability or sick leave when furloughed would receive significantly greater health and welfare

benefits than other employees – up to two years rather than four months. CSX's letter to the RRB was careful and measured in its language. The letter notified the recipients of a "potential conspiracy to defraud," identified the pattern and timing that prompted the company's "concerns" and "suspicions," and requested that the recipients "fully investigate" the claims. Letter from Craig S. Heligman, Chief Med. Officer, CSX, to Mr. William Fergus, U.S. R.R. Retirement Bd., July 14, 2017. CSX sent the letter to a limited group of recipients, the Ohio and Kentucky chiropractic licensing authorities and the three health insurance companies responsible for covering the employees' benefits, in addition to the RRB. All of the recipients of this letter had a shared interest in identifying and preventing unethical conduct, including the suspected fraud that the sender, Dr. Heligman, had flagged.

There was no genuine dispute that the company acted in good faith. In fact, a federal district court recently granted CSX summary judgment on Family and Medical Leave Act (FMLA) and other federal and state-law claims brought by the CSX employees who had obtained the suspicion-raising COII forms from Drs. Carey and Johnson and were then terminated by CSX for dishonesty. *See Adkins v. CSX Transp., Inc.*, 2023 WL 4035811 (4th Cir. June 16, 2023) (affirming summary judgment). The district court found that CSX had "a consistent and legitimate, nondiscriminatory reason for terminating the [employees] based on CSXT's belief that the plaintiffs were seeking time off work on an illegitimate basis" and "honestly believed that the [employees] were

seeking leave for an improper purpose." *Id.* at *2. The U.S. Court of Appeals for the Fourth Circuit affirmed, holding that "the pattern of similar leave requests in the context of the furlough notices was certainly ample evidence to raise legitimate suspicions of benefits abuse." *Id.* at *5. The employees had not shown that CSX's reason for terminating the employees – dishonesty – was a pretext for discrimination or retaliation. The Fourth Circuit understood that "[i]n order to maintain the integrity of the FMLA, employers must be able to investigate and address plausible allegations that employees have been dishonest in their medical leave claims." *Id.* at *7. The same sound policy considerations underlie the qualified privilege to defamation claims and should apply here with equal force.

At a minimum, the jury should have been instructed that if CSX's report of suspicious and potentially illegal activity was made in good faith and for a proper purpose, with a reasonable belief that the statement was true and made to recipients with a corresponding interest, it was required to find for CSX on the defamation and intentional interference claims. *See Calor v. Ashland Hosp. Corp.*, 2011 WL 4431143, at *13 (Ky. Sept. 22, 2011).[4] That did not occur in this case. The trial court failed to properly instruct the jury on the plaintiffs' burden of showing actual malice to overcome the qualified privilege.

Finally, the trial court here also erred in ruling as a matter of law that the qualified privilege did not apply, finding that CSX engaged in excessive

[4] This opinion is not binding authority but is persuasive on the issue for which it is cited.

publication by alerting licensing authorities and insurers to its concerns in addition to the RRB. Those with whom CSX shared its concerns had an obvious shared interest in investigating the railroad's reasonable suspicions that suggested the possibility of fraudulent medical diagnoses to support claims for inflated benefit payments. At the very least, whether CSX engaged in excessive publication or otherwise abused the privilege should have been left to the jury to decide with proper instructions.

CONCLUSION

For these reasons, the Court should reverse the judgment below.

Respectfully submitted,

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Dated: September 8, 2023

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/s/ Michael D. Risley
Michael D. Risley

Dated: September 8, 2023

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