17-12583

United States Court of Appeals
for the
Eleventh Circuit

CRAWFORD'S AUTO CENTER, INC., on behalf of Itself and all others similarly situated, K & M COLLISION, LLC, on behalf of itself and all others similarly situated,

Plaintiffs-Appellants,

– v. –

THE ALLSTATE CORPORATION, ALLSTATE INSURANCE COMPANY, ALLSTATE COUNTY MUTUAL INSURANCE COMPANY, ALLSTATE FIRE & CASUALTY INSURANCE COMPANY, ALLSTATE INDEMNITY COMPANY, ALLSTATE NEW JERSEY INSURANCE, ALLSTATE NEW JERSEY PROPERTY & CASUALTY INSURANCE COMPANY, ALLSTATE PROPERTY & CASUALTY INSURANCE COMPANY, ENCOMPASS INDEMNITY COMPANY, ESURANCE INSURANCE COMPANY, ESURANCE PROPERTY & CASUALTY INSURANCE COMPANY, STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, STATE FARM GENERAL INSURANCE COMPANY, STATE FARM INDEMNITY COMPANY, STATE FARM GUARANTY INSURANCE COMPANY, STATE FARM FIRE AND CASUALTY COMPANY, *et al.*,

Defendants-Appellees.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA (CASE NO. 6:14-cv-06016-GAP-TBS)

BRIEF FOR PLAINTIFFS-APPELLANTS

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CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1 and 11th Cir. R. 26.1-1, 26.1-2, 26.1-3, and 27-1, the following is an alphabetical list of the trial judges, attorneys, persons, firms, partnerships, and corporations that are known to have an actual or potential interest in the outcome of this appeal:

1. Allied Property & Casualty Insurance Company;
2. Allstate Corporation (Parent Company, Allstate Corp.'s ticker symbol: ALL);
3. Allstate County Mutual Insurance Company (Parent Company, Allstate Corp.'s ticker symbol: ALL);
4. Allstate Fire & Casualty Insurance Company (Parent Company, Allstate Corp.'s ticker symbol: ALL);
5. Allstate Insurance Company (Parent Company, Allstate Corp.'s ticker symbol: ALL);
6. Allstate New Jersey Insurance (Parent Company, Allstate Corp.'s ticker symbol: ALL);
7. Allstate New Jersey Property and Casualty Insurance Company (Parent Company, Allstate Corp.'s ticker symbol: ALL);
8. Allstate Property & Casualty Insurance Company (Parent Company, Allstate Corp.'s ticker symbol: ALL);

9. AMCO Insurance Company;

10. Artisan & Truckers Casualty Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

11. Austin, Brent R., EIMER STAHL LLP, attorneys for Defendants/Appellees;

12. Barrett, John W., BAILEY & GLASSER LLP, attorneys for Plaintiffs;

13. Barthel, David J., CARPENTER LIPPS & LELAND LLP, attorneys for Defendants/Appellees;

14. Beekhuizen, Michael N., CARPENTER LIPPS & LELAND LLP, attorneys for Defendants/Appellees;

15. Bloch, Steven L., BAILEY & GLASSER LLP, attorneys for Plaintiffs/Appellants;

16. Bristol West Insurance Company (Parent Company, Zurich Insurance Group AG's ticker symbols: ZURN.VX; ZURN.DE);

17. Caldwell, Lori J., Rumberger, Kirk & Caldwell, P.A., attorneys for Defendants/Appellees;

18. Carpenter, Michael H., CARPENTER LIPPS & LELAND LLP, attorneys for Defendants/Appellees;

19. Cashdan, Jeffrey S., KING & SPALDING LLP, attorneys for Defendants/Appellees;
20. Chapman, Trischa Snyder, BAKER HOSTETLER LLP, attorneys for Defendants/Appellees;
21. Clark, Johanna W., CARLTON FIELDS JORDEN BURT, P.A., attorneys for Defendants/Appellees;
22. Coast National Insurance Company (Parent Company, Zurich Insurance Group AG's ticker symbols: ZURN.VX; ZURN.DE);
23. Colonial County Mutual Insurance Company;
24. Crawford's Auto Center, Inc.;
25. Depositors Insurance Company;
26. DeSanto, Mark B., BAILEY & GLASSER LLP, attorneys for Plaintiffs/Appellants;
27. Encompass Indemnity Company (Parent Company, Allstate Corp.'s ticker symbol: ALL);
28. Esurance Insurance Company (Parent Company, Allstate Corp.'s ticker symbol: ALL);
29. Esurance Property & Casualty Insurance Company (Parent Company, Allstate Corp.'s ticker symbol: ALL);
30. Ezzie, Joseph E., attorneys for Defendants/Appellees;

31. Farmers Insurance Company, Inc. (Parent Company, Zurich Insurance Group AG's ticker symbols: ZURN.VX; ZURN.DE);

32. Farmers Insurance Company of Arizona (Parent Company, Zurich Insurance Group AG's ticker symbols: ZURN.VX; ZURN.DE);

33. Farmers Insurance Company of Oregon (Parent Company, Zurich Insurance Group AG's ticker symbols: ZURN.VX; ZURN.DE);

34. Farmers Insurance Company of Washington (Parent Company, Zurich Insurance Group AG's ticker symbols: ZURN.VX; ZURN.DE);

35. Farmers Insurance Exchange (Parent Company, Zurich Insurance Group AG's ticker symbols: ZURN.VX; ZURN.DE);

36. Farmers Texas County Mutual Insurance Company (Parent Company, Zurich Insurance Group AG's ticker symbols: ZURN.VX; ZURN.DE);

37. Fenton, Richard L., Dentons US LLP, attorneys for Defendants/Appellees;

38. Fischer, Ian M., LEWIS ROCA ROTHGERBER CHRISTIE LLP, attorneys for Defendants/Appellees;

39. Foremost County Mutual Insurance Company (Parent Company, Zurich Insurance Group AG's ticker symbols: ZURN.VX; ZURN.DE);

40. Fry, Allison P., JOHN ARTHUR EAVES, ATTORNEYS AT LAW, attorneys for Plaintiffs;

41. GEICO Advantage Insurance Company (Parent Company, Berkshire Hathaway's ticker symbol: BRK.A);

42. GEICO Casualty Company (Parent Company, Berkshire Hathaway's ticker symbol: BRK.A);

43. GEICO Choice Insurance Company (Parent Company, Berkshire Hathaway's ticker symbol: BRK.A);

44. GEICO County Mutual Insurance Company (Parent Company, Berkshire Hathaway's ticker symbol: BRK.A);

45. GEICO General Insurance Company (Parent Company, Berkshire Hathaway's ticker symbol: BRK.A);

46. GEICO Indemnity Company (Parent Company, Berkshire Hathaway's ticker symbol: BRK.A);

47. GEICO Secure Insurance Company (Parent Company, Berkshire Hathaway's ticker symbol: BRK.A);

48. Goldberg, Joshua S., CARPENTER LIPPS & LELAND LLP, attorneys for Defendants/Appellees;

49. Goldfine, Dan W., LEWIS ROCA ROTHGERBER CHRISTIE LLP, attorneys for Defendants/Appellees;

50. Government Employee's Insurance Company (Parent Company, Berkshire Hathaway's ticker symbol: BRK.A);
51. Grabel, Joshua, LEWIS ROCA ROTHGERBER CHRISTIE LLP, attorneys for Defendants/Appellees;
52. Halavais, Jamie L., LEWIS ROCA ROTHGERBER CHRISTIE LLP, attorneys for Defendants/Appellees;
53. Hanover, Mark L., Dentons US LLP, attorneys for Defendants/Appellees;
54. Hochstadt, Eric S., WEIL, GOTSHAL & MANGES LLP, attorneys for Defendants/Appellees;
55. Illinois Farmers Insurance Company (Parent Company, Zurich Insurance Group AG's ticker symbols: ZURN.VX; ZURN.DE);
56. Kipnis, Patricia M., BAILEY & GLASSER, LLP, attorneys for Plaintiffs;
57. Kenny, Michael P., ALSTON & BIRD LLP; attorneys for Defendants/Appellees;
58. Kochis, Kymberly, SUTHERLAND ASBILL & BRENNAN LLP, attorneys for Defendants/Appellees;
59. K&M Collision, LLC;
60. Lau, Bonnie, Dentons US LLP, attorneys for Defendants/Appellees;

61. Liberty County Mutual Insurance Company, Texas;

62. Liberty Mutual Fire Insurance Company;

63. Liberty Mutual Group, Inc.;

64. Liberty Mutual Holding Company, Inc.;

65. Liberty Mutual Insurance Company;

66. Litchford, Hal Kemp, BAKER, DONELSON, BEARMAN, CALDWELL & BERKOWITZ, PC, attorneys for Defendants/Appellees;

67. LM General Insurance Company;

68. Mastando III, John P., WEIL, GOTSHAL & MANGES LLP, attorneys for Defendants/Appellees;

69. McCluggage, Michael L., EIMER STAHL LLP; attorneys for Defendants/Appellees;

70. Mid-Century Insurance Company (Parent Company, Zurich Insurance Group AG's ticker symbols: ZURN.VX; ZURN.DE);

71. Mumford, Michael E., BAKER HOSTETLER LLP, attorneys for Defendants/Appellees;

72. Nationwide Affinity Insurance Company of America;

73. Nationwide Agribusiness Insurance Company;

74. Nationwide Insurance Company of America;

75. Nationwide Mutual Fire Insurance Company;

76. Nationwide Mutual Insurance Company;

77. Nationwide Property & Casualty Insurance Company;

78. Nelson, Michael R., SUTHERLAND ASBILL & BRENNAN LLP, attorneys for Defendants/Appellees;

79. Nolan, Francis X., SUTHERLAND ASBILL & BRENNAN LLP, attorneys for Defendants/Appellees;

80. Oates, Claire C., KING & SPALDING LLP, attorneys for Defendants/Appellees;

81. Peerless Insurance Company;

82. Presnell, The Honorable Gregory A.;

83. Progressive Advanced Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

84. Progressive American Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

85. Progressive Casualty Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

86. Progressive Choice Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

87. Progressive Classic Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

88. Progressive County Mutual Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

89. Progressive Direct Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

90. Progressive Garden State Insurance (Parent Company, Progressive Corp.'s ticker symbol: PGR);

91. Progressive Gulf Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

92. Progressive Marathon Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

93. Progressive Michigan Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

94. Progressive Mountain Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

95. Progressive Northwestern Insurance (Parent Company, Progressive Corp.'s ticker symbol: PGR);

96. Progressive Northern Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

97. Progressive Paloverde Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

98. Progressive Preferred Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

99. Progressive Security Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

100. Progressive Select Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

101. Progressive Southeastern Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

102. Progressive Specialty Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

103. Progressive Universal Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

104. Progressive West Insurance Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

105. SAFECO Insurance Company of America;

106. SAFECO Insurance Company of Illinois;

107. Sorensen, David F., BERGER & MONTAGUE, PC, attorneys for Plaintiffs;

108. Sprengel, Jennifer Winter, CAFFERTY CLOBES MERIWETHER & SPRENGEL LLP; attorneys for Plaintiffs;

109. State Farm County Mutual Insurance Company of Texas;

110. State Farm Fire and Casualty Company;

111. State Farm General Insurance Company;

112. State Farm Guaranty Insurance Company;

113. State Farm Indemnity Company;

114. State Farm Mutual Automobile Insurance Company;

115. The First Liberty Insurance Corporation;

116. The Progressive Corporation (ticker symbol: PGR);

117. Truck Insurance Exchange (Parent Company, Zurich Insurance Group AG's ticker symbols: ZURN.VX; ZURN.DE);

118. United Financial Casualty Company (Parent Company, Progressive Corp.'s ticker symbol: PGR);

119. Vargo, Ernest E., BAKER HOSTETLER LLP, attorneys for Defendants/Appellees;

120. Yohai, David L., WEIL, GOTSHAL & MANGES LLP, attorneys for Defendants/Appellees;

121. 21st Century Centennial Insurance Company;

122. 21st Century Indemnity Insurance Company;

123. 21st Century Insurance Company;

Counsel for Plaintiffs-Appellants hereby certify that the foregoing is a full and complete list of all persons and entities known to have an interest in the outcome of this appeal.

/s/ Steven L. Bloch
Steven L. Bloch

STATEMENT REGARDING ORAL ARGUMENT

Plaintiffs-Appellants respectfully request oral argument. This appeal raises a number of significant legal and factual issues, and Plaintiffs-Appellants believe that oral argument will assist the Court in its analysis of the issues presented on appeal, including the district court's consideration of Plaintiffs-Appellants' complaint in light of Federal Rule of Civil Procedure 12(b)(6) and the standards for pleading actionable claims under the Racketeer Influenced and Corrupt Organizations Act ("RICO"), as codified in 18 U.S.C. §§ 1962 (c) and (d), as well as state law, based on Appellees' long-running unlawful conduct to suppress compensation to repair facilities for automotive collision repairs covered by insurance, the district court's exclusion of relevant and material exhibits and evidence, and the district court's failure to grant leave to amend the complaint.

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STATEMENT OF SUBJECT MATTER AND APPELLATE JURISDICTION

Plaintiffs-Appellants, Crawford's Auto Center, Inc. and K&M Collision, LLC (collectively, "Appellants") brought a putative class action against Defendants-Appellees State Farm Mutual Automobile Insurance Company ("State Farm"), Allstate Corporation ("Allstate"), Government Employees Insurance Company ("GEICO"), The Progressive Corporation ("Progressive"), Farmers Insurance Exchange ("Farmers"), Liberty Mutual Group, Inc. ("Liberty"), Nationwide Mutual Insurance Company ("Nationwide") and their respective affiliates, subsidiaries and divisions (collectively, "Appellees" or "Insurers"), as defined in Appellants' Second Amended Complaint (DOC. 205)[1] ("SAC"), alleging violations of RICO, including 18 U.S.C. §§ 1962(c) and (d), and other state laws. [2]

The district court had federal question subject matter jurisdiction for Appellants' claims arising under RICO (§§ 1961 *et seq*.) pursuant to 28 U.S.C. § 1331 and 18 U.S.C. § 1964, and supplemental subject matter jurisdiction over Appellants' pendant state law claims pursuant to 28 U.S.C. §1367. The district court also had diversity jurisdiction over Appellants' action pursuant to 28 U.S.C.

[1] "DOC." refers to the Record Excerpts.

[2] Appellants are not pursuing this appeal against the Progressive and Farmers Defendants.

§ 1332(d) because the amount in controversy exceeds $5,000,000, and there are members of the classes who are citizens of a different state than the Appellees.

By Order dated May 8, 2017 (the "Order"), the district court dismissed with prejudice all claims asserted in the SAC on the grounds that Appellants failed to plead actionable RICO extortion and fraud claims, as well as stat law claims for unjust enrichment and fraud under both North Carolina and Pennsylvania law. (DOC. 205).

Appellants timely appealed. (DOC. 282). This Court has jurisdiction to review the final decision of the district court under 28 U.S.C. §1291.

I. STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

1. Did the district court err in holding that the Complaint failed to allege a claim for RICO fraud? This issue is reviewed *de novo.*
2. Did the district court err in holding that the Complaint failed to allege a claim for RICO extortion? This issue is reviewed *de novo.*
3. Did the district court err in holding that the Complaint failed to allege a claim for common law fraud? This issue is reviewed *de novo.*
4. Did the district court err in holding that the Complaint failed to allege a claim for unjust enrichment? This issue is reviewed *de novo.*
5. Did the district court err in sustaining Appellees' objections pursuant to DOC. 274? This issue is reviewed *de novo.*
6. Did the district court err in sustaining Appellees' objections pursuant to DOC. 275? This issue is reviewed *de novo.*
7. Did the district court err by dismissing the action with prejudice without granting Appellants' leave to amend? This issue is reviewed *de novo.*

II. STATEMENT OF THE CASE

A. Nature of the Case

This class action asserts claims under RICO, 18 U.S.C. § 1962(c) (fraud and extortion), common law fraud, and unjust enrichment against State Farm, Allstate, GEICO, Nationwide and Liberty Mutual (and their affiliates) to remedy the insurers'

respective long-running unlawful conduct to suppress compensation due to repair facilities for automotive collision repairs performed for first and third party insurance claimants by misrepresenting what is necessary to restore the damages vehicles to "pre-loss condition", which is the standard that defines Insurers' loss payment obligations for repairs. Insurers rely on artificial rates and repair standards – so-called prevailing or competitive rates and processes – to mispresent to insurance claimants and repair professionals alike what is necessary to properly repair and restore vehicles to pre-loss condition, and, thereby, the appropriate measure of compensation for the restorative repairs. Each proposed class consists of collision repair facilities, like Appellants, which have *not* contracted with that particular insurer to abide by its purported rates and repair processes. (*See, e.g.*, "State Farm Enterprise Class").

All collision repairs use the estimating programs from one of the three co-conspirator "Information Providers" (CCC, Mitchell and AudaExplore). The estimating programs appraise the damage to the vehicle and construct a blueprint for repair. The three IPs hold 99% of the U.S. market, and sell their estimating programs to both Insurers and collision repair facilities alike. (DOC. 205 ¶¶ 67, 71, 78). The Insurers have exclusive relationships with the Information Providers. Each Insurer in collaboration with its respective Information Provider partner – which together comprise the alleged RICO enterprises – establishes: (i) industry data on collision

repair rates; and (ii) industry standards for repair procedures and processes, and the time to perform the repairs, which each Insurer promulgates as the prevailing or competitive rates and repair procedures. (DOC. 205 ¶¶ 69-84, 113-139, 166-168, 187-189). However, all of this data is cleansed and diluted, and it reflects only repair data concerning Insurer's DRP facility repairs – the facilities that enter into contracts to abide by the Insurers' rates and repair standards – and repair data that Insurers manipulate by under-reporting or misreporting. In any event, it is not representative of collision repair data nationally, because it does not accurately or appropriately incorporate repair data from non-DRP facility repairs like Appellants. (DOC. 205 ¶¶ 85-86, 89-94, 115, 138).

Notwithstanding their position as industry-neutral and the purported independent guideposts of collision estimating, the Information Providers collaborate with their Insurer partner to establish strict estimating parameters that apply to the Information Provider estimating system used by the Insurers, then programmatically scrub repair estimates for the Insurer, furthering the fraud in misrepresenting and/or concealing fair compensation for collision repairs by Appellants and the proposed classes of repair facilities, predicated on the misrepresentation of necessary repair procedures and the time and scope to perform those procedures. (DOC. 205 ¶¶ 142 – 147). In short, the Information Providers sell their estimating systems to both repair facilities and Insurers, then together with

Insurers, defraud those same repair facilities like Appellants and the proposed classes.

In sum, insurance claimants' vehicles must be restored to pre-loss condition. Insurers use questionable and ambiguous policy language—limiting liability for loss payments for repairs to the so-called "prevailing competitive price" or repairs of "like kind and quality" (DOC. 205 ¶¶ 34, 66; DOC. 216-2, *passim*; DOC. 229-2 at 14)—to misrepresent to insurance claimants and repair facilities alike the so-called prevailing or competitive rates and repair standards necessary to properly repair and restore vehicles to pre-loss condition, which, in turn, improperly suppresses compensation to Appellants and the proposed classes for repair work.

The district court dismissed Appellants claims with prejudice, improperly excluded relevant and material exhibits and evidence. Appellants timely filed their notice of appeal on June 7, 2017 (DOC. 282), seeking review of the district court's orders. (DOC. 274, 275, 278).

B. Statement of Facts

This class action asserts claims under RICO (Counts 1-3, 6-7), Fraud (Count 8) and Unjust Enrichment (Count 9) against State Farm, Allstate, GEICO, Nationwide and Liberty Mutual (and their affiliates) by Appellants and proposed classes of collision repair facilities to remedy Insurers' long-running unlawful conduct to suppress compensation due to repair facilities for automotive collision

repairs performed for first and third party insurance claimants by misrepresenting what is necessary to restore the damages vehicles to "pre-loss condition", which is the standard that defines Insurers' loss payment obligations for repairs. Insurers rely on artificial rates and repair standards—so-called prevailing or competitive rates and processes—to mispresent to insurance claimants and repair professionals alike what is necessary to properly repair and restore vehicles to pre-loss condition, and, thereby, the appropriate measure of compensation for the restorative repairs.[3] Each class consists repair facilities, like Appellants, which have not contracted with that particular Insurer to abide by its purported rates and repair processes. (*See*, *e.g.*, "State Farm Enterprise Class").[4]

All of the Insurers have direct repair programs (DRP), which are networks of facilities that agree to abide by Insurers' protocol and guidelines in performing repairs and to accept Insurers' rates.[5] In exchange, the DRP facilities receive a steady volume of repairs referred by the Insurers. Insurers are thereby able to control and minimize their costs. However, the DRP model is predicated upon speed and

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[3] Appellants are not pursuing this appeal against the Progressive and Farmers Defendants.

[4] The claims for fraud and unjust enrichment are asserted by the respective classes against each particular Insurer (DOC. 205 at ¶ 463-69, 470-75), not collectively (DOC. 278 at 5).

[5] GEICO does not have a traditional DRP framework, but utilizes similar mechanism to enforce repair guidelines and rates.

volume, which leads to lower quality repairs, including the failure to properly repair and restore vehicles to pre-loss condition, and often creates unsafe, dangerous vehicles. There is a natural tension with Insurers' obligation to pay for repairs to restore the vehicles to pre-loss condition, and for the DRP facilities to perform safe and sufficient repairs. Each of the Insurers' DRP programs has led to frequently-required attempts to re-repair vehicles that were not correctly repaired initially, as well as buybacks that have been rendered total losses—or simply safety hazards—as the result of failed DRP repairs. (DOC. 205 ¶¶38-66).

Recent figures indicate that Insurers' utilization of DRP facilities ranges between 25%-35% on the low end, and between 40% and 45% on the high end. Thus, Insurers' utilization of DRP facilities is approximately one-third of the total of the repairs paid for by Defendants Insurers. (DOC. 205 ¶ 44).[6] Insurers use their respective DRPs to help establish what they contend are the so-called prevailing or competitive rates and repair procedures to define and limit their loss payment obligations to insurance claimants and to likewise limit the compensation paid to repair professionals like Appellants for their repair work.

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[6] Appellants omitted a word in the SAC (DOC. 205 ¶ 44), which should have read: "the DRP rates are utilized by Insurers to establish the artificial prevailing rate, which is then imposed upon the entire collision repair industry, even though the rates conservatively represent (at most) one-third of **[their]** insured repair rates nationwide.

All collision repairs use the estimating programs from one of the three co-conspirator Information Providers (CCC, Mitchell and AudaExplore). The estimating programs appraise the damage to the vehicle and construct a blueprint for repair. The three IPs hold 99% of the U.S. market, and sell their estimating programs to both Insurers and collision repair facilities alike. (DOC. 205 ¶¶ 67, 71, 78). As noted by the FTC in its action to block the proposed merger of CCC and Mitchell, the Information Providers have deep retention rates with their insurer partners (CCC alone at 95%) and there is virtually no movement in this mature market, with market shares remaining consistent. (DOC. 205 ¶¶ 71-73). The majority of Information Provider revenue that comes from their estimating systems derived from insurers. Insurers purchase the estimating systems from the respective Information Providers with which they partner, and their DRP facilities are mandated to do so as well. (DOC. 205 ¶¶ 69-75). Further, as established by the FTC, insurers, which includes the Insurers, wield substantial leverage and economic influence with the Information Providers. (DOC. 205 ¶¶ 75, 80).

Together, each Insurer in collaboration with their respective IP partner (which make up the respective RICO enterprises) establishes: (i) industry data on collision repair rates; and (ii) industry standards for repair procedures and processes, and the time to perform the repairs, which each Insurer promulgates as the prevailing or competitive rates and repair procedures. (DOC. 205 ¶¶ 69-84, 113-139, 166-168,

187-189). However, all of this data is cleansed and diluted, and it reflects only repair data concerning Insurer's DRP facility repairs, and repair data that Insurers manipulate by under-reporting or misreporting. In any event, it is not representative of collision repair data nationally, because it does not accurately or appropriately incorporate repair data from non-DRP facility repairs like Appellants. (DOC. 205 ¶¶ 85-86, 89-94, 115, 138).

Each of the Insurers has significant influence over the three Information Providers' and their estimating systems. (DOC. 205 ¶¶ 76-84, 136-139, 140-146, 166-168, DOC. 205-6, *passim*). Insurers regularly meet, study and consult with the Information Providers regarding the repair processes in the estimating systems. Further each of the Insurers has input into the estimating systems. (DOC. 205 ¶¶166-168). As noted by the court in the FTC case blocking the proposed merger between CCC and Mitchell, Insurer "customization" and influence is substantial. (DOC. 205 ¶¶76, 80).

Notwithstanding their position as industry-neutral and the purported independent guideposts of collision estimating, the Information Providers collaborate with their Insurer partner to establish strict estimating parameters that apply to the Information Provider estimating system used by Insurers, then programmatically scrub repair estimates for the Insurer, furthering the fraud in misrepresenting and/or concealing fair compensation for collision repairs by

Appellants and the proposed classes of repair facilities, predicated on the misrepresentation of necessary repair procedures and the time and scope to perform those procedures. (DOC. 205 ¶¶ 142-147). In short, the Information Providers sell their estimating systems to both repair facilities and Insurers, then together with Insurers, defraud those same repair facilities like Appellants and the proposed classes.

The conduct at the heart of this action is confirmed by Appellant K&M's recent dealings with Defendant Liberty Mutual. After delineating the necessary repairs that were not recognized by Liberty Mutual, including providing support from the AudaExplore (Audatex) Guide and manufacturer specifications for the procedures (*see* DOC. 205-16), Liberty Mutual admitted:

> The *major difference is the labor allowances from my system to K&M's*. Audatex is the system that is chosen to be used as a basis for our appraisals and *I can't alter the preset times or labor operations allowed in it for a procedure*. K&M has provided other documents from various other resources indicating that our system is incorrect, however, *I must follow [the system] and not change any preset times to do the procedures*. Audatex also takes overlap into consideration as they are added to a repair appraisal.

(DOC. 205 ¶ 299; DOC. 205-17).

The so-called prevailing or competitive rates and repair standards are flawed and misleading. First, the rates and repair standards have been established through Insurers' DRP agreements and Insurers' manipulated repair data that is then

promulgated (with the Information Providers) as the industry prevailing or competitive rates and repair procedures but, in truth, represent only an incomplete subset of the repair data. (DOC. 205 ¶¶ 44, 85-94). Only approximately one-third of Insurers' repairs are conducted through DRP facilities. (DOC. 205 ¶ 44). These rates and repair standards are not based on accepted professional industry standards; nor are they based on any statistically valid data. (DOC. 205 ¶¶ 85-94). Appellants and the proposed classes of collision repair facilities see no data concerning the rates and repair standards. Nor is there any way for Appellants to verify the accuracy. Further, Appellants have not agreed to these so-called rates and repair standards or to participate in the Insurers' DRPs, and these repair standards and rates are not in accordance with Appellants' custom and practice. (DOC. 205 ¶¶ 35, 38-42).

Second, both labor rates measures and repair processes are frequently misrepresented, and have a flawed foundation, as noted by regulators, legislators and other industry personnel. (DOC. 205 ¶¶ 35, 36).

Third, the rates and repair standards developed through the DRP programs are an inaccurate measure. DRP facilities are effectively subsidized by Insurers through steered repairs and the "compensation" they receive from Insurers for minimizing loss payments. The strict focus on volume and minimal repair cycle time (rather than quality and competency) has resulted in flawed and failed repairs, requiring re-repair and ultimately purchase from vehicle owners. (DOC. 205 ¶¶ 38-51). This

occurs with respect to each of the Insurers' DRP facilities. (DOC. 205 ¶¶ 52-65). DRP failed repairs and total loss "buybacks" occur nationwide, and has a "profound effect on the profitability of MSOs and other DRP facilities". (DOC. 205 ¶ 50, 65).[7] Insurers have been forced to purchase vehicles and pay substantial sums in damages as a result of their DRP facilities' failed repairs, which includes the failure to adhere to manufacturer specifications or industry guidelines impacting the structural integrity and safety of the vehicles, including after trial. *See, e.g.*, GEICO (DOC. 205 ¶¶ 54, 56, 62, 64); Nationwide (DOC. 205 ¶ 63); State Farm (DOC. 205 ¶¶ 52-53); and Allstate (DOC. 205 ¶¶ 57-61). These material costs are not factored into or accurately reflected in the determination of the so-called prevailing or competitive rates and repair standards. (DOC. 205 ¶ 48). Indeed, the reason that re-repairs and buybacks are necessary is because of the way that DRP facilities must operate under the mandates of the Insurers (putting cycle times and volume above all else). (DOC. 205 ¶¶ 45-47). Accordingly, even if one were to assume, *arguendo*, that there is any validity to the so-called prevailing or competitive rates and repair standards—which are predicated on Insurers' DRP repair data and manipulated claim data that Insurers run through Information Providers—the rates do not account for these substantial failure costs.

[7] That, of course, is in addition to the considerable functionality and safety issues resulting from DRP flawed and failed repairs. (DOC. 205 ¶¶ 48-49, 57-62)

In sum, insurance claimants' vehicles must be restored to pre-loss condition. Insurers use questionable and ambiguous policy language—limiting liability for loss payments for repairs to the so-called "prevailing competitive price" or repairs of "like kind and quality" (DOC. 205 ¶¶ 34, 66; DOC. 216-2, *passim*; DOC. 229-2 at 14)—to misrepresent to insurance claimants and repair facilities alike the so-called prevailing or competitive rates and repair standards necessary to properly repair and restore vehicles to pre-loss condition, which, in turn, improperly suppresses compensation to Appellants and the proposed classes for repair work.

III. SUMMARY OF THE ARGUMENT

The district court erroneously dismissed the Complaint with prejudice for failing to state a claim for relief under RICO, as well as claims for unjust enrichment and common law fraud. *See* DOC. 278.

First, the district court held, "[t]here is no description of the role played by the individual insurers in the alleged enterprises, or the reason they played that role. Without more, such allegations are insufficient to support the existence of an association in fact RICO enterprise." *Id.* at 12. The district court is wrong. Appellants alleged detailed allegations showing how each Insurer Enterprise is engaged in creating a mechanism by which the Insurers could under-compensate Appellants and the proposed classes through the use of manipulated, flawed and misrepresented data that the Insurers create through their interdependent

relationships with the Information Providers. Appellants also plead facts showing how the Information Providers receive substantial revenue from the Insurers in return for their efforts to manipulate the repair data. As discussed below, Appellants provided specific examples of these interactions between Insurers and the Information Providers, which sufficiently illustrate their involvement in the RICO enterprises.

Second, with respect to Appellants' RICO fraud claims, the court erroneously held, "the [Appellants] have not identified the precise misrepresentations made; the times and places where those misrepresentations were made, and the persons responsible for them; the content and manner in which these statements misled the [Appellants] (or anyone else); and what the [Appellees] gained by the alleged fraud." DOC. 278 at 16. Contrary to the district court's holding, Appellants alleged the Insurers misrepresent (1) the rates at which [Appellants] are compensated for labor and for reimbursement for paint and materials, and (2) the time, scope and extent of repair procedures necessary to properly repair and the restore the vehicles to pre-loss (or pre-damaged) condition. (DOC. 205 ¶¶ 2, 34, 66). These misrepresentations are contained in the Insurers estimates presented to Appellants, which Appellants summarized in the SAC (DOC. 205 ¶¶ 196, 202, 220, 226, 250, 286, 296) and attached as exhibits to their various briefs before the district court (DOC. 216-5 – 216-11). Therefore, Appellants did specify the Insurers' communications (and

provided Insurers' own documents as support) and how they misrepresented Appellants.

Third, the district court erroneously dismissed Appellants' RICO extortion (Hobbs Act) claims, holding that Appellants' alleged fear of economic loss—i.e., being coerced and/or forced to accept suppressed compensation for repairs for fear of losing the ability to perform future repairs—"is not the sort of fear of economic loss that can support an extortion claim under the Hobbs Act." This holding is directly contrary to well-settled law which uniformly holds that a plaintiff's fear of "actual loss" of business is sufficient to establish a Hobbs Act claim.

The district court also concluded that Appellants failed to allege Appellees obtained property by way of the alleged extortion, (DOC. 278 at 14-15); however, Appellants alleged that they performed repairs services for Insurers' insureds and vehicles covered by their insurance policies for which the Insurers were obligated to pay, and thus the value of the services performed by Appellants is "something of value" that Appellees "could exercise, transfer, or sell", constituting property.

Fifth, the district court held that Appellants failed to plead actionable claims for unjust enrichment because they failed to allege that the conferred a benefit on Appellees. To the contrary, however, Appellants alleged two different benefits they conferred on Insurers: (1) Appellants' repairs satisfied Insurers' policy obligations to *either* repair *or* pay a repair shop to repair their insureds' vehicles; and (2) Insurers

benefitted by paying Appellants *less* (in the form of suppressed rates) for their repairs to insureds' vehicles (DOC. 235 at 13-15), yet the court erroneously analyzed only the former, holding that Appellants' satisfaction of Insurers' repair obligations did not confer a benefit on Insurers. This conclusion is directly contrary to numerous cases cited below, all of which uniformly hold that satisfaction of another's obligations gives rise to a claim for unjust enrichment. As for the second benefit Appellants alleged they conferred on Insurers, Appellants' acceptance of suppressed compensation indisputably benefitted Insurers and is sufficient to establish this claim.

Sixth, because it dismissed Appellants' RICO fraud claims, the district court also dismissed Appellants' common law fraud claims; however, for the reasons discussed above, Appellants sufficiently alleged Insurers' fraudulent conduct.

Seventh, Magistrate Smith improperly excluded seven exhibits attached to Appellants' opposition to Appellees' motions to dismiss. Magistrate Smith concede that the exhibits were "central" but "not so central" to Appellants' claims to include them in Judge Presnell's consideration of the pending motions to dismiss, despite the fact that the case on which Magistrate Smith relied does not discuss varying degrees of "centrality," and instead applies a binary test: if the exhibits are central to the movant's claims, they should be considered.

Eight, similarly, Judge Presnell failed to conduct a *de novo* review of Magistrate Smith's legal conclusions (and review his factual conclusions under the "clearly erroneous, contrary to law" standard) as required by FRCP 72(a)

Finally, despite the bedrock principle that "leave to amend shall be freely given," the district court ignored Appellants' requests—on *six* separate occasions—for leave to amend their pleadings to add additional facts and cure deficiencies.

IV. STANDARD OF REVIEW

This Court "review[s] a district court's order dismissing a complaint de novo." *FindWhat Investor Grp. v. FindWhat.com*, 658 F.3d 1282, 1295 (11th Cir. 2011). In deciding a Rule 12(b)(6) motion, "all well-pleaded facts are accepted as true, and the reasonable inferences therefrom are construed in the light most favorable to the plaintiff." *Id*. at 1296. The complaint's factual allegations "must be enough to raise a right to relief above the speculative level," *Bell Atlantic Corp. v. Twombley*, 550 U.S. 544, 555 (2007), and cross "the line from conceivable to plausible." *Ashcroft v. Iqbal*, 556 U.S. 662 (2009).

V. ARGUMENT

A. The District Court Erred in Concluding that Appellant Failed to Allege an Actionable RICO Enterprise Pursuant to 18 U.S.C. § 1962(c) and 18 U.S.C. § 1961(4)

1. Standards for Pleading an Actionable RICO Claim under 18 U.S.C. § 1962(c) and an Actionable RICO Enterprise under 18 U.S.C. § 1961(4)

It is illegal "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…." 18 U.S.C. § 1962(c). To establish a federal civil RICO violation under 1962(c), plaintiff must prove (1) conduct (2) of an enterprise (3) through a pattern (4) of racketeering activity. *Williams v. Mohawk Indus., Inc.*, 465 F.3d 1277, 1282 (11th Cir. 2006). In addition, "any 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). Accordingly, Appellants must show (1) the requisite injury to "business or property" and (2) that such injury was "by reason of" the substantive RICO violation. *Mohawk Indus.*, 465 F.3d at 1283. The "by reason of" requirement implicates two concepts: (1) a sufficiently direct injury so that a plaintiff has standing to sue and (2) proximate cause. *Id*. at 1287 (citing *Anza v. Ideal Steel Supply Corp.*, 547 U.S. 451 (2006)). Appellants have satisfied their burden of pleading viable RICO claims.

An "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). The RICO enterprise must have: (1) a purpose; (2) relationships among those associated with the enterprise; and (3) longevity sufficient to permit those associates to pursue the enterprise's purpose. *Boyle v. U.S.*, 556 U.S. 938, 946 (2009). Appellants satisfied this pleading standard regarding the respective Insurer Enterprises.

2. The District Court Erred in Holding That Appellants Failed to Plead RICO Enterprises

Each Insurer and its Information Provider partner(s) have long-standing, generally exclusive, relationships, and the Information Providers' revenue is heavily dependent on Insurers. (DOC. 205 ¶¶ 67, 69-75). The Insurers work with their respective Information Provider partner(s) to establish: (i) data for collision repairs covered by the Insurers; and (ii) the standards for repair procedures, including the time scope and extent of those procedures. (DOC. 205 ¶¶ 69-75, 76-80, 81-84, 113-139, 166-168, 187-189).[8] This data is then promulgated by the Insurers and the Information Providers—who sell their estimating systems to repair facilities—as the

[8] Indeed, State Farm collaborated with Mitchell, one of its IPs, in establishing its estimating system, and had severe penalty provisions in the event labor and time corrections mandated by State Farm were not corrected. State Farm had these penalty provisions with CCC and Audatex as well. DOC. 205 ¶¶ 81-82, 84, DOC. 205-6 (pages ending in 1417 and 0147).

so-called prevailing, competitive rates and standards for repairs, which serve as the foundation for repairs to restore vehicles to pre-loss condition and, in turn, sets the compensation paid for repairs. (DOC. 205 ¶¶ 85, 195, 197, 201, 203, 219, 221, 225, 227, 249, 251). This data is manipulated so that it is a sanitized feedback loop of Insurer DRP repair data (and even that data is manipulated), lacking statistical validity. (DOC. 205 ¶¶ 85-86, 89-94, 115, 138).

Further, the Information Provider estimating systems collapse and bundle repair procedures, reduce labor times, and many essential or frequently necessary procedures require manual entry because they are "Not Included" in the estimating systems' standard repair procedures—i.e., these procedures *must* be added by the repair facilities. Manual entry of labor procedures or deviations in time (or change of labor or material rates) are automatically highlighted by the estimating systems. (DOC. 205 ¶¶ 77, 136, 137, 140-141, 145, 146); (DOC. 216 at 25).

Each Insurer, with their Information Provider partner, sets up customized estimating protocol and parameters to apply to all repair claims based, in part, on the manipulated repair data and standards. (DOC. 205 ¶¶ 197-198, 203-204, 221-222, 227-228, 251-252). Repair estimates submitted to Insurers by Appellants and the proposed classes are programmatically scrubbed by or with the aid of the Information Providers to enforce Insurers' protocol, and Insurers produce repair estimates which they present to Appellants and the proposed classes which

systematically eliminate, reduce and/or modify repair processes and the labor times, impose artificial caps on reimbursement for paint, materials and other necessary items, and enable Insurers to represent that manually added or expanded procedures, modified labor times or deviations are not prevailing or competitive in the market, are unnecessary to restore the insurance claimants' vehicles to pre-loss condition, and are not compensable. (DOC. 205 ¶¶ 137, 142-143, 199, 205, 223, 229, 253); (DOC. 216 at 25-26, 39, 65). For example, State Farm's claims manual expressly instructs that deviations in labor times on repair facilities' estimates should be rejected, that manually added procedures for "Not Included" procedures should be rejected or diminished by representing that other facilities in the purported local market "do not charge" for those procedures (and the same for "recommended" procedures" or "necessary operations"). (DOC. 205-3); (DOC. 216 at 45-47 and n. 32).

Insurers are able to make these representations in their repair estimates based on the so-called industry repair data and standards, which purport to set the benchmark for compensable repair procedures, because the repair estimates they present to Appellants and the proposed classes come from the Information Provider estimating systems and have the imprimatur of the Information Providers. (DOC. 216-5 – DOC. 216-11).

Thus, in addition to establishing and promulgating industry repair data and repair standards, Insurers and the Information Providers defraud repair professionals like Appellants, the same repair professionals that purchase the estimating systems from the Information Providers for use in repairs and rely on the Information Providers as the industry neutral guidepost. (DOC. 205 ¶¶ 67, 71, 78, 79). Each Insurer Enterprise is engaged in creating a mechanism by which the Insurers could under-compensate Appellants and the proposed classes through the use of manipulated, flawed and misrepresented data. The Information Providers provide the cover of legitimacy as the ostensible independent arbiters of industry repair data and standards—even though Insurers heavily influence that information—and are the exclusive sellers and suppliers of data and estimating programs to the repair industry.

The district court's reliance on *Ray v. Spirit Airlines, Inc.*, 836 F.3d 1340 (11th Cir. 2016) is inapt. The plaintiffs there failed to plead the "common purpose" of the enterprise because Spirit's technology and public relations vendors were not involved in the actual decisions of how to portray the Passenger Usage Fee, did not know the true nature of the fee, and did not work to intentionally misrepresent the fee. Thus, there was no allegation that the vendors knowingly cooperated in a scheme with Spirit to misrepresent the fee in question. *Id.* at 1352-55. Here, in stark contrast, the Information Providers share a common purpose in the respective Insurer

RICO enterprises to establish and falsely represent repair standards and rates and to create a mechanism to defraud Appellants by, *inter alia*, collaborating and sharing information on the estimating programs, the time, scope and extent of repair procedures, industry repair data, Defendants Insurers' claims estimating parameters, and scrubbing repair estimates, reflecting exercise of control and involvement in the affairs of the enterprise (and the members' affairs). Nor are the Insurers and the Information Providers simply engaged in a typical business relationship, given that the Information Providers work with the Insurers to defraud Appellants, which must rely on those same estimating systems, but neither the so-called industry data, nor the programmatic estimate profiling and scrubbing, is provided by the Information Providers to Appellants.

There is thus an "interdependence" between the members of the respective RICO Enterprises in this case, *Bible v. United Student Aid Funds, Inc.*, 799 F.3d 633, 655-56 (7th Cir. 2015) (entities managing the loan rehabilitation and collection process), which demonstrates "involvement in the affairs" of the other. *Kostovetsky v. Ambit Energy Holdings, LLC*, 2016 WL 105980, at *5 (N.D. Ill. Jan. 8, 2016); *Klay v. Humana*, 382 F.3d 1241, 1246-48 (11th Cir. 2004) (insurers, software claims developers and reviewers used computer systems to wrongfully deny and underpay providers for medical services); *In re Managed Care Litig.*, 298 F.Supp.2d 1259, 1275, 1278 (S.D. Fla. 2003) (overarching "common purpose" among defendants to

develop payment processes to underpay health claims, fostered by sharing guidelines, software packages, and trade information); *George v. Urban Settlement Svs.*, 2016 WL 4272377, at *8 (10th Cir. 2016) (common purposes of denying HAMP loan modifications); *Ouwinga v. Benistar 419 Plan Servs., Inc.*, 694 F.3d 783, 794-95 (6th Cir. 2012) (common purpose of marketing fraudulent benefit plan); *Spencer v. The Hartford Fin'l Svs. Grp., Inc.*, 256 F.R.D. 284, 295-98 (D. Conn. 2009) (insurers and their brokers collectively misrepresented the underlying cost or value basis for annuities); *Mohawk Indus.*, 465 F.3d at 1282, 1284-87 (common purpose of obtaining illegal workers for employment to suppress wages); *Coleman v. Commonwealth Land Title Ins. Co.*, 2013 WL 4675713, at *6-7 (E.D.Pa. Aug. 30, 2013) (bilateral enterprises functioned to overcharge for insurance).

And, given the substantial revenue that the Information Providers earn from Insurers, including, without limitation, revenue for collaborating on customized estimating profiles, manipulating the time, scope and extent of repair procedures, and programmatic scrubbing of repair estimates, it cannot reasonably be disputed that the Information Providers share in the motive of financial gain from the scheme. (DOC. 205 ¶¶ 69-75, *passim*). *See, e.g., Mohawk Indus.*, 465 F.3d at 1284-85 ("common purpose of making money [is] sufficient under RICO…. members of the enterprise stand to gain sufficient financial benefits from Mohawk's widespread employment of harboring of illegal workers…."); *Id*. at 1286-87 (it may often be

that different members of the RICO enterprise will enjoy different benefits from the commission of the predicate acts; all that is required is that the enterprise have *a* common purpose); *Nesbitt v. Regas*, 2015 WL 1331291, at *7 (N.D. Ill. Mar. 20, 2015) ("common purpose of enriching defendants"); *Coleman*, 2013 WL 4675713, at *6-7 (bilateral enterprises functioned to overcharge for insurance, collecting additional fees); *Montoya v. PNC Bank, N.A.*, 94 F.Supp.2d 1293, 1313 (S.D. Fl. 2015) (common purpose of extracting profits from bank borrowers on forced-place insurance); *George*, 2016 WL 4272377, at *8 (common purpose of enriching lender with excessive loan fees).

An enterprise can even include a member's acquiescence to losing money so long as the member is advancing the enterprise's goals. *See MCM Partners, Inc. v. Andrews-Bartlett & Assocs., Inc.*, 62 F.3d 967, 979 (7th Cir. 1995) (enterprise benefitted "upper management", but resulted in "lower-rung" participants paying artificially inflated prices as part of the scheme). Profit is *not* required for all participants in the scheme. Accordingly, the district court erred in concluding that, because the Information Providers purportedly do not make money *directly* from defrauding Appellants, no RICO enterprises have been established.

Notably, even if the sole purpose of the Insurer RICO enterprises consisted of the joint efforts of the respective Insurers and their Information Provider partner(s) to compile and promulgate objective industry repair data and standards, Insurers'

conduct in using those enterprises to engage in a pattern of racketeering to defraud Appellants would still be actionable. "RICO protects the public from those who would unlawfully use an enterprise (whether legitimate or illegitimate) as a vehicle through which unlawful … activity is committed." *Young v. Wells Fargo & Co.*, 671 F.Supp.2d 1006, 1028 (S.D. Iowa 2009) (quoting *Cedric Kushner Promotions, Ltd. v. King*, 533 U.S. 158, 164–65, 121 S.Ct. 2087, 2092, 150 L.Ed.2d 198 (2001)). "Congress clearly intended RICO liability to extend to situations where one entity directs the formation of a RICO enterprise and then makes use of the association to further a pattern of unlawful activity, even where portions of the unlawful activity do not issue directly from the RICO enterprise." *Id.* at 1028 (lender charging excessive fees on mortgagors through enterprise with property inspections vendors).

To establish liability under section 1962(c), the *defendant* must "conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity." 18 U.S.C. § 1962(c). Conduct "requires an element of direction," and that, "[i]n order to participate, directly or indirectly, in the conduct of such enterprises affairs, one must have some part in directing those affairs." *Reves v. Ernst & Young*, 507 U.S. 170, 179 (1993) (internal quotation marks removed). The statute provides that §1962(c) liability arises from the actions of the RICO "person(s)", not the actions of the enterprise. *See, e.g.*, *King*, 533 U.S. at 163; *Jay E. Hayden Found. v. First Neighbor Bank*, 619 F.3d 382, 389 (7th Cir.

2010) ("RICO offense is using an enterprise to engage in a pattern of racketeering"); *Bible*, 799 F.3d 633, 657. Here, as the district court recognized, the Insurers have conducted the respective enterprises "to justify not paying."[9] (DOC. 278 at 14).

The district court also erred when it found that Appellants had not sufficiently alleged the involvement of the Insurer affiliates in the respective RICO enterprises. (DOC. 278 at 10-11). As an initial matter, the district court's finding that the SAC generically references the Insurers, as opposed to distinguishing claims and allegations against them individually, is plainly incorrect. The SAC sets forth conduct and claims exclusive to each Insurer. (DOC. 205, *passim*; DOC. 216-12). But, "there is no flaw in a pleading, however, where collective allegations are used to describe the actions of multiple defendants who are alleged to have engaged in precisely the same conduct." *U.S. v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1184 (9th Cir. 2016).

In any event, Appellants' exhibits of 90 sample transactions (DOC. 205-12 and 205-14) set forth the insurer parent or affiliate preparing the estimate, employing

[9] In any event, "an enterprise is operated not just by upper management but also by lower rung participants in the enterprise who are under the direction of upper management." *Id.* at 179 (internal quotation marks removed); *see also MCM Partners*, 62 F.3d at 978-79 ("a RICO enterprise may be operated at least by upper management, lower-rung participants in the enterprise who are under the direction of upper management, or others associated with the enterprise who exert control over it….'") The Information Providers here have, at the very least, played "some part" in directing the operation and/or management of the RICO Enterprises.

the claims personnel responsible for the estimate, making the payment determination of the repairs and, if known, the company on the policy. In addition, Appellants provided the estimates the underlying repair estimates from Insurers and the estimates and reconciliation statements from Appellants, which outline in further detail the companies and claims personnel involved. (DOC. 216-5 – DOC. 216-11).[10]

Further, each of the Insurers has company-wide, systematic and uniform claims management practices, and operates as a single, integrated enterprise for claims adjustment and administration purposes. (DOC. 205 ¶¶ 16-22, 193-194). The Insurers' repair estimates use centralized, systematic programs, which is demonstrated by the estimates themselves, and, as outlined by Appellants below, in their systematic conduct in misrepresenting so-called prevailing repair procedures and rates. (DOC. 205 Exs. K and M, ¶¶ 193-194; DOC. 216 at 38-54, DOC. 216-5 – 216-11). Often, the estimates reflect a generic reference to the insurer: "State Farm Insurance Companies" or "State Farm," "Nationwide *Enterprise*," or "Nationwide," "GEICO," and the claims personnel for each of the Insurers on all of the claims operate out of the parent company under company-wide protocol. Further, payments

[10] In addition, Appellants' exhibits provide claim numbers and dates of the estimates and repair transactions, affording Insurer sufficient pleading notice. (DOC. 205 Exh K and Exh M; DOC. 216 at 30-32)

for repairs are frequently made by parent companies, even if affiliates are the insurer on the first-party or third-party claims for which the repairs are performed. *Id*.

Appellants have provided specifics about the Insurers involved in the systematic conduct outlined in the RICO predicate acts. It was error for the district court to conclude otherwise. At the very least, it was error to dismiss the specific Insurers and affiliates expressly set forth in the documents.

Lastly, the district court erred in its finding that the State Farm Enterprise was deficient because the State Farm DRP facilities do not share a common purpose with State Farm:

> Finally, with regard to [Appellee] State Farm, the [Appellants] allege that the participants in the RICO enterprise include not only Information Providers but State Farm-affiliated DRP facilities, which are known as "Select Service" repair shops. (DOC. 205 at 104-05). However, the [Appellants] also allege that State Farm "coerces and intimidates" the Select Service shops into keeping repair costs "as low as possible" (DOC. 205 at 106) – showing that the Select Service shops do not share a common purpose with State Farm.

The district court misquoted the SAC, which alleges, in pertinent part, that:

> State Farm Select Service facilities all understand that they are part of a centralized program by which State Farm has implemented a uniform industry repair protocol for performing repairs and determining compensation. At the same time, each of the Select Service facilities understand the essential nature of the scheme to establish and enforce industry prevailing rates (and estimating protocol) and knowingly agreed to participate – even, assuming that Select Service facilities did so solely *because they deemed participating in the program fundamental to their economic survival, and/or because they were intimidated or coerced to do so*.

(DOC. 205 at 256). Thus, the district court mischaracterized the Select Service facilities' motivation for participation in the enterprise (and the plausibility), which was based on economics. Moreover, all of these facilities agree by contract to abide by uniform standards, company estimating protocol, repair methodologies and compensation, and to participate in State Farm's on-line survey to assist in establishing State Farm's so-called prevailing rates. (DOC. 205 at 232, 255-256, 241-247). Accordingly, the Select Service facilities are "vital" to help the State Farm Enterprise "meet its goals." *See MCM Partners,* 62 F.3d at 978-79; *State Farm Mut. Auto Ins. Co. v. Weiss,* 410 F.Supp.2d 1146, 1157 (M.D. Fl. 2006); *Negrete v. Allianz Life Ins. Co. of N. Amer.*, 2011 WL 4852314, at *5, 7 (C.D. Cal. Oct. 13, 2011) (enterprise members directed through "variety of contractual provisions and company rules."). Nor does there have to be collaboration among lower level enterprise members. *Weiss v. Bank of America Corp.*, 2015 WL 9304506, at *12 (W.D. Pa. Dec. 22, 2015).[11]

[11] Nor is the number of Select Service facilities (which is known exclusively to State Farm) pertinent to the determination of the whether Appellants have sufficiently pled the structure of the State Farm Enterprise. The fact remains that the Select Service facilities play a role in establishing State Farm's so-called prevailing rates in order to artificially suppress compensation for repairs. Indeed, State Farm Claims Director Russ Hoffbauer confirmed that Select Service facilities help establish how the field adjusters write their estimates and to inform State Farm on what the marketplace charges are. (DOC. 205 ¶ 256).

Even if the Select Service facilities were coerced or intimidated to participate in the enterprise, it would not defeat a finding of common purpose. *MCM Partners, Inc.*, 62 F.3d at 979 ("even if A–B and FDC may have been reluctant participants in a scheme devised by 'upper management,' they still knowingly implemented management's decisions, thereby enabling the enterprise to achieve its goals"); *Nesbitt*, 2015 WL 1331291, at *7 n. 19 (same); *VFI Associates, LLC v. Lobo Mach. Corp*., 2012 WL 975705 *8, (Mar. 22, 2002 W.D. Va. 2012) (same).

Appellants have satisfied the enterprise pleading elements under *Boyle*, 556 U.S. at 946.

B. The District Court Erred in Concluding that Appellants Failed to Plead their RICO Fraud Claim, Pursuant to 18 U.S.C. § 1962(c)

Wire fraud occurs when a person (1) intentionally participates in a scheme to defraud another of money or property and (2) uses the mails or wires in furtherance of that scheme. *American Dental Assn. v. CIGNA Corp.*, 605 F.3d 1283, 1292 (11th Cir. 2010). Each of the Insurers has committed at least two predicate acts of wire fraud as part of the scheme to defraud Appellants by under-compensating them for their repairs services for insurance claimants.

The district court held that Appellants failed to sufficiently plead a fraud-based RICO claim because Appellants (i) failed to satisfy the particularity requirements of Fed. R. Civ. P. 9(b), and (ii) failed to set forth actionable misrepresentations that misled the Appellants. These conclusions, however,

improperly disregard and mischaracterize Appellants' allegations and evidence. To the contrary, Appellants sufficiently alleged the "(1) the precise statements, documents, or misrepresentations made; (2) the time, place, and person responsible for the statement; (3) the content and manner in which these statements misled the plaintiffs; and (4) what the Defendants gained by the alleged fraud." (Order at 16) (citing *Brooks v. BCBS of Fla., Inc.*, 116 F.3d 1364, 1380-81 (11th Cir. 1997)).[12]

As discussed above, Insurers misrepresent both repair rates and procedures. The former are the rates at which Appellants are compensated for labor and for reimbursement for paint and materials. The latter constitute the time, scope and extent of repair procedures, which are necessary to properly repair and the restore the vehicles to pre-loss (or pre-damaged) condition, which is the indisputable standard for repairs. (DOC. 205 ¶¶ 2, 34, 66). The repair rates and procedures misrepresented by Insurers are contained in, *inter alia*, the repair estimates and supplements presented to Appellants and the insurance claimants whose vehicles are being repaired, and represent the alleged prevailing repair rates and procedures necessary to properly repair vehicles. (DOC. 205 ¶¶ 196, 202, 220, 226, 250, 286, 296). This data is manipulated and cleansed so that it is a sanitized feedback loop

[12] With respect to Insurers gain, Appellants unmistakably assert that, as a result of Insurers' conduct, they have received less in compensation for collision repairs and, thus Insurers paid less. (DOC. 205 at 282, 283, 286, 287, 288, 291, 293, 296, 297, 298, 306, Exh K, Exh M).

of Insurer DRP repair data (and even that data is manipulated), lacking statistical validity. (DOC. 205 ¶¶ 85-86, 89-94, 115, 138). Each Insurer, with their Information Provider partner, sets up customized estimating protocol and parameters to apply to all repair claims, which is based, in part, on the manipulated repair data and standards. (DOC. 205 ¶¶ 197-198, 203-204, 221-222, 227-228, 251-252). Repair estimates submitted to Insurers by Appellants and the proposed classes are programmatically scrubbed by, or with the aid of, the Information Providers to enforce Insurers' protocol, and Insurers produce repair estimates which they present to Appellants and the proposed classes which systematically eliminate, reduce and/or modify repair processes and the labor times, impose artificial caps on reimbursement for paint, materials and other necessary items, and enable Insurers to represent that manually added or expanded procedures, modified labor times or deviations are not prevailing or competitive in the market, are unnecessary to restore the insurance claimants' vehicles to pre-loss condition, and are not compensable. (DOC. 205 ¶¶ 137, 142-143, 199, 205, 223, 229, 253; DOC. 216 at 25-26, 39, 65) Insurers are able to make these representations based on the so-called industry repair data and standards, which purport to set the benchmark for compensable repair procedures, because the repair estimates they present to Appellants and the proposed classes come from the Information Provider estimating systems and have the imprimatur of the Information Providers. (DOC. 216-5 – DOC. 216-11).

Appellants set forth approximately 90 samples of repair claims, in which Appellants provided repair estimates based on Appellants' necessary restorative procedures performed for insured claimants covered by Insurers' insurance, and Insurers' misrepresented—through estimates using their Information Provider partner estimating programs—the necessity of the repairs, as well as the rates for those repairs, and advised Appellants that the repairs and the charges were not prevailing or necessary, nor compensable as set forth in Appellants' estimates. **(**DOC. 205 ¶¶ 282-307); (DOC. 205 Exs. K and M); (DOC. 216 at 38-54).

Contrary to the district court's mischaracterization concerning the lack of particularity under 9(b), Appellants sample repair claims included Crawford's or K&M's repair order number, the insurer's claim number, the insurer identified on the insurer's repair estimates, the names of the insurers' claims personnel identified on the estimates who made the representations to Appellants and insurance claimants, the date of each estimate and supplemental estimate, the insurer that made the payment on the claim, the name of the insurer on the policy (if known), the total compensation due Appellants from the repairs, the amounts of the payments by the Defendant on the initial and supplemental estimates, and the "shortfall itemization," showing Insurers' represented labor rates, as well as the various labor and refinishing procedures, including paint and materials reimbursement (typically expressed by Insurers in a rate as opposed to dollar amount) and additional labor associated with

parts, and, in most cases, an itemization of the discrepancy in time for each of the respective procedures or operations. (DOC. 205 ¶¶ 283, 286, 293, 296); (DOC. 205 Ex. K and M). For every repair, Appellants' repair orders (estimates) reflected their standard labor rates and necessary procedures to restore each of the particular vehicles to pre-loss condition. (DOC. 205 ¶¶ 283, 294). Accordingly, the foundation and source for Appellants' exhibits containing the 90 representative samples are the estimates and supplements exchanged by the parties. Further, the itemization of shortfall is reflected in Appellants estimates and reconciliations. (DOC. 216-5 – 216-11).

As alleged, in connection with each of the repairs, Insurers' estimates and supplements—prepared by their employees and agents who were identified by name on Appellants' exhibits and in the estimates and supplements—contained the misrepresentations and omissions concerning the labor rates and the repair procedures necessary to properly repair the vehicles, Insurers' representations of purported prevailing rates and industry repair practices. (DOC. 205 ¶¶ 285-86, 295-96). Further, Insurers conceal the fact that the estimates and supplements were the result of their systematic adherence to their respective estimating parameters (based on flawed and manipulated data) and Information Provider scrubbing, irrespective of the work and charges necessary to properly repair the vehicles. (DOC. 205 ¶¶

285, 288, 295, 298). In each case, Appellants were subjected to shortfall in payment for repair services. (DOC. 205 ¶¶ 287, 288, 291, 297, 298, 306).

Appellants provided those repair estimates and supplements (DOC. 216–5 – 216-11); (DOC. 216 at 25-26, 38-54); (DOC. 237 at 6-7), which contain: (i) the Insurers' representations of the purported prevailing or competitive rates for labor and materials; and (ii) the Insurers' misrepresentations and omissions of necessary and compensable repair procedures to properly repair and restore vehicles to pre-loss condition, including the time, scope and extent of the necessary procedures. Further, like Appellants' charts, the estimates identify the Insurers' personnel making the representations to Appellants and insurance claimants, including claims adjusters or appraisers inspecting the vehicle and preparing an estimates, and supervisors conducting "desk reviews" of the estimates without having inspected the vehicle to ensure that each of the Insurers' estimating parameters are enforced and applied to the repair claims submitted to the respective Insurers insurance claimants. (DOC. 205 at 285, 295); (DOC. 216–5 – 216-11); (DOC. 216 at 38-54). Again, contrary to the district court's mischaracterization concerning the lack of particularity under 9(b).[13]

[13] Appellants walked the district court through samples of the systematic shortfall reflected in the Insurers' estimates in comparison to Appellants' estimates, using State Farm, Nationwide and GEICO as exemplars (DOC. 216 at 38-54, DOC. 216-5 – DOC. 216-11). This applies equally to the Allstate and Liberty Mutual samples,

Critically, the Insurers' estimates contain uniform statements which reinforce the Insurers' misrepresentations and omissions, that Insurers' estimates reflect the prevailing or competitive repair procedures to properly repair and restore vehicles to pre-loss condition, and the prevailing or competitive labor and material rates to perform those repairs:

> The attached estimate represents an appraisal of the cost of repair for the visible damage to the vehicle notes at the time of inspection necessary to return the vehicle to its pre[-]damaged condition. Costs above the appraised amount may be the responsibility of the vehicle owner…. Information regarding repair facilities which will be able to repair the vehicle for the appraised amount is available from the Insurance Company.

Nationwide estimate (DOC. 216-6 at 102); GEICO estimate (DOC. 216-7 at 123); Allstate estimate (DOC. 216-8 at 56); Liberty Mutual estimate (DOC. 216-9 at 53).

Allstate further provides:

> If you have a preference for a particular shop, your adjuster will write or approve an estimate of repairs with that shop based on competitive prices in the area. Information regarding repair facilities, which may be able to repair the vehicle for the appraised amount, if available from your adjuster or insurer.

Allstate estimate (DOC. 216-8 at 23). Likewise, State Farm provides:

> Costs above the appraised amount may be the responsibility of the vehicle owner. Information regarding repair facilities which will be able to repair the vehicle for the appraised amount is available from your claim handler or online at www.statefarm.com.

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which likewise demonstrate adherence to systematic estimating parameters. (DOC. 216 – 8 and 216-9)

State Farm estimate (DOC. 216-5 at 193).

The estimates demonstrate that the vehicles must be returned to pre-loss condition, and that the Insurer estimates are representing the necessary procedures to properly repair the vehicle and restore it to pre-loss condition, and the labor and materials rates necessary for those procedures. These representations are made to insurance claimants and Appellants alike. The claimants, relying on the Insurer, is certainly at an information disadvantage. In addition, the misrepresentations and omissions concerning the necessary and compensable repair procedures, as well as the so-called prevailing labor and material "rates", are made in a "black box", and Appellants and repair facilities have no access to the purported industry data, and no means of verifying or assessing the validity or accuracy of Insurers' representations. Nor are they privy to the customized estimating parameters and programmatic scrubbing by the Insurers and Information Providers. (DOC. 205 ¶¶ 179, 181, 272, 272, 275, 285, 295; DOC. 216, *passim*).

The district court found that the Appellants could not have been misled because "the basis for a number of the payments was the estimate itself, [and] the spreadsheets show that the Appellants knew at the outset of each job that they were not being offered the price they wanted (or the price that they felt they were entitled to) but they took the job anyway." (DOC. 278 at 17 n.8). This a severe mischaracterization of the evidence. As Appellants explained, repair transactions

are a fluid, evolving process, which generally occur over the course of days or weeks (or months, depending on the severity of the damage), and typically require more than one (frequently several) estimates and supplements to account for the extent of the damage to vehicles and required scope of repairs. It is not until the repair process begins to take shape that the full measure of repairs and the processes required are understood, which occurs during the repair process (and sometimes not until completion). It is inaccurate, then, to characterize the transactions as a static offer and acceptance where both the repair facility and the insurer are aware of the required repairs and the cost with precision from inception; thus, there is not a firm "price" or representation of what will be paid at inception. Rather, it is throughout the process that Insurers misrepresent what the prevailing and necessary repairs are to restore the vehicle to pre-loss condition, which, in turn, is what determines the compensation that is paid. (DOC. 205 Exs. K and M, ¶¶ 282-307); (DOC. 216 at 3); (DOC. 216-5 – DOC. 216-11); (DOC. 235-1). Exhibits K and M to the SAC irrefutably demonstrate that there was no "price" offered at the inception of the repairs. Rather, the Insurers paid hundreds or thousands in additional compensation through multiple supplements, even though those increased amounts still did not fully compensate Appellants for their repair work. (DOC. 205 Exs. K and M).

More importantly, that misses the point of the fraud, which is the Insurers' misrepresentation of what is necessary to properly repair and restore vehicles to pre-

loss condition through flawed and manipulated industry prevailing or competitive procedures and rates. The district court relied solely upon *American Dental* (*see* DOC. 278 at 15-16) in concluding that Appellants failed to sufficiently allege actionable, misleading misrepresentations by the Insurers. Contrary to the district court's characterization, Appellants have provided more specific and compelling allegations in this case.

First, the plaintiff providers in *American Dental* did not point to any specific misrepresentations regarding how they would be compensated, nor did they allege the manner in which they were misled by the documents. 605 F.3d at 1291-92. As set forth above, using pre-determined and flawed estimating parameters and data, Insurers estimates are scrubbed to misrepresent—using the *same estimating systems* that Appellants rely upon—what is necessary to properly repair and restore vehicles to pre-loss condition, and the so-called prevailing labor and material rates. *Second*, the EOBs in *American Dental* gave the express reasons for the bundling and downcoding. *Id.* at 1292. Here, in contrast, no reasons (other than generic representations of prevailing, competitive, reasonable and necessary) are provided for the Insurer estimates to explain the bases to Appellants. *Third*, the plaintiff providers there did not provide any examples of which claims were bundled and downcoded (*see id.*), whereas Appellants clearly have done so here. (DOC. 205 Exs. K and M); (DOC. 216 at 38-54); (DOC. 216-5 – 216-11). In addition, the plaintiff

providers in *American Dental* were also in-network, akin to DRP facilities accepting contract rates, unlike Appellants. *Id.* at 1291.[14] *American Dental* thus is distinguishable.[15]

Further, Appellants have made repeated attempts to ascertain the methodology and validity underlying Insurers' representations. For example, Appellants submitted record evidence of written and oral communications between K&M and Nationwide concerning, among other things, Nationwide's deficient repair estimates, industry and manufacturer required and recognized repairs that Nationwide refused to recognize or compensate, K&M's requests for information concerning its repair estimating guidelines and Nationwide's imposition of a so-called "reasonable and necessary" standard for repair estimating and compensation, and how that standard is employed, and why Nationwide imposed a "monetary restriction" on K&M repair services. (DOC. 235-1); (DOC. 238, passim); (DOC. 238-1 – 238-3). But the district court struck those exhibits (*see* DOC. 274) notwithstanding their clear relevance and Appellants request for leave to amend to directly incorporate the evidence into their pleadings.

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[14] In addition, providers failed to sufficiently allege a conspiracy among the defendants to employ the same procedures. *Id.* at 1291-92.

[15] More apt is *Klay*, 382 F.3d 1241, which also involved claims on behalf of out-of-network ("fee-for service") providers, who were subjected to systematic and programmatic underpayment for medically necessary services. *Id.* at 1247-48, 1252-54, 1259-60.

"Where a plaintiff repeatedly confronts a defendant with the apparent falsity of its representations, and the defendant repeatedly confirms its original statement, asserting special knowledge, reliance is justified." *DeLong Equip. Co. v. Washington Mills Electro Minerals Corp.*, 990 F.2d 1186, 1202-03 (11th Cir. 1993); *see U.S. v. Yeager*, 331 F.3d 1216, 1222 (11th Cir. 2003) (mail fraud reliance reasonable where "on-site audits and requests for corrected and completed information by BIPI were deflected by active deception by Yeager. The type of information misrepresented … was not easily obtainable by BIPI from another source"); *Corcoran v. CVS Health Corp.*, 2016 WL 948880, at *10 (N.D. Cal. Mar. 14, 2016) (fact that plaintiff patients continued purchasing prescriptions with inflated co-pays did not render reliance "implausible"); *see also Smith v. American Family Mut. Ins. Co.*, 289 S.W.3d 675, 681-82, 685-87, *passim* (Mo. Ct. App. 2009) (breach of insurance policy obligations based on systematically omitted repair procedures).[16]

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[16] Appellants' RICO claims predicated on mail fraud or, as here, wire fraud "need not show, either as an element of [their] claim or as a prerequisite to establishing proximate causation, that it relied on the defendant's alleged misrepresentations." *Bridge v. Phoenix Bond & Indemnity Co.*, 553 U.S. 639, 661 (2008). Based on the misrepresentations and omissions of material fact to Appellants and to insurance claimants concerning the necessary and compensable repairs – and prevailing labor and material rates – in defining and limiting the amount that Insurers would pay for repairs pursuant to the purportedly applicable terms of insurance policies – and the manner in which those representations occurred, Appellants have established Appellants have established that Insurers' conduct led "directly to their injuries", *Anza*, 547 U.S. at 461, and that, as a direct and proximate result, Plaintiffs received

C. The District Court Erred in Concluding that Appellants Failed to Allege that they Suffered Injury to their Businesses or Property as a Result of Appellees' RICO Violations

The "by reason of" requirement implicates two concepts: (1) a sufficiently direct injury so that a plaintiff has standing to sue and (2) proximate cause. *Mohawk Indus.*, 465 F.3d at 1283. Appellants were the victims directly injured by Insurers' fraudulent conduct through the suppression of compensation for repair services. (DOC. 205 ¶¶ 177-179, 273-275).

Appellants were paid compensation by Insurers for their repair work and services predicated on material misrepresentations and omissions concerning purported prevailing rates and repair standards, and Appellants would not have accepted the suppressed compensation for repair work and services, i.e., being paid less for their repair work and services, but for Insurers' conduct. The injuries sustained by Appellants were caused by overt acts in furtherance of the Insurers' respective violations of 18 U.S.C. § 1962(c), including the misrepresentation and omissions of materials facts concerning rates and repair standards and the artificial suppression of compensation for repairs performed on vehicles covered by Insurers.

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less in compensation for repairs, often thousands of dollars less. *See Bridge*, 553 U.S. at 658-59, 661; *BCS Services, Inc. v. Heartwood 88, LLC*, 637 F.3d 750, 756-57 (7th Cir. 2011); *Corcoran*, 2016 WL 948880, at *11; (DOC. 205 ¶¶ 177-179, 273-275).

Further, *none* of the shortfall in compensation was paid by any other source, including insureds and/or vehicle owners. (DOC. 205 ¶¶ 282-307).

Accordingly, there is no more "direct" or "immediate" victim of the Insurers' RICO conduct that are more likely to vindicate the laws by pursuing a claim than the collision repair facilities that have professionally performed the work to bring the vehicles back to the appropriate condition, but have not been fully compensated. *Anza*, 547 U.S. at 460. Further, the Insurers' conduct was the direct and proximate cause of Appellants' injuries, and that includes the event of suppression of repair compensation that resulted from reliance by insureds and third party vehicle owners on Insurers misrepresentations and omissions of materials fact regarding the so-called prevailing rates and repair standards for repairs which limited the compensation to be paid to repair their vehicles pursuant to the purportedly applicable terms of insurance policies. *Bridge*, 553 U.S. at 658-59; *BCS Services*, 637 F.3d at 756-67.

There is no risk of duplicative recovery, and Appellants are best situated to remedy the Insurers' conduct given that they have suffered the loss. *In re Avanadia Mktg, Sales Practices & Prod. Liab. Litig.*, 804 F.3d 633, 645 (3d Cir. 2015).

Lastly, the district court's comment about Appellants' damages theory must be addressed. The district court noted that Appellants' theory is "flawed" because their proffered "market rate" is merely the rate they would like to receive for their

services (which they attempt to justify by asserting the policy rights of their customers) but fails because there is no claim that Insurers have market power or the ability to control prices. (DOC. 278 at 18 n. 9). The district court mischaracterizes Appellants' argument and the facts. First, Appellants are asserting that there is no "market rate." That is a fiction created by the Insurers to cap the compensation for repairs under the terms of the insurance policies. Further, there is no "market rate" for repair procedures. And, the so-called market rates or prevailing or competitive rates for labor and materials is manipulated and flawed as discussed above. Second, though Appellants do not have to assert market power to pursue RICO fraud claims, the Insurers do have the power to control (or attempt to control) the compensation for their own insured repairs because it the Appellants customers who dictate which Insurers are paying for the repairs. Appellants cannot simply go to an Insurer's competitor to get higher rates; the customer would have to switch insurers. Third, the Insurers, in fact, tout their ability to control prices for auto repair work: in June 5, 2014 testimony before the Rhode Island Senate Committee on Judiciary, counsel representing various insurers, including GEICO, Liberty Mutual and Nationwide, stated: "[w]e sell the insurance, we pay the bills, we'd like to make the decisions with respect to what the rates are." (DOC. 205 ¶ 87).

D. The District Court Erred in Concluding that the Complaint Failed to State a Claim for Extortion under the Hobbs Act, as Codified in 18 U.S.C. § 1951(b)(2)

1. Standards for Pleading Extortion under the Hobbs Act

RICO "racketeering activity" includes specific predicate acts as defined in 18 U.S.C. § 1961(1), including extortion (18 U.S.C. § 1951). Under the Hobbs Act, extortion "means the obtaining of property from another, with his consent, induced by wrongful use of actual or threatened force, violence, or fear, or under color of official right." 18 U.S.C. § 1951(b). As the district court recognized, "fear of economic loss can support an extortion claim." *U.S. v. Haimowitz*, 725 F.2d 1561, 1572 (11th Cir 1984). The district court held that Appellants fear of losing the right to do business with the Insurers was merely a "potential benefit," not an "actual loss" (citing *U.S. v. Tomblin*, 46 F.3d 1369, (5th Cir. 1995); *U.S. v. Capo*, 817 F.2d 947 (2d Cir. 1997), and further, that the Insurers did not obtain "property" from Appellants under *Scheidler v. National Organization of Women, Inc.*, 537 U.S. 393, 404 (2003); (DOC. 278 at 14-15). The district court erred in both respects.

2. The District Court Improperly Held That Appellants Failed to Establish a Claim of Extortion in Violation of the Hobbs Act

The district court's finding is based on a narrow interpretation of Appellants' allegations, and an overly restrictive view of what constitutes property. The insurance claimants for whom Appellants perform repairs are Appellants'

customers, with whom they have repair contracts. (DOC. 205 ¶¶ 289, 302-304). Appellants alleged that they were coerced or forced accept suppressed compensation for insured collision repairs under fear that they would not be able to perform the insured repairs, (Insurers would steer Appellants customers to DRP facilities), that they would not be free to pursue their collision repair services without interference (properly repairing customers' vehicles), and that Insurers would steer Appellants' customers away to DRP facilities in the future. (DOC. 205 ¶¶ 268, 270 (5)). Accordingly, Appellants did fear "actual loss", the loss of their repair jobs and their customers. *Tomblin*, 46 F.3d at 1384.[17]

Further, in *Scheidler*, the Supreme Court found that "property" under the Hobbs Act constituted "something of value" that defendants "could exercise, transfer, or sell." *Scheidler,* 537 U.S. at 405. In other words, "[t]he property extorted must therefore be transferable—that is, capable of passing from one person to another…" *Sekhar v. United States,* 133 S.Ct. 2720, 2725 (2013).

Appellants performed repairs services for Insurers' insureds and vehicles covered by their insurance policies for which the Insurers were obligated to pay. The value of the services performed by Appellants is "something of value" that Insurers "could exercise, transfer, or sell", in that it satisfied Insurers' loss obligations under

[17] The district court's erred in relying on *Capo,* because those claims failed for lack of any threats. *Id., passim*.

their policies. *Scheidler*, 537 U.S. at 405. This is a benefit to the Insurers, constituting property. *See, e.g., Benchmark Construction, LLC v. Auto-Owners Ins. Co.*, 2013 WL 3479682, at *3-4 (D. Utah July 10, 2013) (insurer realized benefit from vendors' labor at insured site); *Hibbs v. Allstate Ins. Co.*, 193 Cal. App.4th 809, 819-20 (2011) (election to repair the vehicle relieves insurers of obligation under the policy); *Team Healthcare/Diagnositic Corp. v. BCBS of Texas*, 2012 WL 1617087, at *6-7 (N.D. Tx. May 7, 2012) (healthcare to insureds also benefitted insurer); *see also U.S. v. Thompson*, 647 F.3d 180, 186-87 (5th Cir. 2011) (labor of independent contractor); *Ranieri Constr. v. Taylor*, 63 F.Supp. 3d 1017, 1025-6 (E.D. Mo. 2014) (plaintiff's allegation that the property defendants sought to obtain were health benefits pursuant to a collective bargaining agreement sufficiently states "obtainable property" to support extortion claim).

Likewise, the Insurers violated the Hobbs Act by depriving the Appellants and Class Members of the fair value of the repair services. Insurers paid less for the services, which was an economic benefit (money), which is clearly property. *See, e.g., DeFalco v. Bernas*, 244 F.3d 286, 315 (2d Cir. 2001) (there was sufficient evidence for a reasonable jury to find that the "value of the services" of [defendant] had been extorted such that the jury could have found plaintiff was in fear of economic loss); *United States v. Larson*, 2013 WL 5573046, at *5 (W.D.N.Y. Oct. 9, 2013) (a "contract or contractual rights can be assigned, and therefore constitute

something of value that can be exercised, transferred, or sold"); *NRP Holdings v. City of Buffalo,* No. 11-cv-472S, 2012 WL 2873899, at **11-13 (W.D.N.Y. July 12, 2002) (plaintiff had adequately stated a claim for racketeering activity by alleging defendants "impermissibly used their power to extort the value of the services of" an inexperienced developer); *All World Prof. Travel Servs., Inc. v. Am. Airlines, Inc.*, 282 F.Supp. 2d 1161, 1174-76 (C.D. Cal. 2003) (defendant "utilized threats to terminate All World's ticketing rights, solely for the purpose of obtaining All World's money, money that All World alleges American is not lawfully entitled to claim" upon finding the "right to make decisions and to solicit business free from coercion is a protectable property right" and "allegations of threats by one business entity to cause economic harm to another if the latter does not agree to a change in contract or to pay a kickback is enough to establish the predicate offense of extortion or attempted extortion"); *Dooley v. Crab Boat Owners' Assoc.*, 271 F.Supp.2d 1207, *passim* (N.D. Cal. 2003) (organized strike, threats to and disparagement of competitor and customers resulted in higher profits for defendants); *In re Managed Care Litig.*, 135 F.Supp. 2d 1253, 1264 (S.D. Fla. 2001) (extortion where Defendants have in effect held an "economic gun" to the plaintiffs' heads and used other coercive methods to obtain property from the providers in the form of suppressed compensation).

By the same token, Insurers realized the same economic benefit by paying less

through interfering (or attempting to interfere) with Appellants operations, i.e., the repair services required to properly repair vehicles and restore them to pre-loss condition. *Smithfield Foods,* 633 F.Supp. 2d 214, 224 (E.D. Va. 2008) (*Scheidler* did not remove extortion of intangible property rights from the reach of RICO."); *Scheidler*, 537 U.S. at n.6 ("the dissent is mistaken to suggest that our decision reaches, much less rejects, lower court decisions such as *U.S. v. Tropiano*, 418 F.2d 1069, 1076 (2d Cir. 1969), in which the Second Circuit concluded that the intangible right to solicit refuse collection accounts constituted property within the Hobbs Act definition."). And, Insurers' conduct in usurping Appellants' right to perform repairs for their customers and steering or attempting to steer those repairs to one of Insurers' DRP facilities remains actionable. *U.S. v. Colvard*, 2015 WL 5123893, at *5 and n.2 (M.D. Pa. Sept. 1, 2015) (value of customer list); *Southern Intermodal Logistics, Inc. v. D.J. Powers Co., Inc.*, 10 F.Supp. 2d 1337, 1352 (S.D. Ga. 1998) (threat to take freight away from the carriers and prevent them from acquiring any new business); *Tomblin*, 46 F.3d at 1384 (threatened loss of investment); *c.f. M.V.B. Collision, Inc. v. Allstate Ins. Co.,* 728 F.Supp. 2d 205, 217 (E.D.N.Y. 2010) (steering a car away from plaintiff's auto body shop constituted a "loss of business or other injury.").

The district court erred in finding that Insurers did not obtain or attempt to obtain property sufficient for pleading RICO extortion.

E. The District Court Erred in Concluding that Appellants Failed to Allege a RICO Conspiracy, as Codified in 18 U.S.C. § 1962(d)

18 U.S.C. § 1962(d) provides, in pertinent part, that: "It shall be unlawful for any person to conspire to violate any of the provisions of subsection …(c) of this section." Appellants must allege "that the conspirators agreed to participate directly or indirectly in the affairs of the enterprise through a pattern of racketeering activity." *Daedalus Capital LLC v. Vinecombe*, 8:12-CV-2533-T-35TBM, 2014 WL 11412836, at *5 (M.D. Fla. Aug. 22, 2014). "A plaintiff can establish a RCIO conspiracy claim in one of two ways: (1) by showing that the defendant agreed to the overall objective of the conspiracy; or (2) by showing that the defendant agreed to commit two predicate acts." *American Dental Assn.*, 605 F.3d 1293 (citing *Republic of Panama v. BCCI Holdings (Luxembourg) S.A.*, 1993 F.3d 935, 950 (11th Cir. 1997)). A plaintiff need not offer direct evidence of a RICO agreement; the existence of the conspiracy "may be inferred from the conduct of the participants." *Id*.

As discussed at length herein, by virtue of their conduct, each of the Appellees conspired with their respective Information Providers (and, specific to State Farm, with their Select Service DRP facilities as well) to defraud and extort Appellants and proposed Classes for their money and property, in violation of 18 U.S.C. § 1962(c), by establishing artificial prevailing rates for insured repairs, including hourly labor rates, reimbursement for "paint and materials," compensable repair procedures, and

parts, and suppressing compensation and maintaining suppressed compensation for those repairs. This conspiracy to violate a violation of 18 U.S.C. § 1962(d).

It cannot reasonably be disputed that, in furtherance of the conspiracy, Insurers agreed to conduct or participate in the affairs of the RICO Enterprises and agreed to commit at least two of the predicate acts described above. *American Dental Assn.*, 605 F.3d 1293; *Daedalus Capital LLC*, 2014 WL 11412836, at *5.

F. The District Court Erred in Concluding that Appellants Failed to Allege Actionable Claims for Unjust Enrichment Under North Carolina and Pennsylvania Law

1. Standards for Pleading Unjust Enrichment Under North Carolina and Pennsylvania Law

To establish unjust enrichment under Pennsylvania law, a party must show:

> (1) benefits conferred on defendant by plaintiff; (2) appreciation of such benefits by defendant; and (3) acceptance and retention of such benefits under such circumstances that it would be inequitable for defendant to retain the benefit without payment of value.

Schenck v. K.E. David, Ltd., 666 A.2d 327, 328 (1995). Under North Carolina law, a plaintiff must show: "(1) a measurable benefit was conferred on the defendant, (2) the defendant consciously accepted that benefit, and (3) the benefit was not conferred officiously or gratuitously." *Primerica Life Ins. Co. v. James Massengill & Sons Const. Co.*, 712 S.E.2d 670, 677 (2011).

In both Pennsylvania and North Carolina, it is well settled that the "benefit conferred" does ***not*** have to flow from plaintiff directly to defendant. Specifically,

the Fourth Circuit Court of Appeals held, "[u]nder North Carolina law, it is sufficient for a plaintiff to prove that it has conferred some benefit on the defendant, without regard to the directness of the transaction." *Metric Constructors, Inc. v. Bank of Tokyo–Mitsubishi, Ltd*., 72 Fed.Appx. 916, 921 (4th Cir. 2003); *see also In re TFT–LCD Antitrust Litig.*, 599 F.Supp.2d 1179, 1191 (N.D. Cal. 2009) (under North Carolina law, "there is no requirement of 'direct benefit' in cases alleging fraud or civil conspiracy."). Likewise, in *Sheet Metal Workers Local 441 Health & Welfare Plan v. GlaxoSmithKline, PLC*, 737 F.Supp.2d 380 (E.D. Pa. 2010), the court explicitly rejected the defendant's contention that "Pennsylvania requires conferral of a direct benefit in order to maintain an unjust enrichment claim." *Id.* at 444.

2. Appellants Alleged Viable Claims for Unjust Enrichment Under Both North Carolina and Pennsylvania Law

Ignoring the foregoing principles, the district court concluded that Appellants failed to allege that they conferred a benefit upon Appellees. (DOC. 278 at 19-20). In so holding, the court reasoned:

> [Appellants] argue that "the repair services performed by [Appellants] for insured claimants paid for by [Appellees] satisfies the directness standard under these states' laws." **However, so far as the record discloses, the [Appellees] are obligated to pay for repairs, not perform such repairs themselves. Thus, when one of the [Appellants] repairs a vehicle for one of the [Appellees]' insureds, the [Appellant] has not satisfied an obligation for that [Appellee]**. To the contrary, as the Court previously noted, the performing of the repair is what *triggers* the [Appellees]' obligation to make payment.

Id. (italics in original). This reasoning is flawed for the following two reasons.

First, Appellants alleged **two** different benefits they conferred on Appellees: (1) Appellants' repairs satisfied Appellees' policy obligations to *either* repair *or* pay a repair shop to repair their insureds' vehicles; **and** (2) Appellees benefitted by paying Appellants *less* (in the form of suppressed rates) for their repairs to insureds' vehicles. *See, e.g.*, (DOC. 235 at 13-15). Yet the court curiously analyzed only the former. *See* (DOC. 278, *supra*). By limiting its analysis to only one of the two alleged "benefits conferred" while totally ignoring the other, the court erred.

Moreover, Appellants second alleged "benefit conferred"—that Appellees undercompensated Appellants for their repairs—was sufficient to establish their unjust enrichment claims, and the court's failure to assess these allegations was further error. In *In re Lidoderm Antitrust Litigation*, 103 F.Supp.3d 1155 (N.D. Cal. 2015), indirect purchaser plaintiffs alleged that they conferred a benefit on defendants by paying higher prices for LCD products than they would have absent the defendants' alleged price fixing conspiracy, which the court found sufficient to state a claim for unjust enrichment. *Id*. at 1178; *see also GlaxoSmithKline*, 737 F.Supp.2d at 442 ("plaintiffs' payment of higher prices for a product as a result of unlawful conduct on the part of the defendant is sufficient to state an unjust enrichment claim under North Carolina" and Pennsylvania law); (DOC. 235 at 13-14) (citing multiple analogous cases, all of which uniformly find unjust enrichment). In this case, the roles are reversed: Appellees are the purchasers of Appellants' repair

services. The unjust enrichment results from Appellees undercompensating Appellants for their services and retaining the monies they would have had to pay, but for their wrongful conduct in mispresenting and omitting necessary repair procedures, labor rates, and material rates to restore the vehicles to pre-loss condition. In fact, here, there is an even stronger link because unlike in *Lidoderm*, Appellees are paying Appellants *directly* for the repair services. Thus, these allegations are sufficient to establish that Appellants conferred a benefit on Appellees by receiving undercompensation, and the court's failure to consider them constitutes reversible error.

Second, by holding that "the Defendants are obligated to pay for repairs, not perform such repairs themselves" the court ignored the explicit language of Appellees' policies, which provides that Appellees are obligated to *either* repair insureds' vehicles, *or* pay someone else to do so (e.g., repair shops, such as Appellants). This oversight, alone, constitutes error. Nonetheless, the court further erroneously held: "when one of the [Appellants] repairs a vehicle for one of the [Appellees]' insureds, the Plaintiff has not satisfied an obligation for that Defendant." (DOC. 278 at 19). This conclusion, however, is in direct conflict with authority establishing that "a person confers a benefit upon another if he … performs services beneficial to or at the request of the other [and/or] satisfies … a duty of the other." Restatement (First) of Restitution § 1 (1937); *see also* Restatement (Third)

of Restitution and Unjust Enrichment § 24 (2011) (unjust enrichment "[i]f the claimant renders to a third person a performance for which the defendant would have been independently liable to the third person"). In a case involving analogous facts, another court within the Eleventh Circuit held that a plaintiff's "satisfaction of [the defendants'] obligation will support a claim for unjust enrichment." *In re Managed Care Litig.*, 298 F.Supp.2d 1259, 1298 (S.D. Fla. 2003). Specifically, the plaintiffs (healthcare providers) brought claims for unjust enrichment against the defendants (managed care companies), alleging (as Appellants do here) that they conferred a benefit on the defendants by satisfying their obligation to treat patients within defendants' care, but the defendants argued (like Appellees do here) that the medical treatment provided by the plaintiffs (i.e., the alleged "benefit conferred") "was not the kind of direct benefit required to support a claim" for unjust enrichment because the plaintiffs had an independent obligation to treat defendants' patients, as healthcare providers *Id*. The court rejected the defendants' argument and held that the plaintiffs sufficiently alleged a claim for unjust enrichment. *Id*. Thus, contrary to the court's conclusion, Appellants' satisfaction of Appellees' contractual repair obligations did, in fact, confer a benefit on Appellees.

G. The District Court Erred in Concluding that Appellants Failed to Allege Actionable Claims for Fraud Under North Carolina and Pennsylvania Law

1. Standards for Pleading Fraud Under Pennsylvania and North Carolina Law

In Pennsylvania, "[a] prima facie case of fraud requires a party to establish:

> (1) a representation; (2) that is material; (3) that is made with knowledge or reckless indifference of its falsity; (4) with intent to mislead another; (5) justifiable reliance; and (6) injury.

Borough of Morrisville v. Kliesh, 2014 WL 346589, *8 (Pa. Commnw. Ct. Jan. 30, 2014). Similarly, to plead a viable cause of action for common law fraud under North Carolina law, the plaintiff must prove:

> (a) that the defendant made a representation relating to some material past or existing fact; (b) that the representation was false; (c) that when he made it defendant knew it was false or made it recklessly without any knowledge of its truth and as a positive assertion; (d) that the defendant made the false representation with the intention that it should be acted on by the plaintiff; (e) that the plaintiff reasonably relied upon the representation and acted upon it; and (f) that the plaintiff suffered injury.

Stetser v. TAP Pharma. Prods., Inc., 598 S.E.2d 570, 582 (N.C. Ct. App. 2004).

2. Appellants Alleged Viable Claims for Fraud Under Both Pennsylvania and North Carolina Law

The district court did not conduct a full analysis of Appellants' state law fraud claims; instead, it relied upon its analysis of fraud in the context of Appellants' RICO claims and dismissed Appellants' state law fraud claims in summary fashion. Indeed, the full extent of the district court's analysis is the following single sentence:

"the Court finds that the [Appellants] [] have again failed to plead fraud with the requisite particularity and to allege justifiable reliance upon any statement by any [Appellees]." (DOC. 278 at 20).

As discussed above, the facts underlying Appellees' fraudulent efforts to artificially establish prevailing rates and repair standards, and then force those deflated rates upon Appellants and the proposed Classes, are indisputably material. Further, for the reasons outlined above under the RICO claims, Appellants have alleged (1) false statements and omissions of material facts; (2) known to Insurers to be false; (3) that were made for the purpose of inducing Appellants and the proposed Classes to rely on the statements and omissions—and such reliance was reasonable and justifiable; and (5) as a result, Appellants and the proposed Classes were injured, in that they were paid (and forced to accept) suppressed compensation for repair services. Accordingly, Appellants have sufficiently pled a claim for fraud.

H. The District Court Erred in Affirming Magistrate Smith's June 6, 2016 Order (DOC. 234) Excluding Consideration of Appellants' Exhibits E1-E7

1. Standard of Review

FRCP 72(a) vests magistrate judges with authority to enter orders deciding nondispositive pretrial matters. *See* Fed. R. Civ. P. 72(a). When a party objects to such an order, FRCP 72(a) further provides that "the district judge in the case **must** consider [the] timely objections and modify or set aside any part of the order that is

clearly erroneous to law." *Id*.; *see also McCombs v. Meijer, Inc.*, 395 F.3d 346, 360 (6th Cir. 2005) ("The district court cannot simply 'concur' in the magistrate's findings, but it must conduct its own review in order to adopt the recommendations."). When reviewing a magistrate judge's nondispositive rulings on pretrial matters, this Court has previously stated, "[w]e review the district court's application of the law to the facts *de novo*, but accept the district court's factual findings unless they are clearly erroneous." *U.S. v. Walton*, 323 Fed. Appx. 837, 839 (11th Cir. 2009); *see also Jeffrey S. by Ernest S. v. State Bd. of Educ. of State of Ga.*, 896 F.2d 507, 513 (11th Cir. 1990) ("the clearly erroneous standard of review applies to a magistrate's findings of fact only on appeal.").

2. Standards for Considering Documents Attached to a Brief in Opposition to a Motion to Dismiss

The court may consider a document attached to a motion to dismiss if the document is: "(1) central to the plaintiff's claim; and (2) undisputed." *Horsley v. Feldt*, 304 F.3d 1125, 1134 (11th Cir. 2002); *SFM Holdings, Ltd. v. Banc of America Securities, LLC*, 600 F.3d 1334, 1337 (11th Cir. 2010) ("In ruling on a motion to dismiss, the district court may consider an extrinsic document if it is (1) central to the plaintiff's claim, and (2) its authenticity is not challenged."). "This rule 'logically extends to documents attached to a plaintiff's response.'" *Ritz v. Lake County, Ill.*, No. 08 C 5026, 2010 WL 2025392, at *2 (N.D. Ill. May 20101).

3. Magistrate Smith Erred in Excluding Appellants' Exhibits E1-E7 from Judge Presnell's Review of Appellees' Motions to Dismiss

On May 16, 2016, Appellees filed a motion to strike exhibits filed in support of Appellants' opposition to Appellees' motions to dismiss. (DOC. 225). Judge Presnell referred this nondispositive pretrial matter to Magistrate Smith, pursuant to FRCP 72(a). On June 6, 2016, Magistrate Smith entered an Order granting in part Appellees' motion to strike, which excluded seven exhibits attached to Appellants' brief in opposition to Appellees' motions to dismiss. *See* (DOC. 234 at 5). These exhibits consist of Appellees' repair estimates (setting forth the repairs and parts Appellees would agree to cover for a particular loss) and repair orders created by Appellants (setting forth the actual repairs made and parts used by Appellants when repairing a particular car)[18] (the "Estimates").

As an initial matter, with respect to the second *Horsley* requirement—that the party objecting to the court's consideration of the exhibits does not dispute the authenticity of the documents—Magistrate Smith correctly concluded: "[a]lthough [Appellees] raise the issue of authenticity, they do not claim that they don't recognize the exhibits, some of which they created, or that the exhibits are not what they purport to be …. **the objection based on authenticity is overruled**." (DOC.

[18] *See* DOC. 216-5 – 216-11 (Appellants' Exhibits E-1 through E-7, respectively, consisting of Appellees' repair estimates and Appellants' repair orders).

234 at 3). Thus, Magistrate Smith properly analyzed only the first *Horsley* requirement: whether the exhibits are "central to the plaintiff's claim." *See id*.

The Estimates are central to Appellants' claims for multiple reasons.[19] *First*, the Estimates contain Appellees' fraudulent misrepresentations and omissions concerning the time, scope and extent of the necessary and compensable repair procedures required to properly restore damaged vehicles. *Second*, Appellants allege that the repair procedures and parts set forth in the Estimates are not supported by statistically valid data or bases to support Appellees' representations to Appellants and insurance claimants. Thus, the Estimates and the data contained therein are not only false, but also conflict with manufacturer and industry specifications as well as Information Provider Guidelines. *Third*, the Estimates expressly set forth the hourly "rate" for the various categories of labor, as well as the hourly "rate" for materials reimbursement (i.e., paint and supplies), which Appellees uniformly represent as the so-called market "rates," which again is based on flawed and unsound data (if any data at all).

Magistrate Smith conceded that the Estimates "may turn out to be important

[19] As an initial matter, the Estimates are undoubtedly central to Appellants' claims and should have been considered by Judge Presnell when analyzing the sufficiency of the SAC because they contain the data Appellants used to construct two charts (Exhibits K (Doc. 205-12) and M (Doc. 205-14) to the SAC) that Judge Presnell considered in ruling on Appellees' motions to dismiss. Thus, if the charts were "central" enough to Appellants' claims for Judge Presnell to consider them, then so too were the Estimates containing the underlying data displayed in those charts.

evidence at trial," yet he puzzlingly held that they were "not ***so*** central" enough to satisfy *Horsley*, even though *Horsley* does not specify a threshold level of centrality exhibits must meet in order to be considered. (DOC. at 5).

4. Judge Presnell Failed to Review Magistrate Smith's Nondispositive Order, as Required by FRCP 72(a)

As discussed above, FRCP 72(a) states that the district court "**must** consider timely objections" to a magistrate's nondispositive pretrial rulings and "modify or set aside any part of the order that is clearly erroneous to law." Fed. R. Civ. P. 72(a). "The district court cannot simply 'concur' in the magistrate's findings, **but it must conduct its own review** in order to adopt the recommendations." *McCombs v. Meijer, Inc.*, 395 F.3d 346, 360, 2005 FED App. 0030P (6th Cir. 2005). Thus, "[t]he district court **must actually review and weigh the evidence presented** to the magistrate judge." *Harvard Pilgrim Health Care of New England v. Thompson*, 318 F. Supp. 2d 1, 6 (D.R.I. 2004). It cannot "**merely rely on the magistrate judge's report** and recommendation." *Id.* "[W]here circumstances indicate that the district court has not conducted such review following timely objection to the magistrate's report, the case must be remanded for compliance with the statute [i.e., 28 U.S.C. § 636(b)(1)]." *Bratcher v. Bray-Doyle Indep. Sch. Dist. No. 42 of Stephens County, Okl.*, 8 F.3d 722, 724 (10th Cir. 1993); *see also Summers v. State of Utah*, 927 F.2d 1165, 1167 (10th Cir. 1991) (same); *Tuggle v. Seabold*, 806 F.2d 87, 92 (6th Cir. 1986) ("When circumstances demonstrate that a district court has not conducted the

required de novo review, the case must be remanded for compliance with the statute") (citing *Hill v. Duriron Co*., 656 F.2d 1208 (6th Cir. 1981)); *Ocelot Oil Corp. v. Sparrow Indus*., 847 F.2d 1458, 1462 (10th Cir.1988) (same).

Furthermore, the "clearly erroneous" standard requires *de novo* review of the magistrate judge's legal conclusions. *Seaton Ins. Co. v. Clearwater Ins. Co.*, 736 F. Supp. 2d 472, 474 (D.R.I. 2010); *Eisai Co., Ltd. v. Teva Pharmaceuticals USA, Inc*., 629 F. Supp. 2d 416, 424 (D.N.J. 2009) ("While a magistrate judge's decision typically is entitled to deference, the magistrate judge's legal conclusions are reviewed *de novo*."). Thus, "[f]or questions of law there is no practical difference between review under Rule 72(a)'s contrary to law standard and a *de novo* standard." *CertusView Technologies, LLC v. S & N Locating Services, LLC*, 107 F. Supp. 3d 500, 504 (E.D. Va. 2015); *Bruce v. Hartford*, 21 F. Supp. 3d 590, 594 (E.D. Va. 2014) (same).

Appellants timely objected to Magistrate Smith's June 6, 2016 Order excluding the Estimates and, in the alternative, sought reconsideration thereof. *See* (DOC. 237).[20] Appellants also timely objected to Magistrate Smith's August 10, 2016 Order (DOC. 244) denying Appellants' motion for reconsideration of Magistrate Smith's June 6, 2016 Order. *See* (DOC. 246).

[20] Appellants also objected to Magistrate Smith's June 6, 2016 Order to the extent it excluded Appellants' Exhibit D (DOC. 216-4), consisting of Appellants' license agreements with the Information Providers.

Pursuant to the cases cited above, Appellants' timely objections triggered Judge Presnell's duty, under FRCP 72(a), to conduct his own review of the Estimates and decide whether they met the *Horsley* requirements—namely, whether the Estimates are central to Appellants' claims. *See, e.g.*, *McCombs*, 395 F.3d at 360. Specifically, Judge Presnell was obligated to conduct a *de novo* review of Magistrate Smith's conclusions of law, *Seaton Ins. Co.*, 736 F. Supp. 2d at 474, and was neither permitted to "simply 'concur' in the magistrate's findings," *McCombs*, 395 F.3d at 360, nor "merely rely on the magistrate judge's report and recommendation," *Thompson*, 318 F. Supp. 2d at 6.

Despite the foregoing principles, on April 21, 2017, Judge Presnell entered a one-page order, the entirety of which stated as follows:

> In response to [Appellees]' Motion to Dismiss [Appellants]' Second Amended Complaint, [Appellants]attached numerous exhibits totaling 1,490 pages (DOC. 216). [Appellees] moved to strike those exhibits (DOC. 225). Magistrate Judge Smith sustained the objections to Exhibit D and E1-E7 (DOC. 234). [Appellants]filed an objection to Judge Smith's Order and an alternative Motion for Reconsideration (DOC. 237). [Appellees] responded to the objection/motion (DOC. 240) and [Appellants]replied (DOC. 242). Judge Smith declined to reconsider his Order (DOC. 244). [Appellants] objected to that Order (DOC. 246) and [Appellees] responded (DOC. 253). Upon consideration of the above, it is ORDERED that [Appellants]' objections to Judge Smith's Order denying reconsideration of his order at Doc. 244 are OVERRULED. [Appellants]' objections to Judge Smith's Order at DOC. 234 are also OVERRULED.

(DOC. 275). Nothing in Judge Presnell's Order indicates that he conducted a *de novo* review of Magistrate Smith's legal conclusions, conducted his own review and

analysis of the Estimates, or did anything more than merely adopt Magistrate Smith's prior orders. Respectfully, his failure to do so constitutes reversible error.

I. The District Court Erred in Dismissing Appellants' Complaint with Prejudice without Granting Appellants' Multiple Requests for Leave to Amend Pleadings

1. Standards for Granting Leave to Amend

It is axiomatic that "leave to amend shall be 'freely given when justice so requires.'" *McKinley v. Kaplan*, 177 F.3d 1253, 1258 (11th Cir. 1999) (quoting Fed.R.Civ.P. 15(a)). This Court has previously held that the "district court erred in depriving Plaintiff of an opportunity to amend when Plaintiff plainly and repeatedly requested leave to amend" "in papers filed in opposition to [the defendant's motion to dismiss]." *Ferrell Law, P.A. v. Crescent Miami Center, LLC*, 313 Fed. Appx. 182, 186 (11th Cir. 2008).

2. The District Court Erred in Denying Appellants Leave to Amend

On six different occasions, Appellants requested leave to amend their complaint. Specifically, in their opposition to Appellees' motions to dismiss, Appellants stated: "[Appellants] respectfully request that the Court … grant [Appellants] … the right to file an amended complaint to cure any deficiencies and/or to add additional information, transactions and occurrences." (DOC. 216 at 67). Appellants reiterated this request in their sur-reply (DOC. 235 at 15), opposition to Appellees' motion to strike exhibits attached to Appellants' opposition to

Appellees' motions to dismiss (DOC. 229 at 14), objection to Magistrate Smith's June 6, 2016 order excluding Appellants' Exhibits D and E1-E7 to their opposition to Appellees' motions to dismiss (DOC. 237 at 10), reply in support of Appellants' objection to Magistrate Smith's June 6, 2016 order (DOC. 242 at 3 n. 3 & 5), and opposition to Appellees' objection to Exhibit A attached to Appellants' sur-reply (DOC. 238 at 10).

Despite the fact that "leave to amend shall be freely given," the court refused to grant Appellants' repeated requests for leave to amend. Pursuant to this Court's prior ruling in *Ferrell Law, P.A., supra*, the district court's failure to grant Appellants' leave to amend despite their repeated requests is, in itself, error. *Ferrell Law, P.A.*, 313 Fed. Appx. at 186 ("district court erred in depriving Plaintiff of an opportunity to amend when Plaintiff plainly and repeatedly requested leave to amend" "in papers filed in opposition to [the defendant's motion to dismiss].").

Furthermore, Appellants stated that they sought leave to amend in order to, *inter alia*, "add additional information, transactions and occurrences," including documents to demonstrate Appellees' misrepresentations of the prevailing "rates" and how they misled Appellants. (DOC. 216, 229, 235, 237, 238, 242). Similarly, while Magistrate Smith's order excluding Appellants' exhibits was pending Judge Presnell's required *de novo* review, Appellants requested "to amend or supplement the complaint in the event that Court is inclined to strike [Appellants]' Exhibits E1-

E7 and D." (DOC. 242 at 5). The same request applied in the event that the district court was inclined to strike the exhibits setting forth the written and affidavit evidence from K&M demonstrating its course of dealing with defendant Nationwide. (DOC. 238 at 10). In similar contexts, this Court has repeatedly granted plaintiff leave to amend where the plaintiff filed a specific motion before the district court requesting leave to amend, and filed a proposed second amended complaint setting out significant additional facts relating to the defendant's actual knowledge of an ongoing fraud. *See Ferrell Law, P.A.*, 313 Fed. Appx. at 184-86; *see also, e.g.*, *Perlman v. Wells Fargo Bank, N.A.*, 559 Fed. Appx. 988, 996 (11th Cir. 2014) (granting leave to amend to add significant additional facts relating to the defendant's actual knowledge of an ongoing fraud).

Moreover, in its dismissal order, the court failed to analyze whether Appellants' amendment would be futile, or to conduct any other analysis of Appellants' requests. Instead, with respect to Appellants' RICO claims, the court stated in summary fashion: "[n]othing in the Plaintiffs' oral argument or their voluminous responses to the instant motions suggests that they can ever overcome the issues discussed above so as to state a valid RICO claim. Accordingly, the RICO counts will be dismissed with prejudice." (DOC. 278 at 18). Likewise, with respect to Appellants' state law claims, the court stated: "[t]his is the Plaintiffs' second opportunity to plead these claims, and they show no sign of being able to overcome

these flaws. Accordingly, the state law claims will also be dismissed with prejudice." *Id*. at 20. Depriving Appellants the opportunity to amend to cure deficiencies and add additional facts without determining that such amendment would be futile is patently erroneous. *See, e.g.*, *Castleglen, Inc. v. Resolution Trust Corp.*, 984 F.2d 1571, 1585 (10th Cir.1993) ("Refusing leave to amend is generally only justified upon a showing of undue delay, undue prejudice to the opposing party, bad faith or dilatory motive, failure to cure deficiencies by amendments previously allowed, or futility of amendment.").

VI. CONCLUSION

For the foregoing reasons, the Court should reverse the judgment of the district court dismissing the action with prejudice in its entirety, and all other orders of the district court, and remand the action to the district court, and grant such other and further relief as the Court deems just and proper.

DATED: September 1, 2017

Respectfully submitted,

/s/ Steven L. Bloch

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CERTIFICATE OF COMPLIANCE

The undersigned attorney hereby certifies that this brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 32(a)(7)(B) and Eleventh Circuit Rule 28-1. This brief contains 16,027 words and uses a Times New Roman 14-point font.

/s/ Steven L. Bloch
Steven L. Bloch

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on September 1, 2017, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system. Notice of this filing will be sent to counsel of record by operation of the Court's electronic filing system.

/s/ Steven L. Bloch
Steven L. Bloch