RECOMMENDED FOR FULL-TEXT PUBLICATION
Pursuant to Sixth Circuit Rule 206

ELECTRONIC CITATION: 1999 FED App. 0097P (6th Cir.)
File Name: 99a0097p.06

UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

ADVOCACY ORGANIZATION FOR PATIENTS AND PROVIDERS, a non-profit Michigan corporation, et al.,
Plaintiffs-Appellants/ Cross-Appellees,

v.

AUTO CLUB INSURANCE ASSOCIATION, a Michigan corporation, et al.; ALLSTATE INSURANCE COMPANY, an Illinois corporation; CITIZENS INSURANCE COMPANY OF AMERICA, a Michigan corporation; FARM BUREAU INSURANCE COMPANY, a Michigan corporation; FARMERS INSURANCE EXCHANGE, a California corporation; FRANKENMUTH MUTUAL INSURANCE COMPANY, a Michigan corporation; IMPERIAL MIDWEST INSURANCE

Nos. 97-1821/1832

SERVICES, INC., a Michigan corporation; RECOVERY UNLIMITED, INC., a Michigan corporation, d/b/a Medical Review Systems,
Defendants-Appellees/ Cross-Appellants.

Appeal from the United States District Court
for the Western District of Michigan at Lansing.
No. 96-00177—Robert Holmes Bell, District Judge.

Argued: November 4, 1998

Decided and Filed: March 15, 1999

Before: JONES, RYAN, and BATCHELDER, Circuit Judges.

COUNSEL

ARGUED: Linda S. Fausey, Lansing, Michigan, for Appellants. Lori M. Silsbury, DYKEMA GOSSETT, Lansing, Michigan, for Appellees. **ON BRIEF:** Linda S. Fausey, Lansing, Michigan, for Appellants. Lori M. Silsbury, DYKEMA GOSSETT, Lansing, Michigan, for Appellees.

tortiously interfere with existing business and contractual relationships; (7) common law fraud; and (8)-(15), eight counts of RICO violations against various combinations of two or more of the Defendants.

The Defendants removed the case to federal district court based on federal question jurisdiction arising out of the RICO counts. The Plaintiffs' motion to remand was denied.

The Defendants filed several motions seeking dismissal, including a "Joint Motion to Dismiss Pursuant to FED. R. CIV. P. 12(b)" that raised lack of standing, failure to state claims in various counts (including the RICO counts), and a statute of limitations defense. On June 23, 1997, the district court dismissed the RICO counts under Rule 12(b)(6) for failure adequately to allege a predicate act upon which the Plaintiffs could base their RICO claims and failure adequately to allege a RICO enterprise. The district court also dismissed the federal due process claim for lack of state action. Finding the remaining counts based exclusively upon Michigan law, the court remanded them to the state trial court. This timely appeal followed.[1]

In this appeal Plaintiffs challenge the district court's dismissal of their RICO claims and ask that we either reverse the district court or vacate the district court's judgment and remand the case so as to allow them to amend their complaint. Defendants ask that the district court's order remanding the state law claims be reversed in the event that we reverse the

---

[1] The Defendants filed with the district court an emergency motion to stay the order of remand pending appeal or, in the alternative, for an order vacating the order of remand, which the court denied. Defendants filed a timely notice of cross-appeal challenging the remand of the state law claims to state court. Defendants also filed a motion with this Court to stay the remand pending the outcome of this appeal. This Court denied Defendants' motion. For ease of reference, we will refer to the Plaintiffs/Appellants/Cross-Appellees as "Plaintiffs," and the Defendants/Appellees/Cross-Appellants as "Defendants."

III. "REASONABLE" MEDICAL EXPENSES UNDER MICHIGAN'S NO-FAULT INSURANCE ACT

Michigan has a system of mandatory no-fault automobile insurance. Among other things, this system requires Michigan drivers to purchase "personal protection insurance" ("PPI"), *see* MICH. COMP. LAWS ANN. § 500.3101 (West 1993), under which "an insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, subject to the provisions of [the no-fault statute]," MICH. COMP. LAWS ANN. § 500.3105. Specifically, coverage under PPI includes "[a]llowable expenses consisting of all *reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation.*" MICH. COMP. LAWS ANN. § 500.3107(1)(a) (emphasis added). The statute also circumscribes the amounts that health care providers are permitted to charge for services performed for victims of auto accidents:

> A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, *may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance.*

MICH. COMP. LAWS ANN. § 500.3157 (emphasis added). These statutory provisions leave open the questions of what a "reasonable charge" is, who decides what is "reasonable," and what criteria may be used to determine what is "reasonable"--all questions at the core of this litigation. In 1992 and 1994 referenda and amendments were proposed

issue, basing its entire argument on what was, for that provider, a "customary charge." *Id.* at 557.

In late 1995 and 1996 the Michigan Court of Appeals shed some further light on these questions with three additional opinions. The first was *LaMothe v. Auto Club Ins. Assoc.*, 543 N.W.2d 42 (Mich. Ct. App. 1995), *appeal denied*, 554 N.W.2d 916 (Mich. 1996), in which the court reiterated that the insurer need pay only the "reasonable" medical expenses, rather than all of the medical expenses. *Id.* at 44. If the insurer paid expenses that were unreasonable, the court said, it would be violating the insurance contract, *id.*, and insurer scrutiny of medical charges was "compelled" by the no-fault statute, *id.* at 44 n.3. The next opinion, *Munson Med. Ctr. v. Auto Club Ins. Assoc.*, 554 N.W.2d 49 (Mich. Ct. App.), *appeal denied*, 564 N.W.2d 887 (Mich. 1996), again addressed the issue of "customary charges," *see id.* at 52. In *Munson* ACIA attempted to assess a provider's "customary charge" by considering what a provider received for a particular procedure under Medicare, Medicaid, Blue Cross Blue Shield, and the workers' compensation schedule. *Id.* at 54. Citing *Hofmann*, the court rejected ACIA's arguments stating, "ACIA's use of criteria imposed by other statutory schemes or contractual agreements is hereby rejected as a matter of law." *Id.* at 56. A month after *Munson* was decided the court, in *Mercy Mt. Clemens Corp. v. Auto Club Ins. Assoc.*, 555 N.W.2d 871 (Mich. Ct. App. 1996), *appeal denied*, 569 N.W.2d 168 (Mich. 1997), reiterated and reaffirmed its holdings in *Munson* and *Hofmann* by rejecting an insurer's argument that it was entitled to discovery concerning a health care provider's receipt of payments from Medicare, Medicaid, Blue Cross, workers' compensation, HMOs, and PPOs so it could show the unreasonableness of the provider's bills. *See id.* at 872-74.

insured/patients. Plaintiffs' multiple RICO counts are premised upon these alleged actions.

In order to state a RICO claim, Plaintiffs must allege an injury to their "business or property by reason of a violation of section 1962 of this chapter."[2] Plaintiffs claim violations only under 18 U.S.C. § 1962(b), which makes it unlawful for "any person through a pattern of racketeering activity or through collection of an unlawful debt to acquire or maintain, directly or indirectly, any interest in or control of any enterprise which is engaged in, or the activities of which affect, interstate or foreign commerce." 18 U.S.C. § 1962(b). Thus, to state a claim under § 1962(b), Plaintiffs must plead facts tending to establish that Defendants

(1) acquired or maintained
(2) through a "pattern of racketeering activity" or the "collection of an unlawful debt"
(3) an interest in or control of an enterprise
(4) engaged in, or the activities of which affect, interstate or foreign commerce.

A. "RACKETEERING ACTIVITY" AND PREDICATE ACTS

"In order to establish 'racketeering activity' the plaintiffs must allege a predicate act," *Kenty v. Bank One, Columbus, N.A.*, 92 F.3d 384, 389 (6th Cir. 1996), under 18 U.S.C. § 1961(1). Plaintiffs alleged mail and wire fraud, 18 U.S.C. §§ 1341, 1343, in all of their RICO counts, and extortion, MICH. COMP. LAWS ANN. § 750.213, in two of their RICO counts; mail and wire fraud and extortion are included in the definition of "racketeering activity" in § 1961. *See*

---

[2] 18 U.S.C. § 1964(c). "Any person injured in his business or property by reason of a violation of section 1962 of this chapter may sue therefor in any appropriate United States district court and shall recover threefold the damages he sustains and the cost of the suit, including a reasonable attorney's fee . . . ." *Id.*

> right, and which accomplishes the designed end. *To allege intentional fraud, there must be proof of misrepresentations or omissions which were reasonably calculated to deceive persons of ordinary prudence and comprehension. Thus, the plaintiffs must allege with particularity a false statement of fact made by the defendant which the plaintiff relied on.*

Kenty, 92 F.3d at 389-90 (emphasis added) (internal quotation marks, modification and citations omitted).

Plaintiffs' complaint avers that the Defendants made two misrepresentations in furtherance of their alleged scheme to defraud. The first was the insurance companies' statements to prospective insureds that the insurance companies would pay all of the insured's reasonable and necessary medical charges arising out of automobile accidents. *See, e.g.*, J.A. at 162 (Complaint ¶ 168(a)). The second was the insurance companies' and/or the review companies' statements to the health care providers, after the insureds' claims had been reviewed and discounted, that the amount the insurers had paid the providers was all the providers were entitled to receive under Michigan law. *See, e.g.*, J.A. at 163 (Complaint ¶ 168(d)). We address each in turn.

To support their claim that Defendants misrepresented their intention to pay for their insureds' reasonable auto accident-related medical expenses, Plaintiffs first alleged that the Defendants intended to accomplish their fraud through the knowing use of "irrelevant data, irrelevant fee schedules and other irrelevant cost data in conducting their retrospective review of medical billings, so as either to deny totally health care providers and/or insureds' requests for reimbursement, or artificially decrease the amount [the insurer] thereafter offered to pay for such health care," J.A. at 163, 166-67, 169, 173, 176, 178-79, 181, 184 (Complaint ¶¶ 168(c), 176(c), 183(c), 191(c), 198(c), 205(c), 212(c), 219(c)). The only factual support for this specific allegation appears in

> Our data are updated quarterly, but individual adjustments are made periodically on an as-needed basis.

J.A. at 268 (Complaint Ex. 30).

Plaintiffs' Complaint contains no facts supporting their allegation that these factors are "irrelevant." Review of Michigan's case law, *see supra* Part II, reveals that the Michigan courts have not found some of these factors, such as HIAA tables and billing data from peer providers, irrelevant; furthermore, the state courts did not issue opinions calling the other factors into question until a few weeks before this lawsuit was commenced on September 23, 1996,[3] years after the correspondence cited by Plaintiffs was sent. The fact that the Defendants considered this data back in 1992 does not raise an inference that they did so as part of scheme to defraud their insureds and health care providers by using the data to assess the reasonableness of medical fees, or that the insurance companies' offers to pay for the insureds' "reasonable" PPI medical claims, as required under the statute, were knowingly false when made.

The only other arguable factual support for Plaintiffs' claim that Defendants misrepresented their intention to pay their insureds' reasonable medical expenses is the Plaintiffs' assertion that the fees paid by the Defendant Insurance Companies to Defendant Review Companies are "contingent upon the amount of savings (in the form of decreased payments to health care providers) the review companies' analyses yield[] for their insurance company clientele." J.A. at 118-19 (Complaint). While one might infer from such a fee arrangement the *potential* for fraud, Plaintiffs have failed to allege any fact--other than the mere existence of this fee

---

[3]Indeed, although *Munson* was decided on August 23, 1996, it was not released for publication until October 15, 1996. *See Munson Med. Ctr. v. Auto Club Ins. Assoc.*, 554 N.W.2d 49, 49 (Mich. Ct. App.), *appeal denied*, 564 N.W.2d 887 (Mich. 1996).

198(d), 205(d), 212(d), 219(d)). Assuming the Defendants' letters may be read to say this, Plaintiffs have not alleged facts which would support the inference that such statements were false. They have alleged no facts tending to show that the fees charged by the providers were "reasonable" (or that the amounts paid by the insurance companies were "unreasonable"), and Michigan law clearly states that health care providers are permitted to charge only a "reasonable" amount for auto-accident related medical care when the patient is covered by no-fault insurance, *see* MICH. COMP. LAWS ANN. § 500.3158; *McGill v. Automobile Assoc.*, 526 N.W.2d 12, 14 (Mich. Ct. App. 1994) ("[M]edical care providers are prohibited by law from charging more than a reasonable fee."). Thus, what the providers received from the Defendants may very well have been all they were entitled to receive under Michigan's no-fault act. Other than their general allegation of fraud, Plaintiffs allege no facts indicating that the providers' fees, rather than the insurance companies' payments, were the "reasonable" figures; the general allegation is not sufficient to satisfy Rule 9(b). The "reasonableness" of these charges is a legal conclusion, wholly unsupported by allegation of fact, and therefore it need not be accepted as true for purposes of 12(b)(6) review.

The district court did not err in holding that the complaint did not sufficiently plead mail and/or wire fraud as a predicate act.

2. Extortion: In Counts 8 and 10 of Plaintiffs' multiple RICO counts Plaintiffs also allege the predicate act of extortion. The factual allegations supporting these claims derive from letters sent by Defendants ACIA (Count 8) and Auto-Owners (Count 10) threatening litigation if the providers continued to bill the patient/insureds for the difference between the amount charged by the provider and the amount paid by the insurer ("balance billing").

To be guilty of extortion under Michigan law, one must:

First, Appellees contend that Appellants' "threaten to accuse them of crimes" argument was not raised below and is therefore waived. Appellants respond that their complaint clearly alleges that the insurers' letters contained the statement that the providers "may be violating the Michigan Collection Act," and also that they have argued from the outset that the letters constituted "threats" rising to the level of extortion. This argument is not "new", they contend; rather it merely "expounds" on the same argument made earlier. (Appellant's Reply Br. at 17 n.1.)

The purpose behind the waiver rule is to force the parties to marshal all of the relevant facts and issues before the district court, the tribunal authorized to make findings of fact. *See Hormel v. Helvering*, 312 U.S. 552, 556 (1941).[6] The notion that the statement "you may be in violation of the Michigan Collection Act if you continue to [do a particular act]" amounts to a threat to accuse someone of a crime is anything but obvious, and the forum in which the Plaintiffs were required to urge this interpretation of the facts was the trial court. Accordingly, we agree with the Appellees' assertion that it is appropriate for us to apply the waiver rule in this instance.

---

[6] In *Hormel* the Court stated:

> Ordinarily an appellate court does not give consideration to issues not raised below. For our procedural scheme contemplates that parties shall come to issue in the trial forum vested with authority to determine questions of fact. This is essential in order that parties may have the opportunity to offer all the evidence they believe relevant to the issues which the trial tribunal is alone competent to decide; it is equally essential in order that litigants may not be surprised on appeal by final decision there of issues upon which they have had no opportunity to introduce evidence.

312 U.S. at 556.

> If, in fact, you decide to report this to a collection agency, we will immediately act in the insured's behalf to have this removed and any action taken against the insured will result in our providing a defense.
>
> You have been previously advised of your appeal process with the reviewing company. It is recommended that you pursue that option. Your dispute rests with them or the Auto Club, not with the insured.

J.A. at 288 (Ex. 48) (emphasis added). Although this letter uses the words, "will be violating" rather than "may be violating," it does not threaten to accuse the provider of committing a crime.[7] In fact, the only threat this letter could be construed to make is that the insurance company would defend the insured if legal actions were pursued by the provider--hardly a threat at all, let alone a threat to accuse the provider of a crime.

Third, the threat must be "malicious." In *People v. Watson*, 11 N.W.2d 926, the female defendant engaged in an extramarital affair with the male victim, claimed to have become pregnant, asked for and received money from the victim for an illegal abortion, and then sent the victim a series of notes demanding more money for treatment of medical

---

[7] We also observe that at least one of the Plaintiffs did to a Defendant the very thing that the Appellants are now claiming to be "extortion." Dr. Paul Kenyon wrote to ManageAbility,

> Please be advised that if our patients are categorically told that our charges "are unreasonable," we will take legal action against any company whose representative(s) make such statements. Our attorney has advised us that such statements constitute slander, defamation, interference with contractual relationships, interference with prospective business relationships, *and a violation of various deceptive trade practices acts*.

J.A. at 265 (Ex. 29; emphasis added).

insurer and the provider have been engaged in such a dispute, the health care provider has billed the patient for the disputed amount and has vigorously pursued collection from the insureds or claimant directly.

The purpose of this bulletin is to remind no-fault insurers that they are required to provide insureds and claimants with complete protection from economic loss for benefits provided under personal protection insurance. Auto insurers must act at all times to assure that the insured or claimant is not exposed to harassment, dunning, disparagement of credit, or lawsuit as a result of a dispute between the health care provider and the insurer.

When such a dispute arises, an insurer will meet its statutory obligations by adhering to the following procedures. First, the insurance company must assume its statutory responsibility for complete protection of the insured. To do so, the insurer should notify the provider that the insurer is responsible for paying any reasonable charges, not the insured or claimant. Second, the insurer must also assure the policyholder or claimant of its responsibility. Insureds and claimants should be given directions on how to handle any bills or collection notices they receive. Third, the insurer should notify collection agencies and credit reporting agencies to disregard medical providers' claims against the insured for services covered under personal injury protection benefits. And finally, health care providers should be warned that the insurer will defend the insured or claimant against any attempt to collect, and may also consider any other appropriate action to prevent its policyholder from being pursued for collection.

A dispute between a medical provider and the insurer as to the reasonableness of the charge for services does not void the insurer's obligation to its insureds and claimants to pay the amount ultimately determined to be reasonable. The insurer also has an obligation to protect

B. ACQUIRING OR MAINTAINING AN INTEREST IN OR CONTROL OF AN ENTERPRISE THROUGH RACKETEERING ACTIVITY

A violation of § 1962(b) requires that the RICO defendant acquire or maintain an interest in, or control of, an enterprise *through* (or by way of) the pattern of racketeering activity. *Compagnie de Reassurance D'Ile de France v. New England Reinsurance Corp.*, 57 F.3d 56, 91-92 (1st Cir.), *cert. denied*, 516 U.S. 1109 (1995); *Lightning Lube, Inc. v. Witco Corp.*, 4 F.3d 1153, 1189-90 (3d Cir. 1993); *Danielsen v. Burnside-Ott Aviation Training Ctr.*, 941 F.2d 1220, 1230-31 (D.C. Cir. 1991); *see also BancTraining Video Sys. v. First Am. Corp.*, 956 F.2d 268, 1992 WL 42345, at *5 (6th Cir. Mar. 3, 1992) (per curiam). In their motion to dismiss, Defendants argued that the Plaintiffs did not adequately plead this element of a RICO violation. The district court, however, found that because it was dismissing the case for failure sufficiently to allege predicate acts or an enterprise, it did not need to address this argument. When reviewing a district court's dismissal under FED. R. CIV. P. 12(b)(6), an appellate court may affirm the district court's decision on any ground supported by the record, even if different from the grounds relied on by the district court. *Andrews v. Ohio*, 104 F.3d 803, 808 (6th Cir. 1997) (citing *City Management Corp. v. U.S. Chem. Co., Inc.*, 43 F.3d 244, 251 (6th Cir. 1994); *Russ' Kwik Car Wash, Inc. v. Marathon Petroleum Co.*, 772 F.2d 214, 216 (6th Cir. 1985)). We think it is important to address this argument as well.

Defendants are correct. Plaintiffs' RICO counts are entirely silent with regard to *how* Defendants acquired or maintained an interest in or control of the enterprise, namely the association of the insurance company and the review

C. Injury to business or Property "By Reason of" A Violation of § 1962(b)

Finally, Plaintiffs fail to allege that they were injured by reason of the Defendants' acquisition or maintenance of an interest in or control of the enterprise. The civil remedy created by § 1964(c) authorizes recovery only for injury that a plaintiff suffers "by reason of" the RICO violation; therefore, a complaint for violation of § 1962(b) must allege an "acquisition or maintenance" injury separate and apart from the injury suffered as a result of the predicate acts of racketeering activity. *Danielsen*, 941 F.2d at 1231. The First Circuit in *Compagnie de Reassurance D'Ile de France* found such a flaw fatal:

> Under § 1962(b), the plaintiffs had to show that they were harmed by reason of NERCO's acquisition or maintenance of control of an enterprise through a pattern of racketeering activity. Again, even assuming that plaintiffs proved the underlying RICO violation, they failed to prove any harm *beyond that resulting from the fraud which constituted the predicate act.*57 F.3d at 92 (emphasis added); *see also Danielsen*, 941 F.2d at 1231 ("Plaintiffs do not allege that their purported injury (underpayments of wages and benefits) was caused by the acquisition of an enterprise. . . . [P]laintiffs allege . . . simply that their injuries result from 'the intentional and continuous underpayment of legally required minimum wages and fringe benefits.'"); *but cf. Craighead v. E.F. Hutton & Co., Inc.*, 899 F.2d 485, 494 (6th Cir. 1990) (stating that plaintiffs' § 1962(a) claim fails "because they have not alleged injuries stemming directly from the defendants' alleged use or investment of their illegally obtained income. *Unlike section 1962(c), subsection (a) requires such a separate and traceable injury, and plaintiffs have alleged only injuries traceable to the alleged predicate acts.*") (emphasis added).

1237 (E.D. Mich. 1995), *aff'd*, 129 F.3d 1266, 1997 WL 729451 (6th Cir. Nov. 12, 1997) (unpublished per curiam):

> [A]ccording to 18 U.S.C. § 1964(c), plaintiff can only seek a civil remedy under RICO if her business or property was injured by reason of the § 1962(b) violation. Contrary to plaintiff's assertion, one does not violate § 1962(b) by committing mail fraud or extortion. Instead, one must use racketeering activity to gain control or interest in an enterprise. In other words, plaintiff cannot simply allege that she was injured by the underlying acts of mail fraud and extortion. Rather, she must allege that she was injured by a violation of § 1962(b). In this case, in order to be injured by a violation of § 1962(b), plaintiff must show that her alleged injuries resulted from Auto Club having maintained an interest in itself as an enterprise.

Whaley, 891 F. Supp. at 1242; *see also id.* at 1242-43 (discussing how *Sedima, S.P.R.L. v. Imrex Co., Inc.*, 473 U.S. 479 (1985), did not compel a different outcome).

The Plaintiffs here have alleged only injury resulting from the "scheme to defraud" or "scheme to extort" (*i.e.*, the racketeering activity), rather than from the acquisition of an interest in or control of the alleged enterprise. *See, e.g.*, J.A. at 168 (Complaint ¶ 179) ("The above described scheme to defraud both the Plaintiff insureds, and . . . health care providers, conducted by the enterprise as described above, has caused the Plaintiff insureds and the Plaintiff health care providers to suffer damages . . . ."); J.A. at 171 (Complaint ¶ 187) ("The above described scheme to . . . attempt to extort acts or omissions against the wills of health care providers, conducted by the enterprise described above, has caused the Plaintiff insureds and the Plaintiff health care providers to suffer damages . . . .").

reasonableness to be determined by some neutral party and contains no standards whatsoever for gauging what is reasonable, an allegation that the Defendants promised to pay the reasonable charge while intending to pay less than the reasonable charge cannot even state a claim for fraud as a matter of law.