SUTHERLAND

LEGAL ALERT

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# RICO Claims in Bonus Annuity Case Headed for Trial?

On October 13, 2011, the United States District Court for the Central District of California denied defendant's renewed motion for summary judgment in *Negrete v. Allianz Life Ins. Co. of North America* (No. CV 05-6838) and *Healey v. Allianz Life Ins. Co. of North America* (No. CV 05-6838), two consolidated certified class actions that have been pending since 2005. The insurer's motion challenged the plaintiff class's RICO claims, which allege that the company and its field marketing organizations (FMOs) fraudulently marketed bonus deferred annuities to senior citizens. The court held, among other things, that plaintiffs had advanced adequate evidence of a RICO enterprise and an injury to the plaintiff class by reason of the RICO violation to present a triable issue of fact precluding summary judgment. Click here for the opinion.

According to the court, the insurer's bonus deferred annuity marketing strategy emphasized "no sales charges," an "immediate bonus," and payment of "full value" after certain deferral requirements were met, but the full value of an annuity, including the bonus, could only be obtained if the annuity was held in deferral for at least 10 years and payments were withdrawn for another 10 years. When selling the annuities, agents were required to provide each purchaser with a sales brochure containing the allegedly offending representations and a statement of understanding (SOU), which the purchaser was required to sign, acknowledging that he/she had received and read the brochure.

Plaintiffs alleged a RICO claim under 18 U.S.C. § 1962(c), which imposes liability for (1) conduct (2) of an enterprise (3) through a pattern of (4) racketeering activity, as well as a claim for conspiracy under 18 U.S.C. § 1962(d). Under 18 U.S.C. § 1964(c), RICO plaintiffs must also prove an injury to business or property "by reason" of the Section 1962 violation. "Racketeering activity" is defined as certain criminally indictable acts, including mail and wire fraud, under 18 U.S.C. § 1961(1). The insurer's renewed motion for summary judgment challenged, among other things, plaintiffs' ability to establish an enterprise and an injury proximately caused by the insurer's alleged conduct.

With respect to the existence of a RICO enterprise, the court held that there was adequate evidence of an association-in-fact between and among the insurer and its FMOs to present a triable issue of fact. Specifically, the court found that a rational jury could conclude that each of the elements of such an enterprise were present: relationships between and among the insurer and the FMOs, a common purpose, and sufficient longevity of the relationships to permit the insurer and the FMOs to pursue the common purpose. According to the court, the insurer's Marketing Advisory Committee, comprised of the heads of various FMOs who met with the insurer and representatives from the field on a regular basis, "operated as an intermediary for communications between and among the FMOs, supplying the 'unifying rim' of relationships" necessary to transform the insurer's hub and spoke marketing structure into a fully integrated association-in-fact enterprise. Further, the court found that there was adequate evidence of a common purpose of increasing sales of products "through senior-focused promotional materials and seminar programs," even if the FMOs did not share all of their purposes in common and, in some instances, were in competition with each other.

With respect to injury, the court rejected the insurer's argument that plaintiffs' damages should be calculated based on the accumulation values of their annuities on the dates the annuities were surrendered. According to the court, the surrender values plaintiffs actually received were less than the amounts they paid for the annuities, resulting in net out-of-pocket losses. The insurer's additional arguments that plaintiffs could not establish a RICO injury because they could not present evidence of

concrete financial losses and because the annuity contracts at issue had been approved by state insurance regulators were similarly rejected. Plaintiffs' concrete losses, the court said, were their "overpayments for financial products due to fraudulent misrepresentations." Also, the court refused to allow purported regulatory approvals to deprive it of the authority to adjudicate plaintiffs' claims, pointing out that there was a triable issue of fact as to whether regulators had approved marketing materials. Finally, the court found adequate evidence that the insurer's conduct was the proximate cause of plaintiffs' alleged injuries. Specifically, the court held that a rational jury could determine that the insurer's sales materials affirmatively misrepresented that its bonuses were "immediate" and its annuities paid "full value" with "no sales charges," and plaintiffs' "uncontroverted execution of the SOUs confirming that they reviewed" the sales materials constituted substantial evidence of reliance on the representations.

In 2009, the insurer obtained a jury verdict in its favor in a similar class action, alleging fraudulent annuity sales practices, that was filed in Minnesota federal court (*Mooney v. Allianz*, No. 06-cv-00545). Following that verdict, the insurer moved for summary judgment in the *Negrete* and *Healey* actions, asserting that those class members whose claims were adjudicated in the Minnesota case were precluded from continuing to prosecute their claims in California. The court rejected the claim preclusion defense as untimely, among other reasons, and granted plaintiffs' cross-motion for summary judgment on the issue.

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