UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 0:24-cv-60591-DAMIAN/Valle

CONSWALLO TURNER, TIESHA FOREMAN, ANGELINA WELLS, PAULA LANGLEY, VERONICA KING, NAVAQUOTE, LLC and WINN INSURANCE AGENCY, LLC, individually and on behalf of all others similarly situated,

CLASS ACTION

(Jury Trial Demanded)

Plaintiffs,

v.

ENHANCE HEALTH, LLC,
TRUECOVERAGE, LLC,
SPERIDIAN TECHNOLOGIES, LLC,
BENEFITALIGN, LLC,
NUMBER ONE PROSPECTING, LLC
d/b/a MINERVA MARKETING,
BAIN CAPITAL INSURANCE FUND L.P.,
DIGITAL MEDIA SOLUTIONS LLC,
NET HEALTH AFFILIATES, INC.,
MATTHEW B. HERMAN,
BRANDON BOWSKY, GIRISH PANICKER,
and MATTHEW GOLDFUSS,

Defendants.
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PLAINTIFFS' RESPONSE TO DEFENDANTS' JOINT MOTION TO DISMISS

Plaintiffs, Conswallo Turner, Tiesha Forman, Angelina Wells, Veronica King, Navaquote, LLC, Winn Insurance Agency, LLC and Paula Langley, individually and on behalf of all others similarly situated ("Plaintiffs"), respond to the Joint Motion to Dismiss and Incorporated Memorandum of Law ("Jt. Mot. to Dismiss") [D.E. 100] filed by Defendants Enhance Health, LLC ("Enhance Health"), TrueCoverage, LLC ("True Coverage"), Speridian Technologies, LLC ("Speridian"), Benefitalign LLC, ("Benefitalign"), Number One Prospecting,

LLC d/b/a Minerva Marketing ("Minerva"), Net Health Affiliates, Inc. ("NHA"), Matthew B. Herman ("Herman"), Brandon Bowsky ("Bowsky"), Girish Panicker ("Panicker") and Matthew Goldfuss ("Goldfuss") (collectively, "Defendants"), and state:[1]

I. INTRODUCTION

Plaintiffs' allegations describe an organized, interrelated group of companies and individuals that meet RICO's liberal construction. *See U.S. v. Boyle*, 556 U.S. 938, 944 (2009). As set forth in the Amended Complaint, Minerva and Bowsky discovered that leads generated by falsely telling consumers they would receive a "free cash card" worked three times better than leads offering ACA health insurance. (Am. Compl. ¶¶ 11, 182-95). So Bowsky set out to sell these "dirty" leads to agencies enrolling consumers in ACA policies, and to train agents on how to handle consumers responding to them: when the consumer calls, don't mention a cash card, but if the consumer mentions the cash card, be vague and tell them it comes later through the insurance company. (*Id.* ¶¶ 14-15, 182-95).

TrueCoverage, which is owned and controlled by Panicker, was one of those agencies. (*Id.* ¶¶ 16-17, 196). It implemented a script designed to mislead and quickly enroll consumers calling for a cash card. (*Id.* ¶ 17). TrueCoverage's owner, Panicker, directed the company's overall strategy while its marketing manager, Goldfuss, directed the company's consumer-facing marketing and enrollment efforts. (*Id.*). TrueCoverage created and financed a downline network of other agencies to do the same, including Protect Health.[2] (*Id.* ¶ 20).

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[1] Plaintiffs respond separately to the Motion to Dismiss filed by Defendant Bain Capital Insurance LLC ("Bain Insurance") [D.E. 122].

[2] Protect Health filed for bankruptcy shortly after the Amended Complaint was filed. *See In re Digital Media Solutions, Inc.*, No. 24-90468 (ARP) (S.D. Tex.). An automatic stay is in place.

The largest TrueCoverage downline was Enhance Health. (*Id.* ¶¶ 20-24). Enhance Health's CEO, Herman, learned of the scheme through one of TrueCoverage's other downlines run by Herman's business partner Barachy Lucien. (*Id.* ¶ 20, 213-15). Lucien showed Herman how leads generated by fraudulent ads, along with misleading scripting, could drive lightning-fast, 10-minute ACA enrollments and generate significant revenue. (*Id.*). When Herman learned that the source of TrueCoverage's leads was Bowsky, his former colleague in the dubious mini-med industry, Enhance Health became the largest buyer of leads from Bowsky's company, Minerva, and Minerva became Enhance Health's exclusive lead provider. (*Id.* ¶¶ 23-24, 220). Enhance Health's pivot to ACA enrollments was instantly successful, and Enhance Health and Herman created a downline network of agencies comprised of Herman's colleagues, friends and family, including NHA, to expand and capture market share. (*Id.* ¶ 219).

The enterprise's interrelated core was thus established: Minerva and Bowsky selling tens of millions of dollars of "dirty" leads to TrueCoverage, Enhance Health and their downlines; Enhance Health and TrueCoverage agreeing that Enhance Health would become a TrueCoverage downline; TrueCoverage financing Enhance Health by purchasing its enrolled policies; Enhance Health generating significant revenue for itself and for TrueCoverage; TrueCoverage training Enhance Health's agents; Enhance Health, TrueCoverage and their downlines engaging in the same misleading enrollment practices using similar misleading call scripts; Panicker directing TrueCoverage's enrollment efforts and TrueCoverage's relationships with Enhance Health, its biggest downline, and Minerva; Herman directing the marketing efforts of Enhance Health and its relationships with TrueCoverage and Minerva; and Goldfuss directing TrueCoverage's misleading customer-facing enrollment efforts.

The enterprise did not end there. With knowledge of the above, Bain Insurance directed a significant, $150-million capitalization of Enhance Health, allowing Enhance Health to buy more leads from Minerva, generate more commissions for its upline, TrueCoverage, and grow its downline network of agencies. (*Id.* ¶¶ 292, 298-307). Two TrueCoverage affiliates owned by Panicker, Benefitalign and Speridian, also played a crucial role in the enterprise. Benefitalign agreed to give TrueCoverage, Enhance Health and their downlines private access to "the ACA Marketplace Exchange Database (the "Marketplace"). (*Id.* ¶¶ 16, 24). This allowed the burgeoning enterprise to enroll the highest number of consumers in the shortest amount of time without scrutiny. (*Id.* ¶ 16). Benefitalign had been created by Speridian, which also paid the salaries of TrueCoverage's enrollment agents. (*Id.* ¶¶ 53, 406).

The technology provided by Benefitalign and Speridian was crucial to the activities that most directly injured Agent Plaintiffs, Consumer Plaintiffs and class members in this case: "AOR Swapping" and "Twisting." Using consumer personally identifiable information (or "PII") obtained from consumers lured by the fraudulent cash card ads, TrueCoverage, Enhance Health and their downlines engaged in AOR Swaps by replacing a consumer's agent of record (or "AOR") without the consumer's consent. (*Id.* ¶ 19). AOR Swaps directly injured the businesses of Agent Plaintiffs Navaquote and WINN by stealing the commissions earned by those companies from their clients' policies.

Then, once an agent of TrueCoverage, Enhance Health or a downline took over as the AOR, they could use the consumer's PII to engage in Twisting (or "switching"): accessing a consumer's information through Benefitalign and altering the consumer's insurance carrier or insurance plan without the consumer's knowledge. (*Id.* ¶ 28). This conduct directly injured the property of each of the Consumer Plaintiffs. King, Langley and Turner allege that Enhance Health

switched their policies (*id.* ¶¶ 338, 352, 371), and Foreman and Wells allege that TrueCoverage switched theirs. (*Id.* ¶¶ 361, 379. Turner's policy was switched after responding to a Facebook ad, calling a number and providing PII. (*Id.* ¶ 371). All Consumer Plaintiffs suffered out-of-pocket damages as a result, with Langley and Turner suffering unpaid medical expenses. (*Id.* ¶¶ 344, 353, 369, 370-72, 383).

In addition, Mrs. Foreman suffered and paid a tax penalty as the result of TrueCoverage engaging in another fraudulent practice called "Dual-Apping." Because Mrs. Foreman's household income was too high to qualify for a zero-premium ACA plan, a TrueCoverage agent removed Mrs. Foreman (and her salary) from her husband's application, thereby qualifying a plan for the husband but causing a household tax penalty at the end of the year. (*Id.* ¶ 369).

Because each of the Agent Plaintiffs and Consumer Plaintiffs directly suffered injury to their "business or property" as a result of Defendants' conduct, they have established proximate causation and statutory standing to pursue their claims under RICO. *See Maiz v. Virani*, 253 F.3d 641, 662 (11th Cir. 2001) (holding that lost profits are a recognized business injury for purposes of RICO standing); *In re Managed Care Litig.*, 150 F. Supp. 2d 1330, 1338-39 (S.D. Fla. 2001) (holding that loss or payment of money is a form of injury to property under RICO).

Furthermore, these injuries were caused by a RICO *enterprise*. The "relationships among those associated with the enterprise," as described in the preceding paragraphs and throughout the Amended Complaint, cannot be denied or minimized, particularly at the motion to dismiss stage. *See Al-Rayes v. Willingham*, 914 F.3d 1302, 1307 (11th Cir. 2019). Plaintiffs' allegations do not simply describe "parallel conduct" or siloed defendants acting without knowledge of what the others were doing. Plaintiffs' allegations plausibly describe companies that have discovered a way to exploit an industry and are working *together* toward a common objective: to "*artificially* and

exponentially grow the newly developing, year-round industry for low-income ACA health insurance, *and [using] fraudulent means* to exploit and capture as much of that industry as possible, as quickly as possible, for monetary gain." (Am. Compl. ¶ 405 (emphasis added)).

Moreover, Plaintiffs allege each Defendant's participation in the operation or management of the enterprise by describing how each Defendant played "some part in directing" the enterprise's affairs. *Williams v. Mohawk Indus., Inc.*, 465 F.3d 1277, 1285 (11th Cir. 2006) (quoting *Reves v. Ernst & Young*, 507 U.S. 170, 179 (1993)). RICO liability is *not* limited to those with primary responsibility for the enterprise's affairs." Plaintiffs summarize in detail below the Amended Complaint's allegations of how each Defendant played some role in directing the affairs of the enterprise. (*See supra* Section III.A.4).

Plaintiffs also allege the enterprise's scheme, and its predicate acts, with sufficient particularity. Plaintiffs describe the fraudulent ads sent over the wires. (Am. Compl. ¶¶ 183-85, 407). Plaintiffs describe the sales calls conducted over the wires, as well as the misleading scripts used by TrueCoverage's and Enhance Health's sales agents. (*Id.* ¶¶ 259-73). And perhaps most importantly, Plaintiffs describe in detail, using witness accounts, how TrueCoverage, Enhance Health and their downlines committed additional acts of wire fraud by engaging in AOR Swaps and Twisting. (*Id.* ¶¶ 274-97). Plaintiffs' individual allegations also describe those activities as they relate specifically to Plaintiffs. (*Id.* ¶¶ 331-403).

Importantly, these unauthorized changes to Consumer Plaintiffs' health insurance applications are themselves misrepresentations that amount to a "scheme to defraud" and constitute separate instances of wire fraud. Each is a misrepresentation to CMS that the consumer knew about and consented to the change. Under RICO, direct first-party reliance is not required to establish wire fraud. *See Bridge v. Phoenix Bond & Indemn. Co.,* 553 U.S. 639, 656 (2008)

(reviving RICO claim where misrepresentations were made to government, not plaintiffs). Here, Defendant's misrepresentations to the government are actionable even though Plaintiffs were completely unaware of them, because Plaintiffs suffered injury as a result of them. *See id.*

Relatedly, Plaintiffs' allegations of the thousands of predicate acts of wire and mail fraud generated by the enterprise's AOR Swaps and Twisting activities adequately describes a "pattern of racketeering activity" under RICO. Plaintiffs need only describe two acts or more of continuous racketeering within a 10-year period. *U.S. v. Goldin Indus., Inc.*, 219 F.3d 1271, 1274 (11th Cir. 2000) (citing 18 U.S.C. § 1961(5)). Plaintiffs' descriptions of the predicate wires over the course of more than two years satisfies that standard.

Defendants also attack Plaintiffs' claims for RICO Conspiracy and Aiding and Abetting RICO. For all Defendants other than NHA and Protect Health, these are alternative claims to Plaintiffs' primary RICO claims under Section 1962(c).[3] If the jury determines that a particular Defendant was not a member of the enterprise (say for example, they find that Defendant did not play a role in directing the enterprise's affairs), then Plaintiffs intend to prove that Defendant conspired with and/or aided and abetted the enterprise.

Plaintiffs state a plausible claim for RICO Conspiracy against each of the Defendants. As in most cases, Plaintiffs do not have evidence of a secret, high-end meeting at which Defendants formed a pact to commit the crimes alleged. But such direct evidence is not required. An agreement to participate in the fraud can be inferred through a showing, using circumstantial evidence, of an "overall objective." *In re Managed Care Litigation*, 150 F. Supp. 2d at 1350 (citing *U.S. v. Church*, 955 F.2d 688, 694-95 (11th Cir. 1992)). Here again, Plaintiffs' allegations describe each Defendants' participation a scheme with the overall objective of artificially growing the low-

[3] Plaintiffs have not sued NHA or Protect Health under a direct Section 1962(c) claim.

income ACA health insurance enrollment industry for monetary gain. Plaintiffs' allegations describe shared conduct that goes far beyond a group of agencies doing something bad separately but at the same time.

Plaintiffs' alternate Aiding and Abetting RICO claims must also survive Defendants' Joint Motion to Dismiss. Plaintiffs allege each Defendant's general awareness of its role in the scheme. And Plaintiffs summarize in detail, as compiled *infra* Section III.D.2, their allegations that *each* Defendant knew about the scheme and substantially assisted it.

Similarly, Plaintiffs state sufficient common-law claims for aiding and abetting fraud and aiding and abetting breaches of fiduciary duty. Defendants do not challenge Florida's recognition of these claims. Plaintiffs summarize in detail their allegations of knowledge and substantial assistance, *see infra* Section III.D.2. And Plaintiffs adequately describe the fiduciary duties that agents like TrueCoverage, Enhance Health and their downlines owe to insureds, particularly where, for example, those agents "voluntarily assumed the responsibility for selecting the appropriate insurance policy for the insured." *See Tiara Condo. Ass'n, Inc. v. Marsh, USA, Inc.*, 991 F. Supp. 2d 1271, 1281 (Fla. 2014). Here, each Consumer Plaintiff alleges that TrueCoverage or Enhance Health switched their policy — effectively taking over the responsibility of selecting — without her knowledge, resulting in damages.

Plaintiffs also adequately plead their data breach negligence claim, which is directed at all Defendants except Bain Insurance. First of all, Plaintiffs' negligence claim is not a negligence *per se* claim. Rather, it is a negligence claim based on Defendants' duty to protect the sensitive and private consumer PII they collected. Defendants failed to protect that information. Instead, they used the PII to enter the Marketplace database and change Consumer Plaintiffs' and

class members' healthcare applications and policies without Consumer Plaintiffs' and class members' knowledge or consent.

Finally, Plaintiffs' Amended Complaint is not a shotgun pleading. It is lengthy, but it is detailed. It contains allegations that describe each Defendant's conduct and gives notice and, where needed, particularized detail of what each Defendant is alleged to have done. As a result, Defendants were able to respond with their own lengthy, 60-page Joint Motion to Dismiss.

II. LEGAL STANDARD

At the motion to dismiss stage, the plaintiff's allegations must be accepted as true. *See Reva, Inc. v. Humana Health Benefit Plan of La., Inc.*, No. 18-20136-CIV, 2018 WL 1701969, at *2 (S.D. Fla. Mar. 19, 2018) (citing *Brooks v. Blue Cross & Blue Shield of Fla., Inc.*, 116 F.3d 1364, 1369 (11th Cir. 1997)). The standard "do[es] not require heightened fact pleading of specifics, but only enough facts to state a claim to relief that is plausible on its face." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 570 (2007). "[A] complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal,* 556 U.S. 662, 678 (2009) (quoting *Twombly,* 550 U.S. at 570).

III. ARGUMENT

A. Plaintiffs Adequately Plead Their RICO Claims

"RICO is widely regarded as a broad statute; indeed, the RICO text itself 'provides that its terms are to be liberally construed to effectuate its remedial purposes.'" *Al-Rayes*, 914 F.3d at 1307 (quoting *Boyle v. U.S.*, 556 U.S. 938, 944 (2009) and Pub. L. No. § 904(a), 84 Stat. 922, 947 (1970)). Viewed in this light, Plaintiffs' allegations adequately support their RICO claims.

1. <u>Plaintiffs sufficiently plead proximate causation under RICO</u>

"Proximate cause . . . is a flexible concept that does not lend itself to 'a black-letter rule that will dictate the result in every case." *Bridge*, 553 U.S. at 654 (quoting *Holmes v. Sec. Inv. Protection Corp.*, 503 U.S. 258, 272 n.10 (1992)). All that is required is "*some* direct relation between the injury asserted and the injurious conduct alleged." *Id.* (emphasis added) (quoting *Holmes*, 503 U.S. at 268).

Importantly, "a proximate cause is not . . . the same thing as a sole cause. Instead, a factor is a proximate cause if it is a substantial factor in the sequence of responsible causation." *Cox v. Adm'r U.S. Steel & Carnegie,* 17 F.3d 1386, 1399 (11th Cir. 1994) (citation omitted). "[I]t is beside the point whether [other factors may have] also contributed to the alleged injury." *Id.* (citing W. Page Keeton*, Prosser and Keeton on the Law of Torts* § 41, at 268 (5th ed. 1984) ("If the defendant's conduct was a substantial factor in causing the plaintiff's injury, it follows that he will not be absolved from liability merely because other causes have contributed to the result, since such causes, innumerable, are always present.")).

a. Consumer Plaintiffs plead that Defendants' conduct directly caused their injuries

With regard to Enhance Health's and TrueCoverage's switching and twisting conduct in particular, the Amended Complaint connects that conduct to the specific injuries suffered by each Plaintiff:

<u>Veronica King</u>. Enhance Health, TrueCoverage and their downlines directly switched King's insurance policy at least six times without her knowledge. (Am. Compl. ¶¶ 333-43). Two of those switches were made directly by Enhance Health itself. (*Id.* ¶¶ 338, 342). The Amended Complaint describes each of these switches by date, agent and

company. (*Id.* ¶¶ 333-43). Each switch was accomplished using the wires. (*Id.* ¶ 407). King incurred out-of-pocket costs rectifying the switches. (*Id.* ¶ 344).

Paula Langley. Enhance Health, TrueCoverage and their downlines directly switched Langley's insurance policy at least 22 times without her knowledge. (Am. Compl. ¶¶ 351-53). The Amended Complaint describes six examples of these switches by date, agent and company. (*Id.* ¶ 352). The remaining switches are described in Exhibit 1 of the Amended Complaint. (*Id.* ¶ 353). Defendant Enhance Health made at least one of those switches directly. (*Id.* ¶ 352(c)). Each switch was accomplished using the wires. (*Id.* ¶ 407).[4] Langley suffered thousands of dollars in unpaid medical expenses as a result. (*Id.* ¶ 353).

Tiesha Foreman. A TrueCoverage agent directly switched Mrs. Foreman's policy without her consent on October 17, 2023. (*Id.* ¶ 361). The switch was accomplished using the wires. (*Id.* ¶ 407).[5] As a result Mrs. Foreman suffered unpaid medical expenses and uncovered medications, as well as monetary damages for time spent rectifying the switches. (*Id.* ¶ 369).

Mrs. Foreman also suffered tax-related damages. In February 2023, another TrueCoverage agent enrolled her husband (but not Mrs. Foreman or their child) into a Cigna plan without Mr. Foreman's agreement. (*Id.* ¶ 358). TrueCoverage underreported the Foremans' household income. (*Id.*). As a *direct* result, Mrs. Foreman (and Mr. Foreman) suffered a tax penalty. (*Id.* ¶ 359).

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[4] To the extent Paula Langley's allegations rely on the cash card ad seen by her husband, those allegations are a separate basis for liability than her switching allegations. To the extent Mrs. Langley seeks to pursue that basis, her husband can be added as a plaintiff.

[5] To the extent Mr. Foreman suffered the same damage, he can be added as a plaintiff if necessary.

Conswallo Turner. Turner saw a misleading cash card ad on Facebook. (*Id.* ¶ 371). She provided her PII and she was switched five times, including directly by Enhance Health through agent Daniel Pojoga. (*Id.*). As a result, she suffered uncovered medical payments for her son Joshua, as well as higher deductibles and co-pays. (*Id.* ¶¶ 370-72).

Angelina Wells. TrueCoverage directly switched Wells' insurance policy at least twice without her knowledge. (*Id.* ¶¶ 377, 380). Both switches were accomplished using the wires. (*Id.* ¶ 407). The second was confirmed through the wires, via text message. (*Id.* ¶ 380). Wells suffered out-of-pocket costs rectifying the switches. (*Id.* ¶ 383).

Thus, three Consumer Plaintiffs (King, Langley, Turner) allege that Enhance Health directly switched their policies without knowledge or consent, causing injury. The other two Consumer Plaintiffs (Foreman, Wells) allege they were directly switched by TrueCoverage. The switches were accomplished via wires: electronic switches in the Marketplace database. Each of the Consumer Plaintiffs alleges damages as a result. Each therefore alleges proximate causation relating to the switching practices alleged in the Amended Complaint.

In addition, Turner alleges that she saw the cash card ad and provided her PII as a result. She does not, because without discovery she cannot, specifically allege that the ad was placed by Minerva. But the Amended Complaint is replete with allegations that Minerva was the first and largest user of leads generated by false cash card ads. (*Id.* ¶¶ 193-95). More importantly, Plaintiffs allege that Enhance Health — which used Turner's PII and switched her in December 2023 — used Minerva "exclusively." (*Id.* ¶ 220). These allegations establish a plausible and direct connection between Minerva's conduct and Enhance Health's.

b. Agent Plaintiffs adequately plead that Defendants' conduct directly caused their injuries

Like the Consumer Plaintiffs, the Agent Plaintiffs adequately allege that Defendants' conduct caused them to suffer injury. Very simply, Defendants' agents went into the Marketplace system and removed NavaQuote's and WINN's principals as agents of record on insurance policies that NavaQuote and WINN originated. (*Id.* ¶¶ 387, 397). These "AOR Swaps" directly and immediately resulted in the loss of commission income. (*Id.* ¶¶ 387, 391, 397, 402-03).

The Amended Complaint provides examples of this. Enhance Health replaced NavaQuote's agent of record for Turner. (*Id.* ¶¶ 390). TrueCoverage did the same for Wells. (*Id.*). WINN's principal (Broyer) has been removed from more than 100 policies, and WINN's investigation revealed that "TrueCoverage and Enhance Health's agents are among the biggest offenders." (*Id.* ¶ 398). Enhance Health directly switched WINN clients King and Langley. (*Id.* ¶¶ 335, 338, 352).

These AOR Swaps could not be more directly leveled at the Agent Plaintiffs, who allege that TrueCoverage, Enhance Health and their downlines literally went into the Marketplace to *remove Agent Plaintiffs* from policies and *replace Agent Plaintiffs' principals* as AOR. This is the scheme's purpose or "payoff": to obtain policies, generate commissions and expand market share.

For this reason also, Agent Plaintiffs' claims are not derivative of Consumer Plaintiffs' claims. AOR Swaps harm agents, like NavaQuote, by causing them to lose policy commissions and incur out-of-pocket expenses to rectify the change in AOR. An AOR Swap does not change a consumer's policy, and so does not necessarily harm the consumer. Rather, consumers like Turner are harmed by Twisting: their policy is changed without their knowledge, causing them to incur unpaid medical expenses (and/or their own out-of-pocket expenses to rectify the change). Thus, there is no potential for a "double recovery" here. Agents' and consumers' damages are

distinct and separately calculable. Indeed, an alleged RICO scheme need *not* have only one intended target. *See, e.g.*, *Bivens Gardens Office Bldg., Inc. v. Barnett Banks of Fla., Inc.*, 140 F.3d 898, 908 (11th Cir. 1998) (finding that defendants' conduct affected plaintiff, who was also shareholder of victim corporation, differently than it affected the corporation); *Feld Entm't Inc. v. Am. Soc. for the Prevention of Cruelty to Animals*, 873 F. Supp. 2d 288, 312 (D.D.C. 2012) (denying dismissal of complaint that alleged multiple victims of multiple related schemes). Here, the scheme has more than one target. It targets the Consumer Plaintiffs' PII and insurance policies. It targets the Agent Plaintiffs for the commissions on those policies.

In an attempt to undermine Agent Plaintiffs' claims in particular, Defendants cite *Anza v. Ideal Steel Supply Corp.*, 547 U.S. 451, 457-58 (2006), claiming that it establishes a general principle that RICO claims brought by competitors are too complex to determine proximate causation. (Jt. Mot. to Dismiss at 22). *Anza* is entirely distinguishable. In *Anza* the defendant steel suppliers failed to pay taxes and passed on the savings from those unpaid taxes to their customers. *Id.* A competitor sued, claiming that the scheme had unfairly wrested away market share. *Id.* The U.S. Supreme Court affirmed the case's dismissal, holding that the taxing authority, New York City, was the direct victim of the scheme. *Id.* at 458. The Court also noted the remoteness between the plaintiff competitor's loss of market share to the defendants' failure to pay taxes. *Id.*

Here, again, the link between the conduct by Defendants like Enhance Health and TrueCoverage (using the wires by going into the Marketplace database and removing Agent Plaintiffs as AORs on insurance policies) and Agent Plaintiffs' injury (loss of commissions and out-of-pocket damages) is direct. As soon as Defendants make the switch, Agent Plaintiffs lose

any commissions from that policy. Unlike *Anza*, here there are no other causation factors to consider.[6]

In sum, both the Consumer Plaintiffs and Agent Plaintiffs have alleged in significant detail Defendants' complex and sophisticated fraudulent scheme and how it directly harmed them. In doing so, Plaintiffs adequately allege that the RICO violations were "a substantial factor" in the sequence of proximate causation. Furthermore, the Consumer Plaintiffs and Agent Plaintiffs bring allegations showing they are "immediate victims" of the fraudulent scheme, and that they suffered significant sperate and distinct injuries.

2. Plaintiffs have statutory standing to pursue their RICO claims

RICO's civil-suit provision states that "[a]ny person injured in his business or property by reason of" RICO's substantive provisions has the right to "recover threefold the damages he sustains . . . . ." 18 U.S.C. § 1964(c); *Sedima, S.P.R.L. v. Imrex Co.,* 473 U.S. 479, 496 (1985). The terms "property" and "business" are not defined in the RICO Act, but courts have consistently held that the RICO Act is to be "liberally construed." *Sedima,* 473 U.S. at 497-98; *Williams v. Mohawk Indus., Inc*., 465 F.3d 1277, 1286 (11th Cir. 2006). At the pleading stage of a case, "general factual allegations of injury" suffice provided they plausibly and clearly allege a concrete injury. *Muransky v. Godiva Chocolatier, Inc.*, 979 F.3d 917, 924 (11th Cir. 2020) (quoting *Lujan v. Defenders of Wildlife,* 504 U.S. 555, 561 (1992)); *see also See Nat'l Org. for Women, Inc. v. Scheidler*, 510 U.S. 249, 256 (1994).

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[6] Defendants' inference "that the Agents could have lost consumers purely due to standard market competition" (Jt. Mot. to Dismiss at 23) ignores the direct cause and effect of Defendants' AOR Swaps. More importantly for purposes of this motion, it is speculative and goes beyond the four corners of the Amended Complaint.

a. Consumer Plaintiffs adequately allege injuries to their property

Consumer Plaintiffs allege injuries to their "property." "'[P]roperty' has a naturally broad and inclusive meaning. In its dictionary definitions and in common usage 'property' comprehends anything of material value owned or possessed," even if it is of no commercial significance. *Reiter v. Sonotone Corp.*, 442 U.S. 330, 338 (1979) (interpreting "business or property" in Section 4 of the Clayton Act); *see Holmes v. Sec. Inv. Prot. Corp.*, 503 U.S. 258, 267 (1992) ("Congress modeled § 1964(c) on . . . § 4 of the Clayton Act"). Loss or payment of money is a form of injury to property under RICO. *In re Managed Care Litig.*, 150 F. Supp. 2d 1330, 1338-39 (S.D. Fla. 2001) (citing *Reiter v. Sonotone Corp.,* 442 U.S. 330, 338 (1979)). "A person whose property is diminished by a payment of money wrongfully induced is injured in his property." *Reiter*, 442 U.S. at 340.

Each Class Plaintiff alleges that she suffered monetary damages. Langley alleges that she incurred thousands of dollars in uncovered medical bills and the costs of going to the doctor without insurance. (Am. Compl. ¶ 353). Turner similarly alleges that she suffered monetary damages in the form of uncovered medical payments for her son Joshua, as well as higher deductibles and co-pays. (*Id.* ¶ 372). Foreman alleges that on multiple occasions, TrueCoverage underreported her family's household income in the federal CMS health insurance application, resulting in the Foremans suffering tax penalties, unpaid medical expenses and uncovered medications. (*Id.* ¶¶ 356-69). Turner and King suffered incurred "expenses" and "costs" trying to correct the problems caused by the unlawful conduct. (*Id.* ¶¶ 344, 372). Wells alleges that she suffered uncovered costs for prescription medication as a result of the fraudulent scheme. (*Id.* ¶ 383). These allegations, standing alone, support Consumer Plaintiffs' statutory standing.

Because health insurance is property,[7] Consumer Plaintiffs can also demonstrate RICO standing by alleging that a fraudulent scheme reduces the value of their health insurance coverage. Consumer Plaintiffs allege that by manipulating their health insurance applications by cancelling or altering (ie., "Twisting") their health insurance without valid consent, Defendants diminished the value of Plaintiffs' existing health insurance applications and coverage. For example, in the case of a cancellation, the value of Plaintiffs' policies drops to zero. Plaintiffs King and Langley allege that their health insurance was canceled as a result of Defendants' fraudulent scheme. (*Id.* ¶¶ 335-43, 348-50). Plaintiff Turner's plan was also cancelled, resulting in a loss of coverage. (*Id.* ¶¶ 371-72). The same holds true for Plaintiffs Wells (*id.* ¶¶ 378-79) and Foreman (*id.* ¶¶ 365-69, 383). The same rationale applies to Defendants' alteration or Twisting of Consumer Plaintiffs' health insurance applications and data in the Marketplace database. Defendants caused the data to contain incorrect information, diminishing the value of Plaintiffs' data, applications and coverage.

b. Agent Plaintiffs adequately allege injuries to their business

Agent Plaintiffs also incurred injury: to their businesses. Lost profits are a recognized business injury for purposes of RICO standing. *See Maiz v. Virani*, 253 F.3d 641, 662 (11th Cir. 2001) (citing *Terminate Control Corp. v. Horowitz*, 28 F.3d 1335, 1343 (2d Cir. 1994)); *BCS Servs., Inc. v. BG Invs., Inc.*, 728 F.3d 633, 638 (7th Cir. 2013) ("The plaintiffs were deprived of the profit they would have made had the fraud not prevented them from being awarded as many tax liens as they would have been awarded otherwise.").[8]

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[7] *Berg v. First State Ins.,* 915 F.2d 460 (9th Cir. 1990) (recognizing that insurance policies are property for the purposes of RICO standing).

[8] "Lost value damages," which measures the amount a plaintiff would have earned if money that the defendant obtained through fraud had been invested, is another recognized business injury. *See Maiz*, 253 F.3d at 662 (affirming district court's ruling permitting expert economist to testify as to what plaintiffs would have earned if the amounts they had been defrauded had been invested in a real estate investment trust).

Here, Agent Plaintiff Navaquote alleges that it expended significant resources to market its services online and maintain an online presence, including its website. (Am. Compl. ¶ 386). The agency's revenue, and by extension its profits, relies on the generation of commissions from the sale of ACA health plans. (*Id.*). When NavaQuote sells an insurance policy through the Marketplace, Callie Navrides becomes listed as AOR and NavaQuote receives a monthly commission. (*Id.*). NavaQuote enrolled approximately 50 consumers into ACA health plans, but lost 23 to AOR Swaps. (*Id.* ¶ 387). By replacing Navrides as AOR, the swapping agents received the monthly commissions that Navaquote would have otherwise received. (*Id.*). Those lost commissions result in lost business revenue, which results in lost profits.

The same holds true for Agent Plaintiff WINN Insurance Agency. The agency's revenue, and by extension its profits, relies on the generation of commissions from the sale of insurance policies. (*Id.* ¶ 396). When WINN sells an insurance policy through the Marketplace, Broyer becomes listed as AOR and receives a monthly sales commission of approximately $30 per month per member for each application. (*Id.*). For a family of four on a single application, WINN receives $1,440/year for that policy ($30 x 4 = $120 for 12 months). (*Id.*). Broyer has been removed as AOR on her clients' policies more than 100 times and replaced by agents that have no relationship to her. (*Id.* ¶ 397). More than 20 of those clients have been lost for good. (*Id.*). Through Broyer's investigation, WINN has determined that TrueCoverage and Enhance Health's agents are among the biggest offenders. (*Id.* ¶ 398).

Out-of-pocket expenses and damages flowing from RICO violations such as fraudulent reimbursement denials or reductions, improper requests for refunds, administrative costs associated with handling continual payment disputes and monetary losses flowing from extortionate acts have also been deemed injuries to a business and property for the purposes of

RICO standing. *In re Managed Care Litig.*, 135 F. Supp. 2d 1253 (S.D. Fla. 2001).[9] Here, Navaquote alleges that each time a client is poached, Navrides must spend significant time and expenses to reestablish her position as AOR. (Am. Compl. ¶ 388). Through its investigation, which has been difficult, laborious and costly not only in terms of lost time that could have been used to help more clients and generate more commissions but also in terms of out-of-pocket costs expended through these efforts, NavaQuote has determined that TrueCoverage and Enhance Health agents are among the biggest offenders. (*Id.* ¶ 389). Moreover, Navaquote was forced to spend money purchasing additional leads to replace lost clients. (*Id.* ¶ 391). Similarly, Broyer has incurred out-of-pocket costs relating to the time spent to investigate and address the problem, and for extra expenses associated with buying additional leads to replace lost clients. (*Id.* ¶¶ 402-03).

In sum, Consumer Plaintiffs and Agent Plaintiffs have adequately alleged injury to their property and/or business for the purposes of RICO standing.

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[9] There are many more examples illustrating the broad categories of damages that have been deemed recoverable under RICO in the health insurance context. *See e.g.*, *Iron Workers Local Union No. 17 Ins. Fund v. Philip Morris Inc.,* 23 F.Supp.2d 771, 786 (N.D. Ohio 1998) ("Having found that proving the plaintiffs' damages flowed from defendants' RICO violation is not unduly difficult, and having found there is little risk of double recovery for defendants' purported RICO violations, and having found that, if proven, defendants conduct is sufficiently injurious to warrant deterrence, the factors described in *Holmes* suggest this Court not dismiss plaintiffs RICO counts on standing or proximate cause grounds."); *Ky. Laborers Dist. Council Health & Welfare Trust Fund v. Hill & Knowlton, Inc.,* 24 F.Supp. 2d 755, 770 (W.D. Ky. 1998) (finding RICO standing for allegations that defendants' misrepresentations "prevented the Funds from pursuing proactive measures such as smoking cessation programs and other educational efforts to reduce smoking among the Participants"); *N.J. Carpenters Health Fund v. Philip Morris, Inc.,* 17 F. Supp. 2d 324, 332 (D.N.J. 1998) (RICO standing for allegations "premised upon fraud aimed directly at the Funds"); *Laborers Local 17 Health & Benefit Fund v. Philip Morris, Inc.,* 7 F. Supp. 2d 277, 285 (S.D.N.Y. 1998) (RICO standing for allegations "based on the harm to plaintiffs' infrastructure and financial stability caused by defendants' alleged attempts to deceive the plaintiffs").

3. Plaintiffs' allegations describe a RICO enterprise

As prefaced above, RICO is a broad statute. *Boyle v. U.S.*, 556 U.S. 938, 944 (2009). [I]ts terms are to be 'liberally construed to effectuate its remedial purposes.'" *Id.* (quoting Pub. L. No. § 904(a), 84 Stat. 922, 947 (1970)). RICO's breadth is exemplified in its language regarding the "enterprise": RICO makes it "unlawful for any person employed by or associated with *any enterprise* engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity . . . ." *Al-Rayes v. Willingham*, 914 F.3d 1302, 1307 (11th Cir. 2019) (reversing summary judgment awarded to defendants on RICO claims) (emphasis in original) (quoting 18 U.S.C. § 1962(c)).

"Enterprise" is defined to include "*any* union or group of individuals associated in fact although not a legal entity." 18 U.S.C. § 1961(4). "As the Supreme Court has emphasized, the term 'any' ensures that the definition [of an 'enterprise'] has a wide reach, and the very concept of an association in fact is expansive." *Al-Rayes*, 914 F.3d at 1307 (quoting *Boyle*, 556 U.S. at 944)). An "association in fact" requires, in turn, allegations of three structural features, one of which requires that the plaintiff allege that there are "relationships among those associated with the enterprise." *Id*. (quoting *Almanza v. United Airlines, Inc.*, 851 F.3d 1060, 1068 (11th Cir. 2017)).

It is this slice of the definition of "enterprise" that Defendants attack. (Jt. Mot. to Dismiss at 25-26). They argue that Plaintiffs fail to allege any agreement between Defendants sufficient to establish a relationship among them. (*Id.*). Defendants argue that Plaintiffs describe only self-interested, ad hoc, parallel business conduct. (*Id.*).

Defendants ignore Plaintiffs' extensive allegations describing the relationships among the various Defendants. For instance, Enhance Health became TrueCoverage's largest downline

agency, kicking up portions of its commissions generated from enrollments derived from Minerva's fraudulently derived leads. (Am. Compl. ¶¶ 24, 218-19). With knowledge of Enhance Health's use of fraudulent leads and switching, TrueCoverage provided Enhance Health with financing and training. (*Id.* ¶ 24, 26). Both TrueCoverage (*id.* ¶¶ 17, 259-63) and Enhance Health implemented a vague script (*id.* ¶¶ 26, 253, 264-73). According to Harrison of TrueCoverage, these scripts were alike, suggesting coordination between upline and downline. (*Id.* ¶ 264). Both TrueCoverage (upline) and Enhance Health (downline) engaged in mass switching without consumers' knowledge (*id.* ¶¶ 274-80, 284-85) and enrolled unqualified consumers (*id.* ¶¶ 18-19, 29). And they were directly connected by this endeavor: for every commission Enhance Health made through these enrollments, its upline, TrueCoverage, earned a portion of that commission. (*Id.* ¶ 29).

In turn, Enhance Health and TrueCoverage expanded these practices through a network of downlines. Enhance Health and TrueCoverage recruited, financed and trained downlines like Defendants NHA and Protect Health. (*Id.* ¶ 406(c), (h)). They provided them with scripts and monitored their fraudulent marketing and sales activities. (*Id.* ¶¶ 244-47, 251-57, 406(c), (h)). As further example of shared conduct, TrueCoverage, Speridian and Panicker gave Enhance Health and its downlines access to the BenefitAlign platform, which allowed for high-volume enrollment. (*Id.* ¶ 219).

For its part, Minerva provided leads that it — and TrueCoverage and Enhance Health[10] — knew came from fraudulent cash card ads. (*Id.* ¶¶ 11-14, 17). Minerva showed Enhance Health

[10] Enhance Health and TrueCoverage argue that Plaintiffs' "conclusory allegations show that, at most, TrueCoverage and Enhance Health knew callers may have seen ads that referenced cash cards." (Jt. Mot. to Dismiss at 28). This ignores Plaintiffs' allegations that consumers were inundating the agencies with complaints about not receiving the cash cards. (Am. Compl. ¶ 317). The cash card callers were so pervasive that agents themselves began to feel uncomfortable

and TrueCoverage how to "handle" these dirty leads: don't mention the cash cards to customers, and if they ask, be vague. (*Id.* ¶¶ 14, 16, 191). Bowsky acknowledged that "Everyone in the space I taught how to do it." (*Id.* ¶¶ 33, 179). Bowsky told Herman about the false ads and misleading scripts. (*Id.* ¶ 23). Panicker, Goldfuss and Herman knew about the switching and Twisting, and promoted it. (*Id.* ¶ 291). Herman called it "shooting fish in a barrel." (*Id.* ¶ 29). Bowsky and Minerva also knew about this conduct and promoted it by selling more leads. (*Id.* ¶ 293). Bain Insurance provided Enhance Health with $150 million in capital, with knowledge of what Enhance Health was doing, including knowledge of the fact that Enhance Health fell within a larger group that included an upline (TrueCoverage) and downlines (like NHA). (*Id.* ¶¶ 292, 301-02). Bain Insurance also knew that Enhance Health had an exclusive lead-purchasing agreement with Minerva, and that Minerva was generating leads from fraudulent cash card ads. (*Id.* ¶ 301).

Thus, Defendants' attempt to couch Plaintiffs' allegations as simply describing a parallel group of commercial actors completely ignores Defendants' continuous interaction and interrelatedness in a context where *everyone knew what was going on*. (*See, e.g.*, *id.* ¶¶ 17, 193-94, 223-43, 248-50). And it ignores the very heart of what Plaintiffs allege Defendants were doing: not simply attempting to make an honest buck, but "*artificially* and exponentially grow[ing] the newly developing, year-round industry for low-income ACA health insurance, *and [using] fraudulent means* to exploit and capture as much of that industry as possible, as quickly as possible, for monetary gain." (*Id.* ¶ 405 (emphasis added)). Thus, Plaintiffs' allegations describe conduct among the Defendants that plausibly supports the existence of "relationships among those

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misleading consumers. (*Id.* ¶¶ 226, 243, 247). Defendants' argument also ignores the pages and pages of online reviews by consumers complaining about the scheme. (*Id.* ¶ 317).

associated with the enterprise" that go far beyond just a bunch of companies and individuals working in the same industry.

Indeed, Plaintiffs' allegations of Defendants' relatedness extend far beyond those presented by the plaintiffs in the two principal cases cited by Defendants, *American Dental* and *Almanza*. The operative complaint in *American Dental* provided no details of a fraud upon which the court could even infer an agreement to defraud that took the defendant health care companies' alleged conduct — the automatic downcoding of dentists' invoices — beyond "parallel conduct." *See Am. Dental Ass'n v. Cigna Corp.*, 605 F.3d 1283, 1293 (11th Cir. 2010). Here, by contrast, Plaintiffs allege both the fraudulent conduct and its purpose: to employ fraudulent advertising and switching and twisting tactics to artificially grow the low-income ACA health insurance enrollment industry for monetary gain. And as described in the preceding paragraphs, Plaintiffs allege shared conduct that goes far beyond allegations of a group of agencies doing something bad separately but at the same time.

Almanza also is distinguishable. After noting that "[p]roving sufficient relationships for an associated-in-fact enterprise is not a particularly demanding task," the court in *Almanza* nonetheless ruled that plaintiffs had alleged only parallel conduct and no agreement about a common purpose. *Almanza*, 851 F.3d at 1068. The plaintiffs alleged that a group of Mexican tourism companies constituted an enterprise because each collected a tourism tax from exempt travelers. *See id.* at 1068. The plaintiffs alleged that because the companies were members of the same tourism association, they must have coordinated, even though the association itself prohibited the collection of a tourism tax from exempt travelers. *Id.* Here, unlike *Almanza*, money, services and information flowed *between* Defendants at the core of the enterprise: between the agencies and Minerva, between the uplines and downlines and between the agencies and

technology companies. Unlike the *Almanza* defendants, which did the same bad thing but independently, Defendants here interacted and worked together through shared conduct.

While Defendants attempt to cast their business relationships as ordinary and legitimate, Plaintiffs' detailed allegations of shared and coordinated misconduct demonstrate otherwise. Plaintiffs allege that all Defendants, from Minerva to TrueCoverage, its downlines (including Enhance Health) and Enhance Health's downlines (including NHA) knew about and profited from the use of fraudulent advertisements that falsely promised cash to consumers. All Defendants also knew of, participated in and profited from AOR Swaps, Twisting and Dual-Apping.

Indeed, Plaintiffs' alleged enterprise bears similarity to the enterprise alleged in *In re Managed Care Litigation*. *See* 298 F. Supp. 2d 1259, 1275 (S.D. Fla. 2003) (Moreno, J.). That case involved a sweeping enterprise of companies operating within the nation's health care system. *Id.* at 1273. The court held that despite the size and scope of the alleged enterprise, the plaintiffs had adequately described each entity's role in it, and the fact that "[t]he maintenance of this organized system requires an ongoing enterprise":

> *Every individual entity plays a role in the enterprise equation*: each Defendant and their subsidiaries throughout the country; other health insurance companies not expressly named; third party entities that develop claims processing systems or components; third party entities which promulgate patient care guidelines; third party entities that Defendants hire to review and wrongfully deny claims; trade associations; and a health industry database, MedUnite. *The maintenance of this organized system requires an ongoing enterprise.* Accordingly, the Plaintiffs have set out to the Court's satisfaction the associational links comprising the Managed Care Enterprise and the Court therefore finds that Plaintiffs have sufficiently alleged an enterprise for purposes of RICO.

Id. at 1275-76 (emphasis added).

Despite Defendants' argument to the contrary (Jt. Mot. to Dismiss at 27), Plaintiffs also allege a common purpose: to artificially grow and exploit a burgeoning market by fraudulent means. (Am. Compl. ¶ 405). "[T]he common purpose of making money [is] sufficient under

RICO." *See Williams v. Mohawk Indus., Inc.*, 465 F.3d 1277, 1284 (11th Cir. 2006)[11] (citing *U.S. v. Church*, 955 F.2d 688, 698 (11th Cir. 1992)). This is particularly so when the method of achieving that purpose is neither lawful, legitimate nor traditionally commercial. *See, e.g.*, *In re Nat'l Prescription Opiate Litig.*, MDL No. 2804, 2019 WL 4279233, at *2 (N.D. Ohio Sept. 10, 2019) (denying summary judgment of RICO claims).

As for Herman, who claims the allegations against him "are particularly tenuous" (Jt. Mot. to Dismiss at 29), he completely downplays or ignores those allegations that describe his role and place him within the center of the enterprise. Herman was the first at Enhance Health to learn about the efficacy of the fraudulent leads and misleading enrollment techniques from his friends and former colleagues Barachy Lucien and Brandon Bowsky. (Am. Compl. ¶¶ 215-16, 220). He reached out to TrueCoverage and came to an agreement making Enhance Health a downline. (*Id.* ¶ 218). Then he created Enhance Health's own network of downline entities run by *his* friends, family and former associates. (*Id.* ¶ 219). He monitored those downlines' sales efforts closely. (*Id.* ¶ 255). And he promoted Enhance Health's mass Twisting efforts, telling one agent that the swaps were "like shooting fish in a barrel." (*Id.* ¶¶ 276-77). Plaintiffs' allegations place Herman within nearly every aspect of the scheme, interacting with others within the alleged enterprise.

Speridian and Benefitalign are also sufficiently associated with the enterprise. They agreed to allow the other Defendants to use their platforms *with knowledge* (independently and/or through its owner Panicker) of Defendants' use of those platforms to swap and twist consumer policies. (*Id.* ¶¶ 58, 198, 223, 225, 696, 704). That agreement easily meets the standard.

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[11] Abrogated on other grounds as recognized in *Simpson*, 744 F.3d at 714-15.

Similarly, Minerva and Bowsky agreed to sell the other Defendants leads *with knowledge* of Defendants' use of those leads to enroll consumers on the basis of a fraudulent cash card, and to swap and Twist consumers' policies. (*Id.* ¶¶ 11-14, 293).

Finally, Defendants' argument that Plaintiffs' allegations of switching and Twisting activities show parallel conduct to the extent Defendants were stealing each other's policies (Jt. Mot. to Dismiss at 30-31) ignores the structure of the alleged enterprise. The upline/downline nature of the agencies in the enterprise ensured that switching among them, if any, was net neutral. The real harm was felt by consumers and agents.

4. <u>Plaintiffs allege participation in the enterprise's operation or management</u>

In addition to alleging the enterprise, Plaintiffs adequately allege Defendants' participation in the operation or management of that enterprise. To meet this standard, Plaintiffs need not allege that each Defendant captains the proverbial ship or exerts "significant control." *See Reves v. Ernst & Young*, 507 U.S. 170, 179 n.4 (1993). RICO liability is *not* limited to those with primary responsibility for the enterprise's affairs." *Williams*, 465 F.3d at 1285 (quoting *Reves,* 507 U.S. at 179). Rather, Plaintiffs need only allege that each Defendant plays "some part in directing" the affairs of the enterprise. *Id.* This includes actions by lower-level employees acting "under the direction of upper management." *U.S. v. Browne*, 505 F.3d 1229, 1277 (11th Cir. 2007).

This test — whether the defendant has "some part in directing" the enterprise — is "easy to apply." *Reves*, 507 U.S. at 179. In *Williams*, the Eleventh Circuit held that plaintiff's allegations that the defendant manufacturer paid a fee to recruiters within the enterprise to recruit illegal workers met the standard. 465 F.3d at 1284-85 (affirming district court's denial of motion to dismiss RICO claims). And in *In re Managed Care Litigation*, this court held that the operation or management test was met where the complaint alleged that a group of healthcare companies

developed guidelines and standards for denying insurance claims, hired others to create automated systems to manipulate data, and created software used as an entry point in the scheme. 298 F. Supp. 2d at 1277 (Moreno, J.) (denying motion to dismiss RICO claims).

Similarly here, Defendants each took some part in directing the enterprise. TrueCoverage directed Enhance Health and other downlines by training their agents and financing the insurance policies Enhance Health brought by advancing commissions or purchasing policies in "heap deals." (Am. Compl. ¶¶ 24, 218-19, ¶¶ 244-47, 406(c)). It created the downline structure of entities that expanded the size of the enterprise. (*Id.* ¶ 406(c)). It recruited agents for those downlines, including Protect Health. (*Id.*). TrueCoverage facilitated the downlines' ability to enroll consumers through field market organizations (FMOs) that connected the downlines to major insurance companies. (*Id.*). It facilitated Enhance Health's and the other downlines' use of Benefitalign and Inshura, thus providing crucial access to the Healthcare Marketplace. (*Id.*). It created and provided fraudulent scripts to downlines. (*Id.*). It accounted for, audited and distributed commissions to its downlines generated by swapping and Twisting conduct. (*Id.*). It directed downlines to purchase leads from Minerva. (*Id.*). And TrueCoverage produced its own fraudulent advertising and leads from overseas. (*Id.*).

Speridian created, provided, directed, managed and maintained the technology platforms used by Enhance Health and TrueCoverage's downlines. (*Id.* ¶ 406(d)). It also paid the salaries of TrueCoverage agents who were using the misleading scripts, swapping and Twisting. (*Id.*).

BenefitAlign also created, provided, directed, managed and maintained the EDE platform used by Enhance Health and TrueCoverage's downlines. (*Id.* ¶ 406(e)).

Panicker, as president and owner of TrueCoverage, Speridian and Benefitalign, directed the conduct of those entities, as well as the creation of the downline network that included Enhance Health. (*Id.* ¶ 406(f)).

Goldfuss, whether on his own or at the direction of Panicker and TrueCoverage, managed and directed the fraudulent marketing and sales efforts of TrueCoverage's downlines, including Protect Health. (*Id.* ¶ 406(g)). He directed the use of leads generated by fraudulent ads. (*Id.*).

Enhance Health, as TrueCoverage's largest downline, directed the fraudulent enrollment efforts that generated commissions for TrueCoverage. Enhance Health also directed its own downlines: recruiting, financing and training them to conduct fraudulent marketing and sales activities. (*Id.* ¶¶ 251-57, 406(h)). Enhance Health directed its downlines' purchases of Minerva's leads. (*Id.* ¶ 406(h)). It facilitated the downlines' ability to enroll consumers through FMOs that connected the downlines to major insurance companies. (*Id.*). It directed and monitored the downlines' activities. (*Id.*). It created and provided fraudulent scripts to downlines. (*Id.*). It accounted for, audited and distributed commissions to its downlines generated by swapping and Twisting conduct. (*Id.*).

Herman as CEO, member and shareholder of Enhance Health, directed the conduct of those entities, as well as the creation of the downline network that included Enhance Health. (*Id.* ¶ 406(f)). He reached out to TrueCoverage and came to an agreement making Enhance Health a downline. (*Id.* ¶ 218). Then he created Enhance Health's own network of downline entities run by *his* friends, family and former associates. (*Id.* ¶ 219). He monitored those downlines' sales efforts closely. (*Id.* ¶ 255). And he promoted Enhance Health's mass Twisting efforts, telling one agent that the swaps were "like shooting fish in a barrel." (*Id.* ¶¶ 29, 276-77, 291).

Bain Insurance directed in part the capitalization of the enterprise, providing Enhance Health with $150 million to operate and grow Enhance Health and its downlines. (*Id.* ¶¶ 406(j)). It directed all aspects of Enhance Health's business, including sales, marketing and customer service functions. (*Id.*).

Minerva directed the aggregation and provision of leads to the enterprise. (*Id.* ¶¶ 406(b)). It created and purchased advertisements used to generate those leads. (*Id.*). Using specialized software, it directed consumers to TrueCoverage, Enhance Health and their downlines. (*Id.*). It helped direct those agencies' customer service functions by directing the recordation and storage of consumer calls. (*Id.*).

Bowsky conceived of an industry derived from leads generated by fraudulent ads, then promoted and helped direct the creation of lead-buying agencies that comprised the enterprise. (*Id.*). Bowsky instructed Enhance Health and TrueCoverage how to work around consumers' inquiries about the cash cards. (*Id.* ¶¶ 14, 16, 191). He "taught [them] how to do it." (*Id.* ¶¶ 33, 179). As Minerva's sole owner, he directed its conduct. (*Id.* ¶¶ 406(a)).

These allegations adequately describe how each RICO Defendant directed the *enterprise's* affairs. And they further show Defendants' shared conduct and interaction with the other Defendants and nonparty downlines comprising the enterprise. These allegations do not describe parallel conduct. Rather, they provide examples of each Defendant directing at least some aspect of the *enterprise's* affairs.

5. Plaintiffs allege with particularity two predicate acts of racketeering

Defendants argue at the outset that Plaintiffs must "allege that *each individual defendant* committed two predicate acts." (Jt. Mot. to Dismiss at 32). Neither of the cases cited by Defendants stands for this proposition. *See Am. Dental Ass'n v. Cigna Corp.,* 605 F.3d 1283, 1290-

91 (11th Cir. 2010); *Ambrosia Coal & Constr. Co. v. Pages Morales*, 482 F.3d 1309, 1317 (11th Cir. 2007). To the contrary, all that is required is that "*a* defendant agreed personally to commit two predicate acts." *Church*, 955 F.2d at 694. A defendant "need not have performed every key act herself." *U.S. v. Maxwell*, 920 F.2d 1028, 1036 (D.C. Cir. 1990). The "evidence need only show that defendant was a 'knowing and active participant' in a scheme to defraud and that scheme involved interstate wire communications." *Id.* (quoting *U.S. v. Wiehoff*, 748 F.2d 1158, 1161 (7th Cir. 1984)).

As summarized below, the predicate acts and their relation to each Plaintiff are pled with particularity. The elements of mail and wire fraud include the intentional participation in a scheme to defraud and the use of the interstate mails or wires in furtherance of that scheme. *U.S. v. Maxwell*, 579 F.3d 1282, 1299 (11th Cir. 2009). A scheme to defraud, in turn, requires proof of a material misrepresentation, or the omission or concealment of a material fact, calculated to deceive another out of money or property. *Id.* While the scheme to defraud must involve misrepresentations and omissions, wires and mails used in the furtherance of the scheme need not contain misrepresentations or omissions. *U.S. v. Hasson*, 333 F.3d 1264, 1272-73 (11th Cir. 2003) ("To violate the wire fraud statute, it is not necessary that the transmitted information include any misrepresentation."). Indeed, a mailing or wire may be merely "incident to an essential part of the scheme" or "a step in [the] plot." *Schmuck v. U.S.,* 489 U.S. 705, 711 (1989).

While "allegations of date, time *or* place satisfy the Rule 9(b) requirement that the *circumstances* of the alleged fraud must be pleaded with particularity, . . . *alternative means are also available* to satisfy the rule." *See In re Managed Care Litig.*, 150 F. Supp. 2d 1330, 1347 (S.D. Fla. 2001) (emphasis added) (citing *Durham v. Bus. Mgmt. Assocs*., 847 F.2d 1505, 1512 (11th Cir. 1988)). For example, in *Colonial Penn Ins. Co. v. Value Rent-A-Car, Inc.*, alternative

means satisfied the rule where plaintiff provided a general timeframe in which the misrepresentations and omissions were made, described the scheme in detail, and provided examples of two faxes containing the alleged misrepresentations. 814 F. Supp. 1084, 1093 (S.D. Fla. 1992).

a. Plaintiffs allege the fraudulent scheme with specificity

Like the plaintiff in *Colonial Penn*, Plaintiffs here allege the scheme in detail. Plaintiffs identify the different groups of defendants and their respective roles in the scheme to defraud. Minerva, Bowsky, TrueCoverage, Panicker and Goldfuss created and/or disseminated (or caused to be created and/or disseminated) fraudulent online advertisements containing material misrepresentations falsely representing to consumers that they could receive cash benefits, such as cash cards or stimulus checks, to cover household expenses like groceries, medical bills and rent. (Am. Compl. ¶¶ 183-207). Plaintiffs also allege that Enhance Health exclusively used the leads generated by Minerva containing fraudulent advertisements. (*Id.* ¶ 220).

The Amended Complaint provides examples of the fraudulent ads and cites to multiple witness statements confirming that Minerva and TrueCoverage created and disseminated fraudulent cash card ads to generate leads. (*Id.* ¶¶ 12, 183-186). The Amended Complaint includes text messages from Bowsky himself admitting to the practice. (*Id.* ¶¶ 186, 188-191). It contains statements from former Minerva employees (*id.* ¶ 192), outside agents (*id.* ¶ 187) and former agents with TrueCoverage and Enhance Health and their downline agencies (*id.* ¶¶ 193-207, 220-222), all confirming that Defendants used and relied on false online advertisements containing material misrepresentations about the non-existent cash card to dupe consumers into responding to the advertisements.

These fraudulent advertisements, and the leads that were generated from them, were all sent over the wires. (*Id.* ¶ 407). Standing alone, they allege with sufficient particularity a "scheme to defraud" under the mail and wire fraud statutes. That is, they allege a "material misrepresentation, or the omission or concealment of a material fact calculated to deceive another out of money or property." *U.S. v. Maxwell*, 579 F.3d at 1299.

Plaintiffs' Amended Complaint describes additional examples of wire fraud: the sales calls. Plaintiffs allege that once the consumer was duped into responding to the fraudulent online advertisement, they were transferred to agents in call centers run by Defendants TrueCoverage, Enhance Health and their downlines. (Am. Compl. ¶¶ 206, 244-45, 872-74). Plaintiffs allege that Enhance Health, TrueCoverage and their downline agencies used uniform sales scripts that contained material misrepresentations and omitted material information. (*Id*. ¶¶ 258-73). Plaintiffs provide witness statements from former agents who confirmed the unlawful sales practices and provided internal emails, group chats and text messages with other agents and TrueCoverage and Enhance Health executives evidencing the fraudulent calls. (*Id*. ¶¶ 223-57) Each call between consumers and agents constitutes further support for Plaintiffs' alleged scheme to defraud under wire fraud statute.

The Amended Complaint also provides very detailed allegations about how TrueCoverage, Enhance Health and their downlines committed additional acts of the wire fraud by engaging in Twisting, Dual Apps and AOR Swaps. (*Id.* ¶¶ 274-97). Plaintiffs' allegations of Twisting, Dual-Apping and AOR Swapping are detailed, and include references to witness statements describing their first-hand observations and participation in the illegal conduct. (*Id*. ¶¶ 276-86). Importantly, TrueCoverage, Enhance Health and their downlines used the Benefitalign and Inshura EDE platforms to conduct these activities. (*Id.* ¶¶ 274). Plaintiffs allege that these Defendants used

consumers' names, dates of birth and states of residence ("PII") to gain unauthorized access to health insurance applications through the EDE platform and make changes on the consumers' applications, which as discussed *supra* Section III.A.2.a, was the property of Plaintiffs and Class Members. (*Id.* ¶ 28).[12]

These unauthorized changes to consumers' health insurance applications constitute separate instances of wire fraud. In the RICO context, Defendants are liable for misrepresentations made to third-parties such as CMS and/or the insurance carriers because direct, first-party reliance is not required to establish mail fraud and wire fraud. *See Bridge v. Phoenix Bond & Indemn. Co.,* 553 U.S. 639, 656 (2008) (reviving RICO claim where misrepresentations were made to government, not plaintiffs). Here, TrueCoverage, Enhance Health and their downlines falsely notified CMS and the carriers that consumers intended to change or cancel their existing insurance.[13] (Am. Compl. ¶¶ 28, 276). They falsely stated that consumers authorized changes of household income (*id.* ¶ 30), address (*id.* ¶ 266) or the agent of record (*see e.g., id.* ¶¶ 274, 280) in the Marketplace database. Specific examples of these misrepresentations are documented and alleged in the Amended Complaint. (*Id.* ¶¶ 276-86). Plaintiffs allege that Herman, Panicker and Goldfuss knew about the illegal practices and promoted them to agents. (*Id.* ¶ 291). One witness

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[12] The notion that the Plaintiffs' and Class Members' health insurance applications on the CMS Marketplace database constitute property of the consumer is supported by the fact that CMS regulations require web-brokers and agents to obtain valid consent from consumers before they can access their application or make any changes to the application. Web-brokers and agents are also required to submit attestations to the federal government that the change to the application is with authority and truthful and accurate. *See* https://www.cms.gov/files/document/frequently-asked-questions-consumer-consent-application-review-requirements.pdf.

[13] In the RICO context, Defendants are liable for misrepresentations made to third-parties, such as CMS and/or the insurance carriers, because direct first party reliance is not required to establish mail fraud and wire fraud. *See Bridge,* 553 U.S. at 656 ("[W]hile it may be that first-party reliance is an element of a common-law fraud claim, there is no general common-law principle holding that a fraudulent misrepresentation can cause legal injury only to those who rely on it.")

stated that Herman described the illegal switching as "shooting fish in a barrel." (*Id.* ¶ 277). A former TrueCoverage agent stated that the company gave him lists and instructed him to "switch the health plans of consumers who already had ACA plans regardless of whether it was appropriate for the consumer." (*Id.* ¶ 280).

b. Plaintiffs sufficiently allege how the predicate acts impacted them

Defendants argue that Plaintiffs fail to allege how the misrepresentations made by Defendants impacted each of them. (Jt. Mot. to Dismiss at 38-39). To the contrary, each of the Consumer Plaintiffs provides detailed examples of being switched or Twisted, and suffering monetary damages as a result. (Am. Compl. ¶¶ 330-403). Collectively they represent dozens of switches. Each switch constitutes a separate predicate act of wire fraud, which standing along satisfies Plaintiffs' requirement to allege at least two.

Moreover, Turner alleges she saw a fraudulent cash card ad on Facebook, calling the number and providing her PII, only to be switched numerous times thereafter including an unauthorized switch made by Enhance Health. (*Id.* ¶ 370-71). While she does not remember the exact date or the agent she spoke with, Turner's allegations nonetheless describe the use of the wires, and support the scheme described in the Amended Complaint.[14] Foreman additionally alleges that her healthcare application in the Marketplace database was split or "Dual-Apped" without consent. (*Id.* ¶¶ 355-57). And as for the Agent Plaintiffs, they are victims of AOR Swaps, which were perpetrated through the wires as well.

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[14] "While Defendants protest that the level of factual detail has not been reached, the pleadings are justifiably limited at this stage because Plaintiffs have not had the aid of discovery." *In re Managed Care Litig.*, 298 F. Supp. 2d 1259, 1275 (S.D. Fla. 2003).

In sum, the Amended Complaint describes the "who, what, when and where" of the fraud for each Plaintiff (*id.* ¶¶ 330-403), thus satisfying Rule 9(b)'s requirements that two predicate acts of racketeering be pled with sufficient particularity.

B. <u>Plaintiffs Adequately Plead Claims for RICO Conspiracy</u>

To state a RICO conspiracy claim under Section 1962(d), Plaintiffs must allege that Defendants "agreed to participate directly or indirectly" in the enterprise. *In re Managed Care Litig.*, 150 F. Supp. 2d 1330, 1349-50 (S.D. Fla. 2001) (quoting *U.S. v. Castro*, 89 F.3d 1443, 1451 (11th Cir. 1996)). An agreement to participate is alleged by "showing an agreement of an overall objective." *Id.* at 1350 (quoting *Church*, 955 F.2d at 694). Direct evidence is not required: the agreement may be inferred through participants' conduct. *Id.* (citing *Church*, 955 F.2d at 695). Furthermore, "a conspiracy 'may be proved by either direct or circumstantial evidence; a common scheme or plan may be inferred from the conduct of the alleged participants or from other circumstances.'" *Id.* (quoting *U.S. v. Majors*, 196 F.3d 1206, 1210-11 (11th Cir. 1999).

Here, the Amended Complaint contains allegations describing Defendants' overall objective: to artificially grow the low-income ACA insurance industry by deceptive means, with each Defendant benefiting monetarily by the resulting exponential growth. (Am. Compl. ¶ 405). And as set forth in the summary of facts contained in Plaintiffs' response to Defendants' "parallel conduct" argument *supra* Section III.A.3, Defendants' agreement to pursue that objective can be inferred through allegations about the relatedness of their conduct. Bowsky and Minerva conceived of the industry's growth through leads generated from fraudulent ads. (*Id.* ¶¶ 10-11). TrueCoverage and its downlines began buying those leads, and under Goldfuss and Panicker's supervision, they worked. (*Id.* ¶¶ 16-19). Herman and Enhance Health learned about it from TrueCoverage's downline agent Lucien, who showed them how to use the leads and enroll

consumers calling in for those leads. (*Id.* ¶¶ 22, 213-17). Herman and Bowsky approached TrueCoverage, and Enhance Health became TrueCoverage's biggest downline. (*Id.* ¶¶ 218-19). Enhance Health created its own downline network, which included NHA. Bain Insurance was told about the cash card ads and switching but continued to infuse Enhance Health with capital. (*Id.* ¶¶ 298-307, 410). Speridian and BenefitAlign agreed to allow all of the agencies to access the Marketplace through their technology, with knowledge of the switching. (*Id.* ¶¶ 58, 198, 223, 225, 696, 704).

Again, a fair reading provided at the motion to dismiss stage plausibly describes shared conduct toward a common objective. It describes collective rather than individual action. These Defendants were not siloed from each other. They interacted, and they knew. Going far beyond "a bare assertion of a conspiracy" (Jt. Mot. to Dismiss at 41), the circumstances alleged by Plaintiffs support the inference of a common agreement between Defendants.

Defendants try to minimize their alleged conduct, even calling it "innocuous." (*Id.*). Perhaps most boldly, Defendants contend that the cash card ads do not support an inference of a fraudulent agreement because "many insurance carriers do properly offer cash cards to their consumers." (*Id.*). With this argument, Defendants double down, taking their scripts' method of deceiving consumers and trying it out on this Court. As Plaintiffs allege, the "future cash reward card" offers provided by some carriers involved rewards that insureds could earn over time by getting annual checkups and taking other proactive wellness steps. (Am. Compl. ¶ 204). A reward card of "up to $500" is completely different than a "$500 cash card" or a "$6,400 cash card." (*Id.*). These Defendants knew that. TrueCoverage's Senior Director of Quality Assurance circulated an email to agents admitting that TrueCoverage was "misquoting subsidies and additional benefits," and that while some carriers provided cash rewards for healthy activities, those were not the same.

(*Id.* ¶ 233). He wrote, "[t]he only thing we can do is follow our script and be vague." (*Id.*). That is, don't acknowledge that an insurer's reward card is different than a cash card.

Enhance Health knew the difference between the reward card and cash card as well. A former Enhance Health agent said that the scripts required agents to be vague and tell consumers that any benefits would come in the future, but that the consumers would need to contact the carrier about the reward programs they offer. (*Id.* ¶ 270). And a Minerva marketing director sent a text discussing an agency looking for clean ads, stating "If he's not getting anyone asking for benefits . . . . You would have run such a clean angle no calls would come and if they did the cost would be ridiculous." (*Id.* ¶ 190). Defendants' attempts to spin these and dozens of other specific allegations as "innocuous" or legitimate is nearly as brazen as the scheme itself.

Finally, Defendants argue that Plaintiffs must allege that Defendants "agreed to commit two predicate acts." (Jt. Mot. to Dismiss at 42 (citing *Am. Dental Ass'n v. Cigna Corp.*, 605 F.3d 1283, 1293 (11th Cir. 2010)). But as *American Dental* clearly states, an agreement to commit two predicate acts is just "one of two ways" to establish a RICO conspiracy claim. 605 F.3d at 1293. The other, "an agreement of an overall objective," has been pled as described above. In any event, the "agreed to commit two predicate acts" standard requires only an allegation that "*a* defendant agreed personally to commit two predicate acts." *Church*, 955 F.2d at 694 (emphasis added).[15]

Here, Plaintiffs allege that numerous Defendants committed predicate acts by transmitting or causing to be transmitted wires and mailings that furthered the scheme. For example, Minerva used the wires to post misleading advertisements and transmit fraudulently generated calls to the enterprise. (Am. Compl. ¶¶ 406(b), 407). It monitored, recorded and stored those calls. (*Id.*).

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[15] The *American Dental* court erroneously quoted *Church* as stating "*the* defendant agreed." 605 F.3d at 1293.

TrueCoverage, Enhance Health and their downlines transmitted or caused to be transmitted hundreds of thousands of consumer calls, and used wires to conduct switching and Twisting activities through the Marketplace database, and to pay its downlines. (*Id.* ¶¶ 406(c), 406(h), 407-14). They also sent enrollment information in the form of texts and mailings. (*Id.* ¶¶ 407-08).

C. Plaintiffs State Claims for Aiding and Abetting RICO Violations

The Eleventh Circuit recognizes a cause of action for aiding and abetting RICO: "One who aids and abets two predicate acts can be civilly liable under RICO." *See Cox v. Adm'r U.S. Steel & Carnegie*, 17 F.3d 1386, 1410 (11th Cir. 1994). A plaintiff "must show (1) that the defendant was generally aware of the defendant's role as part of an overall improper activity at the time that he provides the assistance; and (2) that the defendant knowingly and substantially assisted the principal violation." *Id.* Moreover, "knowledge may be shown by circumstantial evidence, or by reckless conduct." *Id.* (quoting *Woodward v. Metro Bank of Dallas*, 522 F.2d 84, 94-95 (5th Cir. 1975)).

Noting that the U.S. Supreme Court denied certiorari review of *Cox* nearly a year after issuing its opinion in *Central Bank of Denver*,[16] Judge Moreno recognized in *In re Managed Care Litigation* that the *Cox* case remains controlling precedent in the 11th Cir:

> The Defendants advance the argument that *Central Bank* implicitly overrules *Cox* insofar as that decision authorizes aiding and abetting claims. . . .
>
> It is the duty of this Court to follow controlling Eleventh Circuit precedent unless there is a direct Supreme Court case on the particular issue in question holding to the contrary. Therefore the Plaintiffs can maintain a cause of action for aiding and abetting [RICO].

[16] *Central Bank of Denver, N.A. v. First Interstate Bank of Denver, N.A.*, 511 U.S. 164, 191 (1994). As Defendants note, *Central Bank of Denver* declined to create a private cause of action for civil aider and abettor liability for violations of section 10(b) of the Securities Exchange Act of 1934. That case did not examine whether a cause of action for aiding and abetting a RICO violation exists.

135 F. Supp. 2d 1253, 1267 (S.D. Fla. 2001). *See also Belin v. Health Ins. Innovations, Inc.*, 19-61430-CIV, 2019 WL 9575236, at *9 (S.D. Fla. Oct. 22, 2019) (Seltzer, M.J.), *report and recommendation adopted*, 19-61430-CIV, 2019 WL 9575230 (S.D. Fla. Dec. 30, 2019) (denying motion to dismiss aiding and abetting RICO claim).

Defendants cite two opinions from Magistrate Judge Goodman and Magistrate Judge Reinhart in an effort to convince this Court that it should not recognize Plaintiffs' aiding and abetting RICO claims. Magistrate Judge Goodman's statements regarding aiding and abetting RICO in the first case, *Emess Capital,* are clearly dicta. The plaintiff in that case did not bring an aiding and abetting RICO claim. *Emess Capital, LLC v. Rothstein*, 2011 WL 13214302, at *1, *5 (S.D. Fla. March 9, 2011) (Goodman, M.J.). In the second case, *Fagan v. Central Bank of Cyprus*, Magistrate Judge Reinhart's dismissal of some of the pro se plaintiff's claims, including the plaintiff's aiding and abetting RICO claim, in an order that granted in part the plaintiff's motion for default, was adopted without analysis by Judge Rosenberg. No. 19-cv-80239, 2021 WL 2845034, at *8 (S.D. Fla. June 28, 2021), *report and recommendation adopted*, 2021 WL 2915109 (S.D. Fla. July 12, 2021).

Thus, Plaintiffs' aiding and abetting RICO claims remain supported by Eleventh Circuit precedent. And because Plaintiffs' allegations sufficiently describe predicate acts in support of their underlying RICO claims, *see supra* Section III.A.5, those aiding and abetting claims should proceed. *See Belin*, 2019 WL 9575236, at *9 ("Plaintiffs have sufficiently plead a substantive RICO violation under § 1962(c), and, therefore, the predicate exists for claiming the aiding and abetting of a RICO Act violation.").

Defendants also contend that Plaintiffs do not set forth allegations of knowledge or substantial assistance sufficient to state claims for aiding and abetting RICO violations, and that

Plaintiffs' allegations supporting a particular Defendant's knowledge and substantial assistance are no different than the allegations naming them a part of the RICO enterprise itself. (Jt. Mot. to Dismiss at 43-45). Defendants misunderstand Plaintiffs' aiding and abetting RICO claims. With the exception of the claim leveled at NHA,[17] Plaintiffs' aiding and abetting RICO claims are alternative claims. Plaintiffs intend them to apply to the other 11 Defendants only to the extent one or more of those Defendants is not proven to be a part of the RICO enterprise. To take one example, if a particular Defendant is found to not have directed any of the enterprise's affairs, then that Defendant could still be an aider and abettor if it provided money to a member or members of the enterprise while knowing about the scheme.

Plaintiffs adequately allege knowledge and substantial assistance by each Defendant. A summary list of those allegations is found *supra* Section III.A.2.a.

D. Plaintiffs Sufficiently Plead Aiding and Abetting Fraud

Under Florida law, "[t]o successfully plead the claim of aiding and abetting fraud, the plaintiff[ ] must allege the: (1) the existence of the underlying fraud; (2) knowledge of the fraud; and (3) the defendant provided substantial assistance to the commission of the fraud." *Gillison v. Flagler Bank*, 303 So. 3d 999, 1002 (Fla. 4th DCA 2020) (internal citations omitted). Plaintiffs' allegations meet all three prongs.

1. Plaintiffs plead the underlying fraud with particularity

Again, "allegations of date, time *or* place satisfy the Rule 9(b) requirement that the *circumstances* of the alleged fraud must be pleaded with particularity, but *alternative means are also available* to satisfy the rule." *See In re Managed Care Litig.*, 150 F. Supp. 2d 1330, 1347

[17] Protect Health is another exception, but that Defendant's bankruptcy precludes Plaintiffs from pursuing their claims against Protect Health.

(S.D. Fla. 2001) (emphasis added) (citing *Durham v. Bus. Mgmt. Assocs*., 847 F.2d 1505, 1512 (11th Cir. 1988)). Plaintiffs here state a general timeframe: the relevant statements and omissions were made to consumers over a two-year period, starting in 2022. (Am. Compl. ¶¶ 17, 220, 413). Plaintiffs similarly plead the underlying fraud in significant detail. Plaintiffs describe the misleading advertisements and the leads generated from those ads. (*Id.* ¶¶ 182-207, 215-57). Plaintiffs detail the contents of the standardized scripts and how the advertisements and scripts misled consumers. (*Id.* ¶¶ 258-73). Plaintiffs allege how the PII garnered from the fraudulent leads was misused to engage in AOR Swaps, Twisting and Dual Apping. (*Id.* at ¶¶ 274-97). Finally, Plaintiffs provide specific examples of the scheme in operation. For example, Langley's switching history, with dates and details, is attached to the Amended Complaint. (*Id.* ¶¶ 352-53 Ex. 1). Similarly, King provides dates, times and agent names for her switches. (*Id.* ¶¶ 335-43), And Turner describes seeing a fraudulent cash card ad on Facebook in December 2023, calling the number and providing her PII, only to be switched numerous times thereafter. (*Id.* ¶ 370-71). While she does not remember the exact date or the agent she spoke with, Turner's allegations nonetheless support the scheme described in the Amended Complaint.[18]

As to the timing of the misrepresentations and omissions, Plaintiffs adequately plead those facts as well. As to the location of the misrepresentations, the misleading ads were placed on social media sites or sent through text messages to consumers. (*Id.* ¶¶ 186-87, 407). The defendant

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[18] The fact that Plaintiffs may not have all of the relevant details yet should not be a basis for dismissal. "[I]t is the law of this Circuit that Rule 9(b)'s heightened pleading standard may be relaxed in instances such as these where the facts of the alleged fraud are peculiarly within the Defendants' knowledge. Additionally, 'Rule 9(b)'s requirements may be relaxed for allegations of prolonged, multi-act schemes.'" *Todd Benjamin Int'l, Ltd. v. Grant Thornton Int'l, Ltd.*, 682 F. Supp. 3d 1112, 1135-36 (S.D. Fla. 2023) (citations omitted) (denying defendants' motion to dismiss plaintiffs' claims for aiding and abetting fraud and breach of fiduciary duty and negligent misrepresentation).

agencies took calls and engaged in AOR Swaps, Twisting and Dual Apping, from offices in South Florida, New Mexico, Pakistan and Central America, impacting consumers nationwide. (*Id.* ¶¶ 16-17, 47, 51, 206, 241-43).

In addition to describing with particularity the common scheme as it applied to all class members, the Amended Complaint also alleges with particularity how that scheme was applied to each named Plaintiff personally. The Amended Complaint describes the "who, what, when and where" of the fraud for each Plaintiff. (*Id.* ¶¶ 330-403).

2. <u>Plaintiffs sufficiently plead actual knowledge and substantial assistance</u>

Plaintiffs also sufficiently allege both actual knowledge and substantial assistance in support of their aiding and abetting claims. With respect to the actual knowledge requirement, Rule 9(b) requires that knowledge be pled only generally. *See* Fed. R. Civ. P. 9(b); *see also Belin*, 2019 WL 9575236, at *9, *report and recommendation adopted*, 19-61430-CIV, 2019 WL 9575230 (S.D. Fla. Dec. 30, 2019).

Plaintiffs nonetheless plead facts giving rise to a strong inference that each Defendant knew about the scheme. For example, Plaintiffs allege the following:

- <u>Bowsky and Minerva</u> created, purchased, and sold leads falsely representing consumers would receive a cash card to cover household expenses, after discovering that those "dirty ads" resulted in higher enrollment rates. (Am. Compl. ¶¶ 11, 15, 183, 184 187, 188, 191, 192, 193). Bowsky and Minerva also knew about the switching by agents. (*See id*. ¶ 293).

- <u>TrueCoverage</u> knew that leads were being used to lure customers that falsely offered free cash cards instead of ACA insurance. (*See id*. ¶¶ 17, 26, 203-06, 239, 243, 688). TrueCoverage knew that consumers were calling in response to the false advertisements promising cash cards, and implemented policies and practices that pressured agents to enroll consumers into ACA plans based on the fraudulent ads. (*See id*. ¶¶ 61, 223). TrueCoverage implemented misleading scripts designed to redirect consumers' questions about cash cards. (*See id*. ¶¶ 17, 258-63). Employees and agents of TrueCoverage complained specifically about the cash card ads misleading consumers. (*See id*. ¶¶ 18, 226, 248-57). Consumers also complained about not receiving cash cards. (*See id*. ¶¶ 26, 203, 223, 225, 317). TrueCoverage also knew its

agents and downlines were misusing consumer information and engaging in AOR Swaps, Dual Apping and Twisting. (*See id*. ¶¶ 19, 27-29, 223, 274-97).

- Speridian knew that leads were being used to lure customers that falsely offered free cash cards instead of ACA insurance. (*See id*. ¶¶ 223, 696). Through its owner Panicker, it knew that consumers were calling in response to the false advertisements promising cash cards and implemented policies and practices that pressured and incentivized call center agents to enroll consumers into ACA plans based on the fraudulent ads. (*See id*. ¶¶ 223, 225). Speridian also participated in the unlawful switching, by designing and servicing the EDE platforms Benefitalign and Inshura, which were used to facilitate AOR Swaps, Twisting and Dual-Apping.

- Benefitalign knew that leads were being used to lure customers that falsely offered free cash cards instead of ACA insurance. (*See id*. ¶ 704). Benefitalign is controlled by Panicker who also oversees and directs Speridian and TrueCoverage. (*See id.* ¶¶ 58, 198). Benefitalign also participated and profited from the unlawful switching, as it was used to facilitate AOR Swaps, Twisting and Dual-Apping.

- Enhance Health knew that leads were being used to lure customers that falsely offered free cash cards instead of ACA insurance. (*See id*. ¶¶ 23, 26, 248-49). Enhance Health knew that consumers were calling in response to the false advertisements promising cash cards and implemented policies and practices that pressured agents to enroll consumers into ACA plans based on the fraudulent ads. (*See id*. ¶¶ 61, 223). Enhance Health implemented misleading scripts designed to redirect consumers' questions about cash cards. (*See id*. ¶¶ 26, 264-72). Employees and agents of Enhance Health complained about the cash card ads misleading consumers. (*See id*. ¶¶ 248-57). Consumers complained about not receiving cash cards. (*See id*. ¶ 26). Enhance Health also knew that agents and downlines were misusing consumer information to engage in AOR Swaps, Dual Apping and Twisting. (*See id*. ¶¶ 27-29, 223, 291).

- Panicker maintains day-to-day control of TrueCoverage, Speridian and Benefitalign. (*See id.* ¶¶ 16, 58). Panicker knew that leads were being used to lure customers that falsely offered free cash cards instead of ACA insurance. (*See id*. ¶¶ 17, 712). Panicker knew that consumers were calling in response to the false advertisements promising cash cards, and implemented policies and practices that pressured and incentivized call center agents to enroll consumers into ACA plans based on the fraudulent ads. (*See id.* ¶ 223).

- Goldfuss knew that leads were being used to lure customers that falsely offered free cash cards instead of ACA insurance. (*See id*. ¶¶ 17, 224). He was in charge of purchasing the misleading leads and drafting sales scripts that were designed to be deceptive about the cash payouts promised in the ads. (*See id*. ¶ 224). Goldfuss knew that consumers were calling in response to the false advertisements promising cash cards, and implemented policies and practices that pressured and incentivized call center agents to enroll consumers into ACA plans based on the fraudulent ads. (*See id.* ¶¶ 223, 225-26).

- Herman is the manager of Enhance Health LLC, and was its CEO. (*See id.* ¶¶ 21, 44). Herman knew that leads were being used to lure customers that falsely offered free cash cards instead of ACA insurance. (*See id.* ¶¶ 23, 110). Herman monitored the original beta-testing at which Enhance Health agents were instructed to maximize enrollments through questionable means, including Dual Apping. (*See id.* ¶¶ 215-16). He monitored enrolment, and told a manager that Twisting was "like shooting fish in a barrel." *(See id.* ¶¶ 29, 277).

- NHA used Enhance Health's misleading scripts and engaged in AOR Swaps, Twisting and Dual Apping. (*See id.* ¶ 32). According to a former NHA employee, about 95% of all inbound calls that came into her call center were based on the fraudulent cash card ads. (*See id.* ¶ 195). NHA was instructed by Enhance Health to tell consumers that "if you approved for a health plan you will then also get a spending card from the carrier for everyday needs yes sir." (*See id.* ¶ 252).

These allegations plausibly support the knowledge element as to each Defendant. Despite these detailed allegations as to each Defendants' knowledge, Defendants attempt to reduce Plaintiffs' allegations to simply alleging that some Defendants knew that some advertisements reference "cash cards" and that because some insurance carriers do offer cash cards, knowledge of these references cannot "give rise to a strong inference of actual knowledge" of fraud. (Jt. Mot. to Dismiss at 48). But as set forth above, Plaintiffs allege that each Defendant had knowledge of the cash card ads and that they were ***false***.[19]

As for the substantial assistance element, it "occurs when a defendant affirmatively assists, helps conceal, or fails to act when required to do so, thereby enabling the breach to occur." *Gillison*, 303 So. 3d at 1003-04; s*ee also Todd Benjamin Internationall, Ltd.,* 682 F. Supp. 3d at 1136. "Whether the assistance was 'substantial' depends on the totality of the circumstances." *Rudolph v. Arthur Anderson & Co.,* 800 F.2d 1040, 1046 (11th Cir. 1986). Here, the Amended

[19] Contrary to Defendants' representation, Plaintiffs do not allege that some insurance carriers actually provide the cash card promised in the ads at issue in this case. Rather, Plaintiffs allege that other carriers offer future cash ***reward*** cards to encourage insureds to earn cash rewards by taking proactive wellness steps over time, such as annual checkups. (Am. Compl. ¶ 204). In contrast, the advertisements at issue in this case promised free cash. (*Id.*).

Complaint contains numerous allegations showing that, despite Defendants' knowledge of the scheme, Defendants substantially assisted the fraud. For example, Plaintiffs allege:

- Bowsky and Minerva conceived of the industry derived from leads generated from fraudulent ads, and promoted and assisted the creation of downlines and buyers. (Am. Compl. ¶ 406). They trained current and prospective ad buyers on how to "handle" dirty leads, including not mentioning the cash cards and, if the consumer brought it up, being "vague" and suggesting that the question is better answered later, by the insurance carrier. (*See id.* ¶ 14). With knowledge that the leads they were selling had been generated by fraudulent cash card ads, they sold those leads to Enhance Health, TrueCoverage and their downlines, including NHA. (*Id.* ¶¶ 11-14, 293).

- TrueCoverage implemented policies for its downlines to mislead consumers regarding the cash card ads. (*See id.* ¶ 223). TrueCoverage created the downline structure of entities. (*See id.* ¶¶ 20, 406). It directed and monitored the downlines' fraudulent marketing and sales activities and directed its downlines to purchase fraudulent leads. (*See id.* ¶¶ 247, 406). TrueCoverage recruited and trained agents for its downlines. (*See id.*). It provided key financing to its downlines through the use of advanced commissions and/or prepaid commissions. (*See id.* ¶ 406). TrueCoverage also trained agents and downlines to use scripts designed to deflect questions about the cash cards. (*See id.* ¶¶ 258-60, 406). It distributed commissions to the downlines for AOR Swaps and Twists. (*See id.* ¶ 406). TrueCoverage reached an agreement with Enhance Health to become a downline of TrueCoverage, allowing Enhance Health to quickly get appointments with health insurance carriers while also getting access to Speridian Technologies' Phase 3 EDE platform, Benefitalign. (*See id.* ¶ 218).

- Speridian created, provided, directed, managed and maintained the Enterprise's technology platforms, including Benefitalign and Inshura, allowing TrueCoverage, Enhance Health and their downlines to access the Healthcare Marketplace. (*See id.* ¶ 206). Speridian financed the operations of TrueCoverage and Benefitalign, entered into employment agreements with TrueCoverage agents and paid them a salary. (*See id.* ¶¶ 53, 406).

- Benefitalign provided access to its proprietary EDE Platform to Enhance Health, TrueCoverage and their downlines, allowing them to access consumers' highly confidential information to enroll consumers into the unsuitable ADA plans and to conduct the AOR Swaps and plan-switching alleged in this lawsuit. (*See id.* ¶¶ 28, 31-32, 197, 206, 218, 246, 274, 276).

- Enhance Health monitored and directed the enrollment efforts of its downlines and instructed its agents and downlines to use the misleading scripts designed to deflect questions about the cash cards. (*See id.* at ¶¶ 252-53, 258-60, 406). It directed its downlines to purchase fraudulent leads. (*See id.* ¶ 406). Enhance Health provided key financing to its downlines through the use of advanced commissions and/or prepaid commissions. (*See id.*). Enhance Health trained agents for its downlines (*See id.*). It also distributed commissions to the downlines for AOR Swaps and Twists. (*See id.*).

- Panicker maintains day-to-day control of TrueCoverage, Speridian and Benefitalign. (*See id.* ¶ 16). He directed the creation of a downline network that included Enhance Health. (*See id.* ¶ 406). Panicker implemented policies and practices that pressured and incentivized call center agents and downlines to enroll consumers into ACA plans based on the fraudulent ads. (*See id.* ¶ 223).

- Goldfuss directed the fraudulent marketing and sales efforts of TrueCoverage and its downlines, and was in charge of purchasing the misleading leads and drafting sales scripts that designed to be deceptive about the cash payouts promised in the ads. (*See id*. at ¶¶ 224, 406). Goldfuss implemented policies and practices that pressured and incentivized call center agents to enroll consumers into ACA plans based on the fraudulent ads at TrueCoverage and its downlines (*See id.* ¶¶ 223, 406). Goldfuss oversaw and directed the TrueCoverage ACA enrollment team and the misleading scripts that TrueCoverage and its downlines used with consumers. (*See id*. ¶¶ 61, 224).

- Herman connected Enhance Health to TrueCoverage and Minerva. (*See id*. ¶¶ 218, 220). Herman and TrueCoverage reached an agreement for Enhance Health to become a downline of TrueCoverage so that Enhance Health could quickly get appointed with health insurance carriers while also getting access to Speridian Technologies' Phase 3 EDE platform, Benefitalign. (*See id*. ¶ 218). Herman created downlines to be run by his friends, family, and former associates, which he could and did control. (*See id*. ¶¶ 219, 406, 413). Herman dictated which carriers and plans Enhance Health's downlines had to sell before ever speaking with consumers. (*See id*. ¶ 255). Herman promoted Enhance Health and its downlines' AOR Swaps, Twisting and Dual Apping. (*See id.* ¶¶ 29, 33, 277, 291).

- NHA bought Minerva's leads. (*Id.* ¶ 32). It used Enhance Health's scripts. (*Id.*). It followed Enhance Health's instructions on which carriers to enroll customers each given day. (*Id.*). NHA's agents told consumers that they worked for "Enhance Health enrollment center." (*Id.*). And NHA engaged in AOR Swaps, Twisting and Dual Apping. (*Id.*).

Defendants argue that they engaged only in legitimate tasks and "ordinary, arms-length transactions . . . such as providing training, purchasing leads, and referring agents." (Jt. Mot. to Dismiss at 48). Defendants cite *Rosenfeld Gallery, LLC v. Truist Bank*, 23-CV-20422, 2024 WL 836789, at *5 (S.D. Fla. Feb. 28, 2024), but it is distinguishable. In that case, the court found there were no plausible allegations that the defendant substantially assisted the fraud because the plaintiff alleged that the defendant bank was not notified of suspicious activity until after the scams were complete. *Id.* Here, Plaintiffs allege that Defendants knowingly participated in the *ongoing* fraud and breach of fiduciary duty. When a defendant has knowledge of the fraud, any kind of

substantial assistance in support of the fraud is actionable. *See, e.g., Belin*, 2019 WL 9575236, at *9 ("Among the several actions that Defendants took with knowledge of the scheme were the following: they financed the agents' operations").

Minerva and Bowsky argue that Minerva could not have actual knowledge of what happened with the leads or consumers after the leads were sold to other entities. (Jt. Mot. to Dismiss at 53). Minerva and Bowsky's argument ignores Plaintiffs' allegations, bolstered by text messages, that they trained current and prospective agency buyers on how to "handle" dirty leads. (*See* Am. Compl. ¶¶ 14, 190-91). Minerva and Bowsky also argue that they did not proximately cause any underlying breach because lead sales do not foreseeably and substantially cause the AOR Swaps, Twisting, and Dual-Apping. (Jt. Mot. to Dismiss at 53-54). But lead sales *do* foreseeably and substantially cause that conduct where Minerva and Bowsky know that their buyers, including Enhance Health and TrueCoverage, are engaged in it. (Am. Compl. ¶ 293).

Minerva and Bowsky further argue that Plaintiffs do not plausibly allege that Minerva and Bowsky failed to act when they had an affirmative duty to do so. (Jt. Mot. to Dismiss at 53). The other Defendants similarly argue that Plaintiffs fail to allege an independent duty to disclose that would give rise to aiding and abetting liability. (*Id.* at 54). First of all, Defendants rely on a case involving a bank defendant. *See Lamm v. State Street Bank & Tr. Co.*, 889 F. Supp. 2d 1321, 1333 (S.D. Fla. 2012). Banks have a very limited duty to disclose transaction irregularities in consumer accounts. *Id.* (citing *Lawrence v. Bank of Am.*, No. 8:09-cv-2162-T-33TGW, 2010 WL 3467501, at *4 (M.D. Fla. Aug. 30, 2010) (same)). Regardless, a failure to disclose is not the only path to supporting a claim of substantial assistance. Substantial assistance "occurs when a defendant affirmatively assists, helps conceal[,] or fails to act when required to do so, thereby enabling the breach to occur." *See Lerner v. Fleet Bank, N.A.*, 459 F.3d 273, 295 (2d Cir. 2006). Again,

Plaintiffs allege that Defendants, including Minerva and Bowsky, not only failed to disclose the scheme, but actively assisted and helped conceal the scheme. *See supra* Section III.A.2.a.

Herman and Enhance argue that Plaintiffs do not allege that they had actual knowledge of or substantially assisted any underlying breach because the allegations support competition between TrueCoverage and Enhance Health. (Jt. Mot. to Dismiss at 54). But Plaintiffs allege that TrueCoverage and Enhance Health worked together. Enhance Health was a TrueCoverage downline. (Am. Compl. ¶¶ 24). TrueCoverage financed Enhance Health's policies and helped train Enhance Health agents. (*Id.* ¶¶ 22, 24). Enhance Health used scripts that were like TrueCoverage's. (*Id.* ¶ 264).

Finally, Defendants argue that Plaintiffs "fail to allege anything but independent misconduct," incorporating their argument with respect to the RICO claim. (Jt. Mot. to Dismiss at 53). To the contrary, Plaintiffs set out in detail the interrelationship between Defendants and their role in the scheme. *See supra* Section III.A.3.

E. <u>Plaintiffs Sufficiently Plead a Fiduciary Duty in Support of Counts 45-54</u>

TrueCoverage, Enhance, and Herman argue that Plaintiffs' aiding and abetting breach of fiduciary duty claims fail because they are alleged to be the primary wrongdoers and they cannot "aid and abet their own breach of fiduciary duty." (Jt. Mot. to Dismiss at 49). But Plaintiffs do not allege that each of those Defendants aided and abetted its ***own*** breach of fiduciary duty. Rather, Plaintiffs allege that Defendants aided and abetted ***each other's*** breaches of fiduciary duty. For example, in Count 45 against TrueCoverage, Plaintiffs allege that TrueCoverage aided and abetted the breaches of fiduciary duty by "[t]he downlines, Enhance Health and/or the licensed agents working for them." (Am. Compl. ¶ 766). In Count 50 against Enhance Health, Plaintiffs allege Enhance Health aided and abetted the breaches of fiduciary duty by "TrueCoverage, the downlines

and/or the licensed agents working for them." (*Id.* ¶ 806). In Count 51 against Herman, Plaintiffs allege that he aided and abetted the breaches of fiduciary duty by "TrueCoverage, Enhance Health, the downlines and/or the licensed agents working for them." (*Id.* ¶ 814). And so forth for each Defendant.

Minerva and Bowsky argue that they cannot be liable for aiding and abetting breach of fiduciary duty because Plaintiffs fail to allege the existence of a fiduciary duty by the primary wrongdoer. (Jt. Mot. to Dismiss at 49-53).[20] However, Plaintiffs sufficiently allege the existence of a fiduciary duty requiring TrueCoverage, Enhance Health, their downlines and/or the licensed agents working for them to select appropriate coverage on their behalf and with their knowledge, and not misuse PII that had been entrusted to them or to not mislead Plaintiffs and the class. (Am. Compl. ¶¶ 308-16).

In Florida, insurance brokers owe a fiduciary duty of care to the insured that requires "the broker to inform and explain the coverage it has secured at the client's direction." *Tiara Condo. Ass'n, Inc. v. Marsh, USA, Inc.*, 991 F. Supp. 2d 1271, 1279-80 (Fla. 2014) (citing *Wachovia Ins. Serv., Inc. v. Toomey*, 994 So. 2d 980, 987 (Fla. 2008)); *see also Randolph v. Mitchell*, 677 So. 2d 976, 978 (Fla. 5th DCA 1996) (stating that an insurance broker owes a fiduciary duty to the insured-principal). An enhanced duty "to advise the client about the amount of coverage prudently needed to meet its complete insurance needs" applies when the broker encourages and engages in a "special relationship" with the customer. *Tiara*, 991 F. Supp. 2d. at 1281. This "special relationship" can be shown where, among other actions, the agent: (i) "misrepresented the nature of the coverage being offered or provided, and the insured justifiably relied on that representation

[20] It appears from the Motion that only Minerva and Bowsky argue that Plaintiffs fail to allege the existence of a fiduciary duty by the primary wrongdoer. Thus, this element is not contested by the remaining Defendants.

in selecting the policy"; (ii) "voluntarily assumed the responsibility for selecting the appropriate insurance policy for the insured (by express agreement or promise to the insured); or (iii) "held itself out as having expertise in a given field of insurance being sought by insured, and the insured relied on that expertise." *Id.* (citations omitted).

Here, Plaintiffs allege a common scheme to use fraudulently generated leads to enroll consumers in plans they were not suited for or did not qualify for, and to obtain and use their PII to engage in AOR Swaps, Twisting and Dual Apps. (*See*, *e.g.*, Am. Compl. ¶¶ 18-19, 27-28, 31, 162). Plaintiffs specifically allege that TrueCoverage, Enhance Health and/or their downlines chose policies on Plaintiffs and consumers' behalf and actually enrolled them in health insurance policies without their knowledge. (*Id.* ¶¶ 334-36, 338, 340, 342-43, 351-53, 361, 365, 371, 377, 379-80).

For those consumer who spoke with an agent, Plaintiffs allege that, as evidenced by the scripts, agents held themselves out as experts and voluntarily assumed a fiduciary role. (*Id.* ¶ 309, 313). The scripts also directed the sales agents to essentially choose the product for the customer. (*Id.* ¶¶ 309, 311). Plaintiffs allege that the agencies knew and encouraged that reliance and trust. (*Id.* ¶¶ 309-11). And to deepen the special relationship with customers, the scripts encouraged customers to rely on sales agents to answer questions and assist with the plans they purchased. (*Id.* ¶¶ 309-13). The consumers targeted in this scheme include our country's most poor and vulnerable. (*Id.* ¶ 308).

Minerva and Bowsky argue that no fiduciary duty arose because none of the Plaintiffs allege that they interacted with Defendants. (Jt. Mot. to Dismiss at 52). Conswallo Turner alleges that she saw an ad on Facebook promising a monthly cash card, called the number on the ad and provided her name, date of birth and state of residence. (Am. Compl. ¶ 371). She alleges that an

agent of Enhance Health then used that information to change her health insurance without her consent. (*Id.*). Further, each Plaintiff alleges that TrueCoverage, Enhance Health, their downlines and/or licensed agents accessed and misused Plaintiffs' personal information obtained in their position as brokers and assumed responsibility for selecting insurance policies on behalf of Plaintiffs.[21] (Am. Compl. ¶¶ 334-36, 338, 340, 342-43, 351-53, 361, 365, 371, 377, 379-80); *see, e.g.*, *Sch. Bd. of Osceola Cnty., Fla. v. Gallagher Benefit Servs., Inc.*, No. 6:21-CV-1979, 2022 WL 19914514, at *6 (M.D. Fla. June 22, 2022) ("Gallagher accepted the School Board's trust by procuring insurance products on its behalf.").

In a case Minerva and Bowsky cite, the court recognizes that "[a]n insurance broker is in a fiduciary relationship with an insured." *Moss v. Appel*, 718 So. 2d 199, 201 (Fla. 4th DCA 1998) *abrogated on other grounds by Wachovia Ins. Servs., Inc. v. Toomey*, 994 So. 2d 980, 990 (Fla. 2008).[22] Another case Minerva and Bowsky cite similarly supports Plaintiffs' position. In *Traditions Senior Mgmt., Inc. v. United Health Adm'rs, Inc.*, the court explains that "[a]s alleged in the complaint, Schwartz has a fiduciary duty to TSM in his capacity as an insurance broker and advisor." No. 8:12-CV-2321-T-30MAP, 2013 WL 3285419, at *2 (M.D. Fla. June 27, 2013). Here, Plaintiffs allege that TrueCoverage, Enhance Health and/or their downlines were brokers who selected policies on behalf of Plaintiffs and enrolled them in health insurance. (Am. Compl.

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[21] Minerva and Bowsky also argue that the CMS regulations cannot be the basis for a breach of fiduciary duty claim, citing *Johnson v. Catamaran Health Sols., LLC*, 687 Fed. App'x 825, 831 (11th Cir. 2017). (Jt. Mot. to Dismiss at 53). Unlike the *Johnson* case, where the claim was entirely based on the assertion that the defendants violated the Florida Insurance code by charging excessive premiums, Plaintiffs fiduciary duty claim is not based exclusively on a violation of a CMS regulation. Rather, that regulation is cited as additional evidence of the existence of the fiduciary duty.

[22] Contrary to Defendants' characterization, the court's conclusion in *Moss* that a fiduciary duty existed arose "***both*** from the sale of the annuity and the consulting relationship." *Moss*, 718 So. 2d at 201. In other words, acting as an insurance broker was sufficient.

¶¶ 334-36, 338, 340, 342-43, 351-53, 361, 365, 371, 377, 379-80). Under Florida law, the allegations made by Plaintiffs are sufficient to overcome Defendants' motion to dismiss. Indeed, "[w]hether an insurance broker shared a 'special relationship' with its client is a question of fact for the jury." *Tiara*, 991 F. Supp. 2d at 1281-82.

F. Plaintiffs Adequately Plead Negligence

Entities that collect sensitive, private data from consumers and store such data on their networks have a duty to protect that information. *In re Mednax Servs., Inc., Customer Data Sec. Breach Litig.*, 603 F. Supp. 3d 1183, 1223 (S.D. Fla. 2022) (citing *Farmer v. Humana, Inc.*, 582 F. Supp. 3d 1176, 1185-86 (M.D. Fla. 2022)); *Weinberg v. Advanced Data Processing, Inc.*, 147 F. Supp. 3d 1359, 1363 (S.D. Fla. 2015); *Brush v. Miami Beach Healthcare Group, Ltd.*, 238 F. Supp. 3d 1359, 1365 (S.D. Fla. Feb. 17, 2017). "Where a defendant's conduct creates a foreseeable zone of risk, the law generally will recognize a duty placed upon [the] defendant either to lessen the risk or [to] see that sufficient precautions are taken to protect others from the harm that the risk poses." *Kaisner v. Kolb*, 543 So. 2d 732, 735 (Fla. 1989); *see also U.S. v. Stevens*, 994 So. 2d 1062, 1066–67 (Fla. 2008).

Here, Defendants[23] collect and store Plaintiffs' and class members' private information. Speridian and their EDE platforms, Benefitalign and Inshura, entered into agreement(s) with CMS governing the way each is required to operate under federal regulations, including provisions related to protecting Consumer Plaintiffs' and class members' PII from unlawful dissemination. (Am. Compl. ¶ 864). Minerva recorded and kept confidential calls between consumers and agents for Enhance Health, TrueCoverage and their downlines without Consumer Plaintiffs' and class

[23] Plaintiffs' negligence claim is leveled at all Defendants except Bain Insurance. Therefore, "Defendants" as used in this section includes all Defendants except Bain Insurance and Protect Health, which has filed for bankruptcy.

members knowledge and consent. (*Id.* ¶¶ 406(b), 876). TrueCoverage, Enhance Health and their downlines collected and used Consumer Plaintiffs' and class members' PII as well. (*Id.* ¶ 876).

Thus, because Defendants collected and stored private information, they had a duty to protect it. They did not. Plaintiffs allege Defendants used that PII to gain unauthorized access to Plaintiffs' and class members' healthcare data on the Database. (*Id.* ¶¶ 877, 879). Defendants changed and/or falsified that data in an effort to direct commissions to TrueCoverage, Enhance Health and their Downlines. (*See, e.g., id.* ¶¶ 28, 32). This included providing false information about the household income and creating duplicate applications on the Database. (*See, e.g.*, *id.* ¶¶ 18, 22, 356).

In addition and/or alternatively, a duty can also arise from "judicial interpretations of such enactments or regulations." *Clay Elec. Coop., Inc. v. Johnson*, 873 So. 2d 1182, 1185 (Fla. 2003). Florida law recognizes the "undertaker's doctrine," under which a duty to act carefully arises "[w]henever one undertakes to provide a service to others, whether one does so gratuitously or by contract." *Id.* at 1186; *see also In re Brinker*, 2020 WL 691848, at *8 ("[Defendant], by collecting personal information and payment card data, had control over the information and had a duty to use reasonable care in protecting that data from theft."). Here, when Defendants obtained Plaintiffs' data and placed that data in a foreseeable zone of risk that Defendants had a duty to mitigate. *See Kaisner*, 543 So. 2d at 735.

In addition to duties created by the collection and storage of data, Defendants have a duty under applicable regulations. Under Florida law, a duty may arise from "legislative enactments or administration regulations." *Clay Electric Cooperative*, 873 So. 2d at 1185. The Amended Complaint details the regulatory framework that governs the business practices of participants such as Defendants in the federal Marketplace, and alleges that Defendants fall within the scope of the

federal regulations designed to protect the PII of consumers in the ACA health insurance marketplace. (Am. Compl. ¶¶ 154-62). For example, federal regulations promulgated under the ACA impose duties to ensure that all Exchange privacy and security standards implemented are consistent with the following principles: PII should be created, collected, used and/or disclosed only to the extent necessary to accomplish a specified purpose or purposes(s). (*Id.* ¶ 868 (citing 45 C.F.R. § 155.260(a)(3)(v)). These federal regulations, which are designed to protect consumers' PII from unlawful disclosure, also apply to agents and brokers that are downline of Speridian and TrueCoverage, such as Enhance Health. (*Id.* ¶ 869) (citing 45 C.F.R. § 155.220(j)(2)(iv), which requires all web-brokers, agents and brokers to protect consumers' PII). The duty also extends to Minerva, Bowsky and Herman, who fall within the definition of a non-exchange entity. (*Id.* ¶ 869 (citing 45 C.F.R. § 155.260(b)(3)). These regulations govern Defendants' responsibilities when doing business in the federal Marketplace and place the safeguarding of consumers' PII within the foreseeable zone of risk on Defendants' shoulders, creating a legal duty to safeguard Plaintiffs' PII from misuse. *Clay Electric Cooperative, Inc.*, 873 So. 2d at 1185.

Finally, in their motion Defendants mischaracterize Plaintiffs' negligence claim as a negligence *per se* claim, and cite to cases holding that negligence *per se* claims only exist when the statute or regulation creates a private right of action. To be clear, Plaintiffs does not bring a negligence *per se* claim. Nor do Plaintiffs claim that the Office of Management and Budget ("OMB") guidance alleged in paragraphs 846 through 854 imposes a statutory duty of care on Defendants. The OMB guidance is helpful because it illustrates that Defendants' misconduct constitutes a major breach under CMS's regulations, and shows that Defendants breached their duties.

G. <u>The Amended Complaint Does Not Constitute a Shotgun Pleading</u>

"The essence of a shotgun pleading is that it is virtually impossible to know which allegations of fact are intended to support which claim(s) for relief." *Millstein v. Holtz*, 21-CV-61179-RAR, 2022 WL 3594915, at *4 (S.D. Fla. Aug. 23, 2022) (denying dismissal of complaint as a "shotgun pleading" where it "adequately details each Defendant's participation in the scheme").

Here, the Amended Complaint provides ample factual detail about each Defendant's conduct, particularly in paragraphs 1 through 35 and 142-329, which provide a narrative that spans more than 65 pages. While Defendants contend that the Amended Complaint is "replete with conclusory, vague, and immaterial facts not obviously connected to any particular cause of action" (Jt. Mot. to Dismiss at 10), they fail to provide any example. And to the extent Defendants complain that the Amended Complaint sometimes groups Defendants together in an allegation, doing so does not create a pleading issue. "When Defendants are referred to collectively, the solution is to simply construe allegations containing the collective references as applying to each defendant individually." *Restless Media GmbH v. Johnson* 704 F. Supp. 3d 1288, 1296 (S.D. Fla. 2023). Moreover, "the fact that Defendants can restate Plaintiff's allegations shows that Defendants are on notice of, and comprehend, Plaintiff's claims for relief, while contradicting any assertion to the contrary." *Id*. at 1296-97. Here, Defendants' Motion devotes almost all of its 60 pages to reciting and attacking Plaintiffs' specific allegations. Accordingly, the Amended Complaint is not a shotgun pleading.[24]

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[24] Even if the Amended Complaint were a shotgun pleading, "a district court *must* sua sponte give [a plaintiff] one chance to replead before dismissing his case with prejudice on non-merits shotgun pleading grounds." *Vibe Micro, Inc. v. Shabanets*, 878 F.3d 1291, 1296 (11th Cir. 2018) (emphasis added).

CONCLUSION

For the reasons stated above, this Court should deny Defendants' Joint Motion to Dismiss the claims brought against them by Plaintiffs in the Amended Complaint. In the alternative, Plaintiffs request leave to amend.

Dated: November 6, 2024

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on November 6, 2024, a true and correct copy of the foregoing was filed via CM/ECF and served upon parties registered with CM/ECF in this case.

By: */s/Jason Kellogg*