Law Update

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NBA Champion's Conviction and Prison Sentence for Insurance Fraud Demonstrates That the Allure of Fraud Crosses All Income Levels



On November 15, 2023, a New York jury convicted former NBA player Glen "Big Baby" Davis of healthcare fraud, wire fraud, conspiracy to make false statements and conspiracy to commit health care and wire fraud for defrauding the league's healthcare plan. On May 9, 2024, he was sentenced to 40 months in prison. The 38-year-old Davis was also sentenced to three years of supervised release. The conviction carried the potential of a 20-year prison sentence.

The same jury also convicted former Detroit Piston Will Bynum of the same charges on the same day it convicted Davis. More than 20 people have been convicted as part of the fraud ring, including 2009 first round draft pick Terrence Williams, the apparent leader of the scheme, who was sentenced to a decade in prison. Prosecutors charged dentists and chiropractors as well.

"Big Baby" Davis and the Scheme

Davis, a forward with Louisiana State University, earned SEC player of the year while leading LSU to the 2006 national championship game. He was a hulking but nimble power forward, a menace on the blocks, and he carried the ironic nickname "Big Baby". He went on to become a first-round draft pick in the NBA and was a key part of the 2008 Boston Celtics championship. Over the course of his NBA career, he earned over \$35 million in salary alone, and untold additional sums in endorsements.

For whatever reason, it wasn't enough for Davis. Perhaps he spent his money unwisely. Perhaps he had a gambling problem. Perhaps he just became greedy and fell for the allure of seeing what he could get away with, an impulse that drives many fraud perpetrators. In any event, Davis willingly participated in a wide-ranging scheme to defraud the NBA's healthcare plan. And like may fraud perpetrators, he and his co-conspirators ended up showing themselves to be too clever by half, and a bit careless on details that led to their discovery, arrest, and conviction.

Federal authorities said that Davis and others defrauded an insurance plan for NBA players and family members of more than \$5 million in a scheme that lasted at least four years. The players



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would make false claims for dental services and various medical care, including chiropractic care, but the defendant physicians never actually provided those services.

Davis submitted a total of \$132,000 worth of claims, including saying he got \$27,200 worth of dental work at Beverly Hills dental office on October 2, 2018. Authorities said he was actually in Las Vegas at the time and flew to Paris that same day, using the geolocation data from his cellphone to prove it.

Key Lesson for Investigators: Financial Motive is an Elastic Term, and is Not Confined Just to Claimants in Obvious Financial Distress

We are used to assessing potential fraudulent claims through the lens of traditional financial motive. Does the claimant demonstrate a level of financial distress that would incentivize him to pursue a false claim in hopes of securing a financial windfall? In such claims, the claims investigation and examination under oath document requests of claimants often include personal and business bank statements, credit card records, loan statements and cell phone records. Indeed, a key piece of evidence against Davis came from his own cell phone.

When we assess the question of potential financial motive, and the scope of reasonable document requests, we often back off of requesting financial records when the claimant is well-off or does not demonstrate traditional financial motives, such as loan delinquencies, unemployment, or a history of failed attempts to sell subject property or vehicles that later catch fire mysteriously. The tendency to steer clear of financial document demands, requests that courts and juries

may view as invasive and harassing in bad faith claims, is especially strong when we know the claimant is a millionaire.

The Glen Davis saga, however, reminds us that some fraud perpetrators may enjoy lavish financial wealth and are simply greedy enough to see what they can get away with. Davis's total claim submissions of \$132,000 represented just .004% of his career salary. Unless he was destitute due to bad luck and unfortunate circumstances, it appears his willing participation in this scheme may have been just another form of competition for him. This case cautions us that each and every suspicious claim demands our objective and fresh scrutiny, even when traditional indicia of financial suspicion may not exist. There is never a good time to treat any one claim just like every other similar claim.

Eric W. Moch, a partner in the Chicago office of HeplerBroom, LLC, focuses his practice on organized medical fraud and insurance fraud, including organized activity and staged losses, as well as first- and third-party coverage and bad faith defense. Mr. Moch counsels and represents national insurers, businesses, not-forprofit organizations and individuals in a variety of matters and litigated disputes. His insurance fraud practice entails the defense of insurers and their insureds against fraudulent claims at trial and the pursuit of civil recoveries for insurance carriers resulting in recoveries against medical fraud perpetrators. He has extensive civil litigation experience in Illinois state and federal courts, including in excess of fifty jury verdicts, victorious oral arguments before the Illinois Supreme Court and Seventh Circuit U.S. Court of Appeals and several published appeals. He is a former national board member of the National Society of Professional Insurance Investigators and is the former President of the Illinois chapter. Mr. Moch has also held several positions in the insurance industry, including as a founding member of a Special Investigations Unit for an international insurer, a role in which he investigated alleged fraudulent claims across a wide range of insurance lines. Mr. Moch can be reached at (312) 205-7712 and at eric.moch@heplerbroom.com