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Supreme Court of Kentucky

2024-SC-0317-DG

DANIEL J. CAREY, II, D.C., ET AL. APPELLANTS

v.

CSX TRANSPORTATION, INC. APPELLEE

APPEAL FROM THE KENTUCKY COURT OF APPEALS
2022-CA-1431

MOTION OF THE KENTUCKY CHAMBER OF COMMERCE, CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA, AMERICAN TORT REFORM ASSOCIATION, AMERICAN PROPERTY CASUALTY INSURANCE ASSOCIATION, NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES, AND COALITION FOR LITIGATION JUSTICE, INC. FOR LEAVE TO FILE A BRIEF AS *AMICI CURIAE*

Pursuant to Kentucky Rule of Appellate Procedure 34(B)(1), the Kentucky Chamber of Commerce, Chamber of Commerce of the United States of America, American Tort Reform Association, American Property Casualty Insurance Association, National Association of Mutual Insurance Companies, and Coalition for Litigation Justice, Inc. respectfully move for leave to file the *amici curiae* brief tendered with this motion.

As explained below, Movants offer the Court a unique perspective on an issue raised in this case, the proper application of the qualified or "common interest" privilege to defamation claims. This privilege is intended to provide parties who share common interests with the "necessary latitude to communicate freely" about suspected fraudulent claims. *Toler v. Sud-Chemie, Inc.*, 458 S.W.3d 276, 283 (Ky. 2014), as corrected (Apr. 7, 2015). The Movants' perspective is broader than that of

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the litigants and helps explain why the trial court's failure to apply the privilege to dismiss the claims presented here, which the Court of Appeals properly reversed, will chill the willingness of individuals, businesses, and insurers to expose potential fraud, not only in the railroad employee benefit context, but also in the broader tort system.

NATURE OF THE MOVANTS' INTEREST

Movants 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 Kentucky Chamber of Commerce is the largest business association in the state working to ensure a prosperous business climate in the Commonwealth and to advance Kentucky through advocacy, information, program management and customer service to promote business retention and recruitment.

The Chamber of Commerce of the United States of America is the world's largest business federation. It represents approximately 300,000 direct members and

indirectly represents the interests of more than three million companies and professional organizations of every size, in every industry sector, and from every region of the country. The U.S. Chamber regularly files *amicus* briefs in cases like this one that raise issues of concern to the nation's business community.

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

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predictability in civil litigation. For over three decades, ATRA has filed *amicus curiae* briefs in cases that have addressed important liability issues.

The American Property Casualty Insurance Association (APCIA) is a 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 66% of the U.S. property-casualty insurance market and over 70% of Kentucky's market. On issues of importance to the insurance industry and marketplace, APCIA advocates sound and public policies on behalf of its members and their policyholders in legislative and regulatory forums at the federal and state levels, and submits *amicus curiae* briefs in significant cases before federal and state courts.

National Association of Mutual Insurance Companies (NAMIC) consists of over 1,300 member companies, including six of the top ten property/casualty insurers in the United States. The association supports local and regional mutual insurance companies on main streets across America and many of the country's largest national insurers. NAMIC member companies write $383 billion in annual premiums and represent 61% of homeowners, 48% of automobile, and 25% of the business insurance markets. Through its advocacy programs NAMIC promotes public policy solutions that benefit member companies and the policyholders they serve, and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.

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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.

POINTS TO BE PRESENTED

This case involves, among other issues, whether the trial court erred in ruling as a matter of law that the common interest privilege to defamation liability did not apply to an employer whose staff doctor reported a suspicious spike in railroad disability claims and shared that information with insurers, state chiropractic boards, and the U.S. Railroad Retirement Board for further investigation. The jury returned a $22.8 million verdict against the Defendant, CSX Transportation, Inc. The Court of Appeals granted a new trial based on several errors committed by the trial court, and this Court granted both parties' petitions for review. The attached *amici curiae* brief exclusively addresses the importance of the common interest privilege to defamation claims for businesses, insurers, and others, which allows them to investigate and share information about suspicious claims.

The ability to report and investigate suspicious claims in good faith—without fear of liability—is critical to exposing fraud or other misconduct. As the brief explains, while the case before this Court arises in the context of railroad disability benefit claims, the potential for fraudulent or exaggerated claims is particularly

[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.

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acute in any litigation or claims process seeking compensation for soft-tissue injuries. Fraud is also a growing concern in mass tort litigation. The brief discusses several instances in which physicians and other medical professionals with close ties to law firms have, or are alleged to have, aided them in submitting fraudulent or exaggerated claims. These situations, which often drew scrutiny due to unexplained surges of claims, may have influenced individuals, businesses, and insurers to collaborate about such trends and report them to those who share an interest in investigating and preventing fraud.

The brief supports the aspect of the Court of Appeals' ruling that found the trial court erred when it permitted the defamation claim to go to the jury without an instruction on the common interest privilege. Failure to properly apply this privilege will deter businesses and insurers from collaborating, identifying, and reporting suspicious claims activity.

RELEVANCE TO DISPOSITION OF CASE

The Movants are uniquely situated to offer the Court, through the attached *amici curiae* brief, insight into the practical effects of the trial court's failure to properly apply the common interest privilege. This perspective will assist the Court in evaluating the potential implications of the trial court's decision for those who might otherwise report suspicious claims activity in the future and for the integrity of the civil justice system and other injury compensation programs.

CONCLUSION

Accordingly, the Kentucky Chamber of Commerce, Chamber of Commerce of the United States of America, American Tort Reform Association, American

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Property Casualty Insurance Association, National Association of Mutual Insurance Companies, and Coalition for Litigation Justice, Inc. respectfully request that this Court grant its motion and consider the *amici curiae* brief attached hereto.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a copy of this Motion for Leave to File a Brief as *Amici Curiae* was sent by email August 26, 2025 to:

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Supreme Court of Kentucky

2024-SC-0317-DG

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v.

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APPEAL FROM THE KENTUCKY COURT OF APPEALS
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In accordance with RAP 30(B), on August 26, 2025, the served copies via email on the following : David J. Guarnieri (dguarnieri@mcbrayerfirm.com), Stephen G. Amato (samato@mcbrayerfirm.com), Katherine K. Yunker (kyunker@mcbrayerfirm.com), Kenneth Reed (kenreedatty@gmail.com), Michael P. Abate (mabate@kaplanjohnsonlaw.com), Burt A. (Chuck) Stinson (cstinson@kaplanjohnsonlaw.com), Evan M. Tager (etager@mayerbrown.com), and Carl J. Summers (csummers@mayerbrown.com), Kate Morgan (KateMorgan@kycourts.net), and the Hon. John F. Vincent, Special Judge (JohnVincent@kycourts.net).

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STATEMENT OF POINTS AND AUTHORITIES

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INTRODUCTION

This *amicus* brief addresses the importance of the qualified or "common interest" privilege to defamation claims for businesses, insurers, and others. Information sharing among these parties is critically important—without it, organizations would be blind to patterns of fraud. The common interest privilege facilitates the collaboration and communication needed to uncover suspicious trends and report them without fear of liability.

The willingness of parties to investigate and report suspicious claims is vital to maintaining the integrity of the civil justice system. While this case arises in the context of railroad disability benefits, as this brief will show, businesses have detected potential fraud in a wide range of contexts. Soft-tissue injuries, the type of injuries that raised questions here, are particularly susceptible to exaggeration and fraud. Mass tort litigation is also especially prone to abuse. 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.

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 claimants to health and welfare benefits for up to two years while other employees would receive

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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 pattern to the attention of appropriate regulatory and licensing authorities, as well as affected insurers. These are precisely the types of circumstances for which the common interest privilege was established. Yet, due to the trial court's failure to properly apply this privilege, a jury found CSX liable for defamation. The result was a staggering judgment—$1.4 million in compensatory damages and $21.4 million in punitive damages.

Failing to reverse the defamation judgment outright, or at minimum, affirm the Court of Appeals' judgment granting a new trial on that claim, risks chilling the willingness of businesses to share information and report their concerns in good faith to the appropriate authorities. The Court should hold that CSX is entitled to dismissal of the defamation claim as a matter of law, or, at minimum, affirm the Court of Appeals' ruling that the trial court failed to properly instruct the jury on this privilege. Such an instruction is essential not only in the railroad employee benefit context, but also in the tort system more broadly.

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PURPOSE AND INTEREST OF *AMICI CURIAE*

Amici curiae are organizations representing businesses, insurers, and others that have an interest in exposing fraudulent or exaggerated claims and preserving the ability of others to detect and report suspicious activity. *Amici* include the Kentucky Chamber of Commerce, Chamber of Commerce of the United States of America, American Tort Reform Association, American Property Casualty Insurance Association, National Association of Mutual Insurance Companies, and The Coalition for Litigation Justice, Inc.[1] A more detailed description of each group is included in the motion for leave to file this *amicus* brief.

ARGUMENT

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

The willingness of businesses and their insurers to report suspicious trends in claims activity, and to share information with those responsible for investigating the validity of questionable claims, is critical to maintaining the integrity of injury compensation programs as well as the civil justice system. As discussed below, investigations into surges of unexplained spikes in claims have exposed fraud and abuse. Soft-tissue injuries, such as those that raised

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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.

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suspicion here, have proven particularly susceptible to exaggeration or fraud. In addition, 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.

A. Soft-Tissue Injuries Are Particularly Susceptible to Fraud

Claims alleging soft-tissue injuries 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, in appropriate contexts, 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, claimants and healthcare professionals have gone so far as to stage accidents, provide unnecessary treatment, and inflate medical bills for soft-tissue injuries. For example, insurance companies flagged a steep rise in commercial vehicle accidents, primarily on a particular stretch of highway, in which claimants were directed to the same doctors and surgeons. *See* 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

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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 49 defendants have been convicted in this widespread scheme. *See* U.S. Dep't of Justice, Press Release, *New Orleans Man Guilty of Staged Automobile Accident Conspiracy*, Oct. 31, 2024.

Similarly, 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.*; *see also* Paula McMahon, *Attorney Owes $1.8 Million for Role in Auto Insurance Fraud at Chiropractor Clinics*, Sun Sentinel, Apr. 16, 2018 (reporting the guilty plea of Florida attorney who steered clients who were actually injured in car accidents to clinics that provided unnecessary and excessive treatment).

In another instance, an insurer and workers' compensation carrier recently filed a civil Racketeer Influenced and Corrupt Organizations Act (RICO) action in New York alleging that attorneys, "runners," and medical providers recruited construction workers to stage fake construction accidents

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and turn minor injuries into lucrative claims through unnecessary and excessive medical care and fraudulent diagnoses. *See* Complaint, *Roosevelt Road Re, Ltd. v. William Schwitzer & Assocs., P.C.*, No. 1:25-cv-03386 (E.D.N.Y. filed June 16, 2025).[2] A similar RICO action pending in New York alleges that impoverished individuals were recruited to file false claims alleging injuries from falls, referred to radiologists who performed imaging services and misrepresented the results to justify months of physical therapy sessions, then sent to medical providers who performed unnecessary treatment and surgeries, and were paid cash advances in installments from litigation funders as a law firm pursued claims on their behalf. *See generally* First Amended Complaint, *Union Mut. Fire Ins. Co. v. Subin Assoc.*, LLP, No. 1:25-cv-02652 (filed Aug. 13, 2025) (Doc. #1494).

Meanwhile, a rideshare company recently filed a RICO action in California alleging that a law firm directed its clients to certain physical therapists, chiropractors, acupuncturists, pain management physicians, and surgeons, including a doctor who would provide false diagnoses and recommend unnecessary surgeries, to artificially increase the value of the lawsuits. *See* Complaint, *Uber Techs., Inc. v. Downtown Law Group*, No. 2:25-cv-06612, ¶ 31-34 (C.D. Cal. filed July 1, 2025) (Doc. #1); *see also*

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[2] *See Racketeering Suit Alleges NY Insurance Fraud Scheme by Lawyers, Medical Providers*, Ins. J., June 19, 2025 (discussing this and similar actions).

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Complaint, *Uber Techs., Inc. v. Law Group of S. Fla.*, No. 1:25-cv-22635, ¶ 39 (S.D. Fla. filed June 11, 2025) (Doc. #1) (RICO action alleging that participants staged auto accidents in Florida, after which claimants were sent to medical providers to begin "a series of unnecessary cookie-cutter medical treatments for the purpose of fabricating false claims for payment").

A federal appellate court has also held that an insurer sufficiently alleged RICO violations involving a massive scheme to fraudulently obtain no-fault auto insurance benefits. *See State Farm Mut. Auto. Ins. Co. v. Tri-Borough NY Med. Prac. P.C.*, 120 F.4th 59 (2d Cir. 2024). That complaint alleges that physicians, physical therapists, chiropractors, and acupuncturists, along with medical clinics and radiology centers, provided medically unnecessary or excessive treatment to insured patients who were injured in car accidents. They then allegedly brought thousands of baseless arbitrations and state-court proceedings when the insurer denied the claims. *See id.*[3]

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 admitted

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[3] Many other instances of schemes involving invented or exaggerated injuries or unnecessary medical treatment claims have recently come to light. *See, e.g.*, *7OYS Investigation Finds Dozens of Injury Lawsuits from People Living in Same Apartment Buildings*, ABC 7, Oct. 7, 2024 (construction site injury lawsuits); Brad Hamilton & Georgia Worrell, *MS-13, Russian Mobsters Use Migrants in Elaborate Injury Scam — Even Getting Spinal Surgery to Pull It Off: Sources*, N.Y. Post, June 16, 2024.

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to submitting $1.37 million in reimbursement claims for medical treatments for Amtrak workers that were either unnecessary or not provided. *See* U.S. Attorney's Office, District of New Jersey, Press Release, *New Jersey Doctor Sentenced to 26 Months in Prison for Health Care Fraud Targeting Amtrak*, May 7, 2024. 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.

Kentucky is not immune from such misconduct. In eastern Kentucky, an attorney who promoted himself on billboards as the state's only social security disability specialist recruited 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). He primarily relied on four favored doctors who allegedly signed pre-completed template medical forms that lacked only the client's name and social security number. *Id.* These forms were submitted in support of hundreds of social security disability benefit applications—whether they met the criteria for a "severe impairment" or not. In that instance, former Social Security Administration workers blew the whistle on the scheme. *See* Garrett Wymer, *Eric Conn*

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Sentenced 15 Additional Years in Prison, Owes Millions in Restitution, WKYT, Sept. 7, 2018; *see also* Dylan Lovan, *Ex-clients of Social Security Fraudster Eric Conn Won't Owe Back Payments to Government*, Assoc. Press, July 30, 2024.

The widespread nature of these examples underscores how important it is for businesses and insurers to have the flexibility to communicate so they can effectively identify suspicious claims and report their findings to regulatory and licensing boards who can investigate further. Such collaboration allows them to identify suspicious trends across separate cases with different defendants and insurers involved, but that may involve the same doctors, medical clinics, or locations. Patterns are revealed only when businesses and insurers share information.[4]

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

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[4] In response to the types of suspicious soft-tissue claims discussed above, insurers, employers, and defense counsel recently established an organization, the iFraud Foundation, because "[s]takeholder collaboration is the key to success in the fight against insurance fraud." iFraud Foundation, The iFraud Defense Database, https://www.ifraud.org/defense-database (last visited Aug. 18, 2025). The organization observes that "critical information and intelligence-sharing among insurers, regulatory agencies, and law enforcement" is limited due to fragmentation, "enabl[ing] bad actors to operate across multiple carriers, jurisdictions, and lines of business with little fear of detection or consequence." iFraud Foundation, Industry Collaboration, https://www.ifraud.org/industry-collaboration (last visited Aug. 18, 2025). The solution: information sharing among stakeholders with a common interest in preventing fraud. *See id.*

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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 first indicator of potential fraud and abuse that the auditor retained by the Inspector General identified was 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, as well as that of insurers and licensing boards that share a common interest. Communicating such justified concerns to these entities cannot constitute malicious conduct as a matter of law.

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

The defamation judgment in this case, if not reversed, may also deter businesses and their insurers from investigating, sharing information, and reporting suspicious activity in other contexts, including mass tort litigation. In such cases, the risk of fraud is particularly high because illegitimate cases may be hidden among viable claims. As businesses and their insurers

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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, communicate about suspicious claims.

Mass tort litigation has surged in recent years. *See* Amanda Bronstad, *MDLs Make Up More Than Half of U.S. Cases, Whether It's 65% or 71%*, Law.com, June 25, 2024 (reporting that the percentage of civil actions in federal courts in multidistrict litigation, which are primarily mass tort claims, rose from 38% in 2014 to 65% in 2023). A federal judge has observed that cases in mass tort dockets are often insufficiently screened and filed *en masse*. *In re Mentor Corp. ObTape Transobturator Sling Prods. Liab. Litig.*, 2016 WL 4705827, at *2 n.2 (M.D. Ga. Sept. 7, 2016). These claims can overwhelm defendants and the civil justice system with cases, avoiding a careful look at whether the individual claims have merit and, instead, pressure a global settlement. In fact, a Federal Advisory Committee on Civil Rules report estimated that 20% to 30% of claims in federal multidistrict litigation are "unsupportable" and that, in some litigation, the figure "may be as high as 40% or 50%." Advisory Committee on Civil Rules, MDL Subcommittee Report–Agenda Book, Nov. 1, 2018, at 142.

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

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settlement value of their cases. *See* Matthew Goldstein & Jessica Silver-Greenberg, *How Profiteers Lure Women Into Often-Unneeded Surgery*, N.Y. Times, Apr. 14, 2018; *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").

Even before the recent surge of mass tort litigation, silica and asbestos claims had proven susceptible to fraud and manipulation. After an unexplained surge of silica claims between 2000 and 2004, an analysis revealed that just twelve doctors diagnosed thousands of plaintiffs with silicosis. *In re Silica Prods. Liab. Litig.*, 398 F. Supp. 2d 563, 571-73, 580 (S.D. Tex. 2005). The most prolific diagnosing physician—a radiologist—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.[5] The radiologist had even diagnosed some plaintiffs as suffering from both asbestosis and silicosis, which have vastly different appearances on an x-ray, for purposes of litigation. *See id.* at 595,

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[5] Further investigation revealed that this doctor 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.

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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. CSX Transportation, the Defendant here, later obtained a $1.3 million RICO verdict against two attorneys and a doctor, finding they conspired to fabricate claims. *See CSX Transp. Inc. v. Peirce*, No. 5:05CV202, 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.*[6]

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 through an x-ray. *See id.* Those diagnoses were also used to support numerous lawsuits against the railroad and other entities. *See id.* Ultimately, BNSF's investigation of this surge of claims led it to sue under

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[6] 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 attorneys' fees and costs. *See* Peter Vieth, *$7.3M Asbestos Fraud Settlement Ends 4th Circuit Appeal*, Va. Lawyers Weekly, Nov. 6, 2014.

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the False Claims Act. *See id.* While the federal government declined to intervene in the case, a jury found that the clinic had filed 337 false medical claims. *See id.* The Ninth Circuit affirmed the judgment. *BNSF Ry. Co. v. Center for Asbestos Related Disease, Inc.,* No. 23-35507, 2024 WL 4273814 (9th Cir. Sept. 24, 2024); *see also* Mara Silvers, *Federal Judge Considers Fate of Shuttered Asbestos-Screening Clinic*, Montana Free Press, June 12, 2025 (discussing BNSF's attempt to collect the resulting multi-million dollar judgment).[7]

In the mass tort environment, as in the soft-tissue injury context, there is a significant danger that some claims will not only lack merit, but be exaggerated, wholly unsupported, or even fraudulent. For this reason, it is imperative that businesses and insurers have the freedom to communicate about questionable trends in claims activity without fear of liability. Reaffirming the applicability of the common interest privilege in this case would protect the ability of businesses and their insurers to investigate, share information, and report suspicious activity in mass tort litigation, as has occurred in these and other instances, and may become even more prevalent in the future.

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[7] Other businesses have filed fraud or racketeering claims after investigating suspicious patterns in asbestos litigation. *See, e.g.*, Complaint, *J-M Mfg. Co. v. Simmons Hanly Conroy, LLP*, at ¶¶ 32-33, No. 1:24-cv-03853 (N.D. Ill. Filed May 10, 2024); *see also* David Thomas, *PVC Pipe Maker JM Eagle Sues US Asbestos Law Firm in Racketeering Case*, Reuters, May 13, 2024.

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II. Failing to Apply the Common Interest Privilege Here Will Deter Individuals, Employers, and Insurers from Investigating, Identifying, and 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 communicating with others who share a common interest in investigating and responding to potential abuse and reporting such findings in good faith to the appropriate authorities.

As is true in other contexts, the best way to prevent wrongdoing is to follow the maxim: If you see something, say something. Fraud can be detected and prevented only if those who see a suspicious pattern are free—indeed, encouraged—to report what they see to those with the ability to investigate. The common interest privilege to defamation actions exists for this very purpose. Here, of course, there were flames. *See Adkins v. CSX Transp., Inc.*, 70 F.4th 785 (4th Cir. 2023) (discussed *infra*). But even when there is smoke and, upon closer investigation, no fire, those who in good faith report suspicions of misconduct should be able to rely on 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 in good faith to proper authorities for investigation. As the court recognized in *Grimes v. Coyle*,

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"[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 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 by recognizing a common-interest privilege that provides 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) (relied upon by the Court of Appeals, Slip Op. at 11-12). As this Court has 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.

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Had the suspicions of fraudulent claims at issue here been aired in a RICO or False Claims Act lawsuit, as in some of the other cases discussed above, any allegedly defamatory statements would be absolutely privileged under Kentucky's judicial statements privilege. *Morgan & Pottinger, Attorneys v. Botts*, 348 S.W.3d 599, 601 (Ky. 2011) ("The prevailing rule and the one recognized in this jurisdiction is that statements in pleadings filed in judicial proceedings are absolutely privileged when material, pertinent, and relevant to the subject under inquiry, though it is claimed that they are false and alleged with malice.") (quoting *Schmitt v. Mann*, 163 S.W.2d 281, 283 (Ky. 1942)). Had attorneys, rather than doctors, engaged in activity indicating that they might have filed fraudulent claims, statements made in a disciplinary complaint submitted to the bar would likewise be absolutely privileged. The same public policy underlying these rules equally applies to the privilege applicable in this case: encouraging people who suspect ethical violations to report such information to regulatory authorities, whether it is the state bar association or the chiropractic board. *See id.* at 604. "If ethics investigations are to be conducted effectively, it is imperative that complainants be free from the threat of themselves being sued." *Id.* (quoting *Farber v. Dale*, 392 S.E.2d 224, 227 (W. Va. 1990)).

Here, as CSX states, 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

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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 more generous 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. In addition to the RRB, CSX sent the letter to a limited group of recipients, namely the Ohio and Kentucky chiropractic licensing authorities and the three health insurance companies responsible for covering the employees' benefits. All 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.

When the qualified privilege applies, as it did here, the burden is on the plaintiff to prove actual malice. *Toler*, 458 S.W.3d at 283-84. Here, there was no genuine dispute that the company acted in good faith, which should have required judgment for the defendant as a matter of law. In fact, a federal district court granted CSX summary judgment on defamation, Family and Medical Leave Act (FMLA), and other federal and state-law claims brought by CSX employees who had obtained the suspicion-raising COII

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forms from Drs. Carey and Johnson and were then terminated by CSX for dishonesty. *See Adkins v. CSX Transp., Inc.*, 70 F.4th 785 (4th Cir. 2023). 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." *Id.* at 791. It granted CSX summary judgment because the company "honestly believed that the [employees] were seeking leave for an improper purpose." *Id.* The Fourth Circuit affirmed summary judgment on the claims appealed by the plaintiffs, 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 794. 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 797. The same sound policy considerations are the foundation for the common interest privilege to defamation claims and, given the lack of malicious intent, should preclude that claim here with equal force.

Here, the trial court erred in ruling that CSX and the recipients of Dr. Heligman's letter lacked a common interest and, as a result, there was no privilege as a matter of law. Not only was that ruling wrong, but the lack of evidence of malice needed to overcome the privilege should have led to judgment for the defendant. If CSX was not entitled to judgment as a matter

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of law, the jury should have been instructed that if CSX's report of suspicious 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 claim. That did not occur.

As the Court of Appeals correctly held, the trial court failed to properly instruct the jury on the common interest privilege, including the need for the plaintiffs to prove actual malice. Slip Op. at 14. It recognized that the licensing authorities, insurers, and RRB had a common interest in investigating the unprecedented spike in benefit claims. *See id.* Sharing information for this purpose does not lead to loss of the privilege. Properly applying these principles is critical for businesses and insurers to uncover fraud without fear of liability.

CONCLUSION

For these reasons, if the Court does not grant judgment to CSX outright, it should affirm the Court of Appeals' remand of this case for a new trial in which the jury would be properly instructed on the qualified privilege applicable to defamation claims.

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