UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

ADVOCACY ORGANIZATION FOR PATIENTS AND PROVIDERS, a non-profit Michigan corporation, et al.,

Plaintiffs,

v.

AUTO CLUB INSURANCE ASSOCIATION, a Michigan Corporation, et al.,

Defendants.
_____/

Case No. 5:96-CV-177

HON. ROBERT HOLMES BELL

OPINION

Before the Court are a number of Rule 12(b) motions filed by (1) the Defendant insurance companies, (2) Defendant Review Works, (3) Defendant TIG Insurance and (4) Defendant State Farm Insurance. These motions are joined by Defendants Manageability, Medaudit and Recovery Unlimited. The underlying action is brought by Advocacy Organization for Patients and Providers, a number of individual doctors, and two patients against the Defendant insurance and review companies. This matter arises out of a dispute over the interpretation of Michigan's no-fault motor vehicle protection statute and the roles of health care providers, insurance companies, and review companies under that statute.

The portions of the Michigan no-fault statute that are at issue include section 3107 which states: "(1) Except as provided in subsection (2), personal protection insurance benefits are payable for the following: (a) Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an

injured person's care, recovery, or rehabilitation." In addition section 3157 of the statute states,

> 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.

MCLA 500.3157.

In their complaint, Plaintiffs claim that the actions of the Defendant insurance and review companies are in clear violation of the no-fault act. They seek a declaratory judgment setting out various rights and responsibilities of the parties under the act, a preliminary injunction, and a permanent injunction. They allege claims of tortious interference with existing contractual relations, tortious interference with business relations, conspiracy to tortiously interfere with existing business and contractual relationships, common law fraud, and eight violations of RICO, 18 U.S.C. § 1962(b).

The Defendants put forward a number of grounds for dismissal under Rule 12(b). This Court will first address the 12(b)(6) motions with respect to the federal claims raised by the Plaintiffs. Because Plaintiffs' state claims raise issues of state insurance regulation which are inextricably involved with state law, this Court will remand this matter to state court if the counts raising federal questions are dismissed.

I.

In evaluating a motion to dismiss under Rule 12(b)(6), a court must construe the complaint in the light most favorable to the plaintiffs, accept all factual allegations as true, and

determine whether the plaintiffs undoubtedly can prove no set of facts in support of their claim that would entitle them to relief. *Columbia Natural Resources, Inc. v. Tatum*, 58 F.3d 1101, 1109 (6th Cir. 1995), *cert. denied* __ U.S. __, 116 S.Ct. 1041, 134 L.Ed.2d 189 (1996).

II.

The Plaintiffs raise a number of alleged violations of section §1962(b) of RICO. Section 1962(b) states "[i]t shall be 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."

> To establish a violation of RICO cognizable in a civil action, the plaintiff: must allege the existence of seven constituent elements: (1) that the defendant (2) through the commission of two or more acts (3) constituting a "pattern" (4) of "racketeering activity" (5) directly or indirectly invests in, or maintains an interest in, or participates in (6) an "enterprise" (7) the activities of which affect interstate or foreign commerce.

United States v. District Council of New York City, 778 F.Supp. 738, 751 (S.D.N.Y. 1991) (citing *Moss v. Morgan Stanley Inc.*, 719 F.2d 5, 17 (2d Cir.1983), cert. denied, 465 U.S. 1025 (1984)).

The predicate acts alleged by the Plaintiffs in this matter are mail/wire fraud and extortion. The Plaintiffs contend that a number of acts on the part of the Defendants constitute fraud and/or extortion. They claim that since 1992, the Defendant insurance companies have used the Defendant review companies to review whether the products, services, and accommodations used by the health care providers were reasonably necessary and whether the billed costs were reasonable. The Plaintiffs claim that the Defendants used irrelevant data, such as worker's compensation fee schedules, in reviewing the bills. The Plaintiffs

also allege that the Defendants have interfered with their attempts to collect from their patients the amount the insurance companies refused to pay. This practice employed by the Plaintiffs is called "balance billing." The Plaintiffs complain that the insurance companies have stated that their insureds are not responsible for the balance, and the Defendants have allegedly sent letters to the patients and providers setting forth their position on this issue. In addition, they have threatened legal action against the providers if the Plaintiff health care providers attempt to balance bill the insured individuals.

"Mail fraud consists of 'a scheme or artiface to defraud and a mailing for the purpose of executing the scheme'.... A scheme to defraud consists of '[i]ntentional fraud, consisting in deception intentionally practiced to induce another to part with property or surrender some legal right, and which accomplishes the designed end.'" *Kenty v. Bank One,* 92 F.3d 384, 389 (6th Cir. 1996)(quoting *Bender v. Southland Corp.*, 749 F.2d 1205, 1215-16 (6th Cir. 1984). The *Kenty* court also explained that "[t]o allege intentional fraud, there must be 'proof of misrepresentation or omissions which were "reasonably calculated to deceive persons of ordinary prudence and comprehension."' ... The plaintiff must also allege 'the facts showing the plaintiff's reliance on the defendant's false statement of fact [or omission].'" *Id.* (quoting *Blount Fin. Servs., Inc. v. Walter E. Heller & Co.*, 819 F.2d 151, 153 (6th Cir. 1987).

"Extortion requires the obtaining of property through the wrongful use of threatened violence, force, or fear." *Whaley v. Auto Club. Ins. Ass'n,* 891 F.Supp. 1237, 1240 (E.D. Mich. 1995)(citations omitted).

With respect to the claims of fraud and extortion, a separate issue is whether the Defendants had the proper intent to commit the alleged acts. Routine business communications that only demonstrate a dispute between the parties do not give a reasonable inference of fraudulent intent. *Atlantic Gypsum v. Lloyds Intern. Comp.*, 753 F.Supp. 505, 513 (S.D.N.Y. 1990). Different positions under a contract, even if one interpretation may constitute a breach, does not constitute fraud. *Blount,* 819 F.2d at 152 - 53. Also, a good faith dispute over the interpretation of a state statute does not constitute an intent to defraud. *Whaley*, 891 F.Supp. at 1240. Finally, "[t]he existence of a genuine dispute,... acts as a bar to RICO claims. *United National Bank v. Federal National Mortgage Ass'n,* 860 F.2d 847, 858 (8th Cir. 1988).

In this matter the Plaintiffs cite to Michigan case law and the no-fault statute and claim that (1) it is clear that the Defendants do not have a right to stand in the way of their attempts to balance bill their patients; (2) the insurance companies may not defend their insureds without the consent of the insured individual; (3) health care providers are permitted to collect from their patients regardless of a determination by an insurance company that the cost or procedure was unreasonable; (4) the Defendants may not use fee schedules in determining the reasonableness of the health care providers' charges. The Plaintiffs conclude that the Defendants' interpretation of the no-fault statute is incorrect. Not only do they claim that the Defendants' interpretation is incorrect, they claim that the Defendants' actions based upon their alleged incorrect interpretation constitute fraud and/or extortion.

The Defendants rely upon Michigan case law, the no-fault statute, and opinions of Michigan's attorney general and insurance commissioner. They claim that under Michigan law (1) insurance companies have a duty to check the reasonableness of the bills submitted by health care providers; (2) insurance companies have a cost policing function under the no-fault act; (3) if the bills submitted by the health care provider are unreasonable, the health care provider is not entitled to enforce the unreasonable contract; (4) if a fee which a health care provider seeks to collect is arguably within the scope of insurance coverage, the insurer has a duty to defend its insured, and (5) any dispute over the reasonableness of a bill is between a provider and insurance company, not the provider and insured.

After reviewing the complaint in a light most favorable to the Plaintiff, this Court finds that at best the Plaintiffs have set forth a valid issue as to the interpretation of the Michigan no-fault statute, not a pattern of racketeering activity. This appears to be a good faith dispute as to the rights, duties, and obligations of the key players involved with the Michigan no-fault statute. Even if a court adopts the Plaintiffs' interpretation of the insurance companies' duties under the no-fault act, there is nothing in the complaint, except numerous legal conclusion by the Plaintiffs, alleging that the Defendants had the intent necessary to sustain a claim of fraud or extortion. On a 12(b)(6) motion, this Court is not obligated to accept the legal conclusions stated by the Plaintiffs.

In addition, as to the fraud claims, the Complaint fails to allege the Plaintiffs' reliance on the alleged false statements by the Defendants. Instead, the Complaint states that the health care providers refused to accept the insurance companies' conclusions regarding the providers' bills. See Complaint, ¶168(e). With respect to the claims of extortion, the only

coercion alleged by the Plaintiffs is the litigation threatened by the Defendants. This threatened litigation arose out of the Defendants' interpretation as to their duties under the insurance policy and no-fault statute. "A statement of intention to file suit to enforce one's claimed legal rights is neither a threat nor the exercise of unlawful or wrongful coercion." *Various Markets Inc. v. Chase Manhatten Inc.*, 908 F.Supp 459, 468 (E.D.Mich. 1995). As a result, the Plaintiffs have failed to allege a claim of fraud or extortion. Therefore, the Plaintiffs have failed to plead a predicate act upon which they can base a RICO claim.

In addition, this Court finds that the Plaintiffs have also failed to allege a RICO enterprise. The RICO statute explains that "enterprise includes any individual, partnership, corporation, association, or other legal entity, and any union or group of individuals associated in fact although not a legal entity." 18 U.S.C. § 1961(4). A RICO enterprise must also have an ascertainable structure separate and apart from the pattern of racketeering activity engaged in by the defendant. *Chang v. Chen*, 80 F.3d 1293, 1298 (9th Cir. 1996)(citing *United States v. Turkette*, 452 U.S. 576, 583(1981)).

The enterprise alleged by the Plaintiffs is the association of individual insurance companies and review companies which assisted them. The Plaintiffs state: "It is clear they acted together. Otherwise, the review companies would have had no part in the processing of automobile no-fault related medical claims." (Plaintiffs' brief [docket # 88] at p.61). The "enterprise ... was created solely for the purpose of carrying out the fraudulent scheme complained of by the Plaintiffs." (*Id.* at 64). "There is no other way in which review companies could have become involved in the processing and/or payment of automobile no-fault related medical claims except for such an association to have occurred." (*Id.* at 66).

This Court finds that the Plaintiffs have failed to allege an ascertainable structure separate from the alleged pattern of racketeering. The Plaintiffs merely claim that the alleged enterprise is synonymous with the alleged racketeering acts. This is not a sufficient claim of an ascertainable structure separate from the alleged enterprise.

The Plaintiffs rely on *Brownell v. State Farm Mut. Ins. Co.*, 757 F.Supp. 526 (E.D. Pa. 1991) for the proposition that the Defendant insurance and review companies combined to form a number of enterprises. However, the *Brownell* court did not even address whether the alleged enterprise was separate and apart from the pattern of activity in which it allegedly engaged. *Id.* at 539. As stated above, the Plaintiffs have not alleged an ascertainable structure separate from the alleged enterprise.

For the reasons stated above, this Court finds that the Plaintiffs have failed to allege a RICO claim under section 1962(b) sufficient to sustain a rule 12(b)(6) challenge by the Defendants. Because the Plaintiffs have failed to sufficiently allege the predicate acts or an enterprise, it is not necessary to determine whether the Plaintiffs have sufficiently alleged that the Defendants acquired and maintained control of the enterprise through racketeering or that the Defendants' acquisition or control of the enterprise resulted in an injury to the Plaintiffs.

III.

The Plaintiffs' second federal claim is found in Count 3 of the Complaint. In Count 3, a request for permanent injunctive relief, the Plaintiffs state that,

> The efforts by the Defendant insurance companies [that they "are entitled to refuse to pay for some of the health care services provided to their insureds" and that their determinations are controlling]... are improper, and, because of the nexus between the insurance companies and the State of Michigan in implementing the objectives of the No-Fault Act, said efforts constitute state action which, to the extent they have succeeded and are likely to continue to

> succeed to interfere with valid contracts between health care providers and their patients, will violate Article 1, §10 of the Michigan Constitution and the due process of law provisions of the Michigan and United States Constitutions.

(Plaintiff's Complaint ¶ 139).

Therefore, the Plaintiffs allege that the actions of the Defendants violate the due process provisions of the United States Constitution.

"The protections of the due process clause can only be invoked when there has been state action." *Shavers v. Attorney General*, 402 Mich. 554 (1978) *cert. denied,* 442 U.S. 934 (1979)(citing *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 349-350, 95 S.Ct. 449, 42 L.Ed.2d 477 (1974)).

The Plaintiffs claim that under *Shavers* and *Jackson,* the entire no-fault insurance regulatory scheme is subject to due process scrutiny. *Shavers* dealt with the denial of applications for no fault insurance. The court found that denial of coverage effectively prevented individuals from driving and that the mobility provided by an automobile is a crucial, practical necessity. *Shavers,* 402 Mich. at 598. It also noted that "[a] driver's license, once issued, is a significant interest subject to constitutional due process protections." *Id.* at 599 (citing *Bell v. Burson*, 402 US 535, 539, 91 S.Ct. 1586, 29 L.Ed.2d 90 (1971)). The court stated,

> The No-Fault Act compels insurance for all motor vehicles; failure to comply with this requirement may result in criminal and civil sanctions. In addition, the No-Fault Act specifies the extent of coverage to be provided and the conditions of payment for insurance benefits. Finally, the No-Fault Act and the Insurance Code provide for the assignment of claims and risks. In effect, insurance companies are the instruments through which the Legislature carries out a scheme of general welfare. This legislation goes beyond a grant of a monopoly or an attempt to regulate a utility; there exists "a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the (regulated entity) may fairly be treated as that of the State itself.

Id. at 597.

The Defendants contend that no essential right equivalent to the right to drive is implicated in this case. The Defendants also cite to the factors listed by the Supreme Court in the *Jackson* decision:

> The mere fact that a business is subject to state regulation does not by itself convert its action into that of the State for purposes of the Fourteenth Amendment. Nor does the fact that the regulation is extensive and detailed, as in the case of most public utilities, do so. It may well be that acts of a heavily regulated utility with at least something of a governmentally protected monopoly will more readily be found to be 'state' acts than will the acts of an entity lacking these characteristics. But the inquiry must be whether there is a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself. The true nature of the State's involvement may not be immediately obvious, and detailed inquiry may be required in order to determine whether the test is met.

Jackson 419 US at 350 - 51.

This Court finds that a dispute between insurance companies and health care providers over what is a reasonable charge and over whether a health care provider is permitted to balance bill under the no-fault act does not convert the insurance companies' actions into state action for due process purposes. *Shavers* should not be read to cause every action by a no-fault insurer to be state action for due process purposes. This case does not implicate issues which are similar to an individual's ability to get no-fault insurance, and consequently to drive. The Defendants' review of the reasonableness of bills and challenge to the health care providers' attempts to balance bill do not have a sufficiently close nexus to the state so that the Defendants' actions may be fairly treated as that of the state itself. Because the alleged actions of the Defendants do not constitute State action, the Plaintiffs cannot invoke the protection of the due process clause. Therefore, the Plaintiffs' due process claims must be dismissed.

The Plaintiffs' remaining claims are based upon state law. Because the only federal claims have been eliminated, comity compels this Court to decline to exercise supplemental jurisdiction over the remaining state law claims. See *Carnegie-Mellon v. Cohill*, 484 U.S. 343, 357, 108 S.Ct. 614, 622, 98 L.Ed.2d 720 (1988). Because the matter was removed from state court, this Court may exercise its discretion and remand the remaining state law matters to state court. *Id.* 484 U.S. at 351, 108 S.Ct. at 619, 98 L.Ed.2d 720. Therefore, the remaining state law claims shall be remanded to Eaton County Circuit Court.

An order consistent with this opinion shall be entered.

Dated: June 19, 2017

ROBERT HOLMES BELL
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

ADVOCACY ORGANIZATION FOR PATIENTS AND PROVIDERS, a non-profit Michigan corporation, et al..

Plaintiffs,

v.

AUTO CLUB INSURANCE ASSOCIATION, a Michigan Corporation, et al.,

Defendants.
/

Case No. 5:96-CV-177

HON. ROBERT HOLMES BELL

ORDER

In accordance with the opinion entered this date

IT IS HEREBY ORDERED that Counts 8 -15 of Plaintiffs' Complaint are **DISMISSED** for failure to state a claim upon which relief can be granted.

IT IS FURTHER ORDERED that Plaintiffs' Federal Due Process claims in Count 3 of the complaint are **DISMISSED** for failure to state a claim upon which relief can be granted.

IT IS FURTHER ORDERED that Plaintiffs' remaining claims are **REMANDED** to Eaton County Circuit Court.

IT IS SO ORDERED.

Dated: Dec 9, 1997

ROBERT HOLMES BELL
UNITED STATES DISTRICT JUDGE