UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
ORLANDO DIVISION

Crawford's Auto Center, Inc. and K&M Collision, LLC, on behalf of themselves and all others similarly situated, **v.** **State Farm Mutual Automobile Insurance Company, *et al*.**	**MDL Docket No. 2557** **Case No. 6:14-cv-6016-GAP-TBS** **Originally filed in the Northern District of Illinois**

PLAINTIFFS' CONSDOLSIDATED MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANTS' FED. R. CIV. P. 12(B) MOTIONS TO DISMISS PLAINTIFFS' AMENDED CLASS ACTION COMPLAINT

Plaintiffs Crawford's Auto Center, Inc. ("Crawford's") and K&M Collision, LLC ("K&M") (collectively, "Plaintiffs"), on behalf of themselves and all others similarly situated, file this Consolidated Memorandum of Law in Opposition to Defendants' Motions to Dismiss pursuant to Fed. R. Civ. P. 12(b) and Fed. R. Civ. P. 9(b), respectively, the Joint Motion of Certain Defendants (Allstate, Progressive, Farmers, Liberty Mutual and Nationwide) (Doc. 158), State Farm's Motion to Dismiss (Doc. 157) and GEICO's Motion to Dismiss (Doc. 159). Unless specifically noted, Plaintiffs' Memorandum of Law addresses and responds to Defendant Insurers' common, overlapping arguments in support of their Motions to Dismiss.[1]

I. INTRODUCTION

Defendant Insurers' respective Motions to Dismiss are without merit. For the reasons set forth below, Plaintiffs have sufficiently pled causes of action for RICO, fraud and unjust enrichment, and the Court should deny Defendant Insurers' Motions in their entirety.

[1] By Order dated February 23, 2015, **(**Doc. 172), the Court granted Plaintiffs permission to file a consolidated memorandum of law in opposition to Defendant Insurers' respective motions to dismiss and afforded Plaintiffs the same total number of pages contained in Defendant Insurers' memoranda, i.e., 85 pages.

II. FACTUAL BACKGROUND

A. The Parties

Plaintiffs Crawford's Auto Center, Inc. ("Crawford's"), a Pennsylvania automotive collision repair business, and K&M Collision, LLC ("K&M"), a North Carolina automotive collision repair business, filed this First Amended Complaint ("Complaint" or "FAC") on August 28, 2014. (FAC ¶¶ 21-22.)

Defendants are seven corporations in the business of issuing automotive insurance in various states and throughout the country: State Farm Mutual Automobile Insurance Company ("State Farm"); Allstate Corporation ("Allstate"); Government Employees Insurance Company ("GEICO"); The Progressive Corporation ("Progressive"); Farmers Insurance Exchange and Truck Insurance Exchange ("Farmers"); Liberty Mutual Holding Co., Inc. ("Liberty Mutual"); and Nationwide Mutual Insurance Company ("Nationwide") (collectively the "Defendant Insurers"). (*Id.* ¶¶ 24-31.) Each of the Defendant Insurers has company-wide, systematic and uniform claims management practices, and each operates as a single, integrated enterprise for claims adjustment and administration purposes. (*Id.*)

Separate and apart from the Defendant Insurers are the Conspirator members of the respective RICO enterprises. The Conspirators fall into two categories: Conspirator Insurers and Information Providers. (*Id.* ¶¶ 33-34.) The Conspirator Insurers are United States Automobile Association ("USAA"); The Travelers Companies, Inc. ("Travelers"); and American Family Mutual Insurance Company Inc. ("American Family"). (*Id.* ¶ 32.) The Information Providers are CCC Information Services Inc. ("CCC"); Mitchell International, Inc. ("Mitchell"); and Audatex North America, Inc. ("Audatex"). (*Id.*) The respective Defendant Insurers and Conspirators were agents and representatives of, and aided and abetted the unlawful conduct of, each of the other

Defendant Insurers and Conspirators in the combinations, conspiracies and enterprises alleged. (*Id.* ¶ 37.)

B. Insured Collision Repairs and Direct Repair Programs

Defendant Insurers and Conspirator Insurers (together the "Insurers") collectively hold the majority of the national market share for automotive repairs, which has allowed them to establish the industry standards for collision repairs as well as compensation for those repairs. Specifically, the Insurers comprise the top ten private passenger auto insurers in the United States (based on premiums written) and collectively hold a national market share of approximately 70%, as follows:

State Farm – 17.9%
Allstate – 10.1%
GEICO – 9.7%
Progressive – 8.4%
Farmers - 6.0%
USAA – 4.9%
Liberty Mutual - 4.8%
Nationwide - 4.1%
Travelers - 2.0%
American Family – 1.9%.

(*Id.* ¶ 38.) Market concentration has steadily increased in recent years, and control of the national market for auto insurance in the United States increasingly rests with these largest insurers. (*Id.* ¶¶ 39-40.) At the same time, automotive collision repairs of damaged vehicles covered by insurance account for approximately $25-$30 billion in repair costs annually (based on both first-party and third-party claims), and these repairs account for between approximately 75% and 90% of all automotive collision repairs in the United States each year. (*Id.* ¶ 41.) Plaintiffs aver and allege that the collision repairs covered and paid for by or through the Insurers track and/or align with their respective percentages of market share. (*Id.* ¶ 42.)

The crux of Plaintiffs' FAC is that Insurers have created an artificial market rate for repairs that has allowed them to artificially suppress compensation to repair facilities for insured collision repairs. They have accomplished this end through what are known as direct repair programs ("DRPs") comprised of collision repair facilities around the country that agree to abide by certain uniform standards and procedures in the repairs covered by the Insurers. Ostensibly, the DRP networks ensure that the Insurers can maintain control and quality in the repair process, but in fact the DRP relationships enable the Insurers to control the cost of insured repairs, and establish what is known as the "prevailing competitive price" or "prevailing rate" of the repairs (hereinafter, the "prevailing rate"). (*Id.* ¶ 44.)

Each DRP facility executes a uniform written agreement with one or more of the Insurers, agreeing to abide by the terms dictated by each respective Insurer for its direct repair facilities. Frequently, repair facilities serve as a DRP facility for multiple insurers. The Insurers control virtually all aspects of the repairs performed by their DRP facilities, including the cost and the methods by which repair estimates are created which, in turn, dictates the time, scope and extent of the repairs using one of the three Information Provider estimating systems. (*Id.* ¶¶ 45-46.)

First, the Insurers either mandate or strongly recommend that their DRP facilities use the same estimating system to create repair estimates. The DRP facilities further agree to abide by the Insurers' customized "estimating profile" that each has with CCC, Mitchell or Audatex, as well as the uniform estimating protocol (i.e., guidelines) that each of the Insurers maintains. Together, the estimating profile and company protocol outline the limits for the time, scope and cost of compensable repairs. (*Id.* ¶ 46.)

Second, the DRP agreements dictate, among other things, compensation for repairs, including hourly labor rates, reimbursement for what is known as "paint and materials", parts prices and required discounts on parts provided to insurers – as well as the types of parts, charges for certain repair procedures, and the permitted mark-up on various items. The DRP repair facilities are willing – or are economically forced – to enter into these agreements with the Insurers and abide by the terms and conditions because, in return, the Insurers refer (i.e., "steer") repair work to these facilities. Accordingly, DRP facilities (willingly or not) trade rate for volume of repair referrals (or, at least, the opportunity for referral). Though the referrals are not "guaranteed" under the DRP agreements, the Insurers are notorious for steering work to their DRP facilities, and indeed are so successful at steering that industry reports indicate that approximately 50-60% of all repairs covered by the Insurers are performed by DRP facilities. (*Id.* ¶¶ 47-49.)

C. Repair Appraisals and the Information Provider Products

Before a damaged vehicle is repaired, a repair appraisal – or estimate – is prepared. The estimate appraises the damage to the vehicle, serves as the blueprint for the repairs that are to be performed, and establishes the scope and cost of the repairs based on required labor operations, time and price. Repair estimates are prepared using estimating software products sold by one of the Information Providers. The Insurers (and virtually every insurer), as well as the vast majority of repair facilities, subscribe to one or more of the estimating software products sold by the Information Providers, which collectively make up the damage repair estimating market in the U.S. (*Id.* ¶ 50.) The Information Providers' estimating systems have become entrenched as the only accepted method of preparing repair estimates, and all members participating in the collision repair industry must utilize one of the three estimating systems. (*Id.* ¶ 61.)

The Insurers each pay millions of dollars per year for Information Provider products. (*Id.* ¶ 57.) With the exception of State Farm (which uses various products from all three Information Providers), the Insurers generally have exclusive contractual relationships with, and purchase estimating products from, one of the three Information Providers. (*Id.* ¶ 52.) The Insurers further mandate – or strongly recommend – that their DRP network facilities license the same estimating product from the same Information Provider with which the Insurers have a relationship. (*Id.* ¶ 53.) The Insurers also regularly meet and consult with the Information Providers. (*Id.* ¶ 59.) Further, the Insurers regularly request, encourage and/or suggest (if not require, under threat of lost business) that Information Providers find ways to suppress repair compensation through rates and repair standards. (*Id.* ¶ 60.)

D. How Insurers Establish an Artificial Prevailing Rate to Control and Suppress Repair Costs

In order to control and suppress costs, the Insurers have, in tandem with the Information Providers, created the prevailing rate – an artificial measure of the market value for all categories of repairs. This purported market value is based on a feedback loop of information to the Information Providers from the Insurers' DRP network facilities, which have previously agreed to repair rates that the Insurers dictate as the prevailing rate. The prevailing rates are thus comprised of flawed and rigged data, predicated on the agreements that the Insurers have executed with their respective DRP network facilities, which facilities see no choice but to accept the purported prevailing rates in exchange for work. These prevailing rates are then forced upon non-DRP facilities (like Plaintiffs and the classes here), which never entered into contracts to accept these rates from the Insurers. And although there is no uniform, industry rate for repairs, nor any statistical validity to the purported prevailing rates, the Insurers have perpetuated this industry prevailing rate with great success.[2] (*Id.* ¶¶ 62-71.)

Through this artificial prevailing rate, the Insurers' practices suppress compensation for: (i) labor rates; (ii) refinishing; (iii) the time, scope and extent of repair procedures; and (iv) parts. (*Id.* ¶ 72.) Specifically, and as described in greater detail in the FAC:

i. All of the Insurers' hourly labor rates for collision repair services have remained depressed in all events and at all material times. Though there have been nominal rate increases, the Insurers' labor rates around the country have remained flat and stagnant – and this is not

[2] Defendant Insurers admit their conduct. In June 5, 2014 testimony before the Rhode Island Senate Committee on Judiciary in opposition to Rhode Island Senate Bill No. 2834, which proposed creating new classifications and licensure of repair facilities based on certification of standards, quality and equipment, and which, in turn, would require new labor rate classifications and higher rates for more qualified facilities, counsel for the Property Casualty Insurance Association of America (Stephen Zubiago of Nixon Peabody LLP) – representing, among others, GEICO, Liberty Mutual and Nationwide –stated: "We sell the insurance, we pay the bills, we'd like to make the decisions with respect to what the rates are." (*Id.* ¶ 64.)

confined or particular to any state or geographic region. This is so despite the fact that repair facilities are operated by skilled professionals, and their services are not fungible, notwithstanding the Insurers' efforts to make them so. Like other professionals – and contrary to artificial and uniform prevailing rates that the Insurers have been able to establish through means that have little to do with free market competition or value – the services of automotive repair professionals should be based on factors such as quality, experience, training and facility capabilities, and the compensation for these services should be based, at least in part, on these factors. (*Id.* ¶¶ 72-80.)

ii. As to refinishing, the Insurers have created an additional artificial prevailing rate for compensation in the manner in which they compensate repair facilities for the costs of "paint and materials", which are the facility's cost of paint, coating, sealant and decontaminant products, as well as the materials used to prepare the vehicle for refinishing and to perform refinishing procedures. The Insurers have historically and consistently used what is known as the "dollar per paint hour" method of compensating repair facilities for the costs of "paint and materials". The "dollar per paint hour" is a standard flat rate, and is a completely arbitrary measure of compensation that has no basis in, or correlation to, the actual costs incurred by repair facilities for "paint and materials". In contrast, Plaintiff Crawford's, like many repair facilities, uses an invoice methodology based on actual prices paid by Crawford's for "paint and materials", to account for and seek reimbursement from insurers for these costs. In addition, there are also software programs known as "paint materials calculators" (used by Plaintiff K&M) or "refinishing materials calculators" that likewise are based on manufacturer pricing and acquisition costs. The Insurers, however, refuse to compensate repair facilities based on these more accurate methodologies. As a direct result of the Insurers' refusal to compensate repair

facilities based on any measure other than the artificial "dollar per paint hour" method, and the restraint of the "dollar per paint hour", compensation to repair facilities has been artificially suppressed. (*Id.* ¶¶ 81-89.)

iii. The Insurers also utilize the prevailing rate to control repair estimates. The industry only recognizes repair estimates prepared using estimating programs (depicted as the so-called independent standard for developing the time, scope and extent of collision repairs) from the Information Providers. The Insurers purchase these estimating programs from the respective Information Providers, and repair facilities all license one or more of the estimating programs. All three estimating systems state that they are to be used merely as a "guide" to determine the time, scope and extent of the repair procedures, which are unique and particular to each repair. Indeed, the intent behind the estimating programs is that the repair procedures and the labor times designated for such procedures will be supplemented, added to and adjusted, predicated on the damage to and condition of each vehicle, and the time, scope and extent of the required repairs. The Insurers, however, each create their own estimating profile that is mandated for use by their respective DRP facilities, as well as their company estimating protocol, which together impose strict limits on the time, scope and extent of compensable repair procedures. The Insurers thus use the Information Provider programs – facilitated by the Information Providers – to constrain repair estimates and suppress compensation to repair facilities. (*Id.* ¶¶ 90-129.)

iv. Finally, the Insurers also frequently impose the pre-determined parts prices that they have with their respective DRP network facilities, including the required price discounts, on non-DRP facilities, under the guise of the purported prevailing rate. (*Id.* ¶ 130.)

E. <u>State Farm's Conduct</u>

Defendant State Farm, given its position as the largest auto insurer in the industry, is able to exercise its dominant power to push the limits of cost control even further by imposing additional mechanisms on its DRP network to suppress repair rates, which, in turn, provides the foundation for what State Farm establishes as purported industry prevailing rates and imposes upon repair facilities like Plaintiffs, which are not part of the State Farm DRP. Further, State Farm is the fulcrum among the Insurers in establishing and maintaining, among other things, labor rates and "paint and materials" reimbursement rates, which further reinforces the suppression of repair compensation. (*Id.* ¶ 131.)

State Farm's DRP network, known as "Select Service", is the largest in the industry, and all Select Service network facilities enter into a uniform written contract with State Farm agreeing to abide by State Farm's repair mandates and cost control measures, as well as State Farm's estimating profile and company protocol to limit and restrict compensation for repairs. (*Id.* ¶ 132.) All Select Service facilities must further agree that between 20% - 25% of their repairs are dedicated to State Farm work, making those facilities financially beholden and reliant on State Farm. (*Id.*)

State Farm also relies upon several other methods to suppress compensation to collision repair facilities. First, State Farm has a heavily policed and strictly enforced most favored nation provision ("MFN") in its uniform DRP agreements by which State Farm ensures the benefit of paying the lowest prices on all aspects of repairs that Select Service facilities charge to – or are paid by – any other insurer. (*Id.* ¶¶ 133-136.)

Second, State Farm has developed "Repairer Performance Management" reports which provide information to each facility about its performance on the Select Service program. These reports, however, lack statistical validity and are merely State Farm's method to coerce Select Service facilities to take whatever means necessary – irrespective of the quality or comprehensiveness of the required repairs – to keep severity low. (*Id.* ¶¶ 137-138.)

Third, State Farm controls its claim costs and suppresses compensation to repair facilities through its so-called survey process, which State Farm uses to establish its prevailing rates. State Farm mandates that its Select Service facilities participate in an on-line survey to provide rate information for repairs that they perform for State Farm. Participation by non-Select Service facilities is voluntary and approximately only 10%-20% of non-Select Service facilities participate in the State Farm survey. Accordingly, like the prevailing rate data that is generally established through the Information Providers by the other Insurers, State Farm's survey process yields results that are heavily weighted and skewed toward rates provided by Select Service (DRP) facilities, which rates are pre-determined based on the DRP agreements executed with State Farm, and then, as with the other Defendant Insurers, the rates are run through Audatex and Mitchell and then promulgated as the prevailing rates by which compensation for collision repairs are paid. State Farm is well aware that the survey process is not representative of the prevailing rate for repairs, and its representation that the survey reflects the so-called prevailing rate is false. State Farm is then able to impose these falsely promulgated prevailing rates on non-Select Service facilities like Plaintiffs, thereby artificially suppressing compensation. (*Id.* ¶¶ 139-148.)

F. Information Sharing between and among Insurers

Plaintiffs have alleged abundant facts demonstrating that the information sharing between and among the Insurers further enables the suppression of compensation in repair facilities through the RICO Enterprises. Specifically, the Insurers share information about, and/or have access to, the costs and compensation of their respective insured repairs, including labor rates and reimbursement for "paint and materials", as well the time, scope and extent of compensable repairs. The Insurers gauge and align, among other things, their hourly labor rates and reimbursement rates for "paint and materials", which together account for more than 50% of all repair compensation. These rates are generally determined and/or guided by State Farm – the market leader – and ultimately imposed upon collision repair facilities like Plaintiffs and the members of the Classes, which do not serve as DRP facilities for the Insurers. (*Id.* ¶¶ 149-152.)

The FAC further discusses several processes through which this information is shared. First, through the subrogation departments of the Insurers, each knows in full detail what the other insurers are paying to repair facilities – both DRP and non-DRP – for insured repairs. In addition, each insurer is privy to repair estimates underlying insured claim repairs paid by other insurers. Thus, the Insurers all know what other insurers are paying in labor rates and reimbursement for "paint and materials" (as well as costs for parts and discounts provided by repair facilities on parts and compensation for certain repair procedures). The Insurers also know which estimating program is utilized by each insurer, as well as the insurer's estimating profile – or, at the very least, the parameters of the estimates that each insurer writes and pays as the prevailing rate. (*Id.* ¶¶ 154-155.)

Second, the Insurers share information through the Information Providers, which maintain data on all facets of automotive collision repairs and the compensation paid by insurers.

The Information Provider data is insurer-specific, which consists of all repairs paid for by that particular insurer, and provides aggregate industry data. This information is provided to the Insurers but is not available to repair facilities. (*Id.* ¶¶ 156-160.)

Third, State Farm and Farmers both heavily police and strictly enforce their MFN provisions. In doing so, State Farm and Farmers request that each facility fill in a form advising them of the specific pricing offered or agreed to with any insurer on virtually every aspect of repairs. In addition, pursuant to the written agreements with their respective DRP facilities, the Insurers all have the right (and have exercised the right) to audit the records of their facilities, which, upon information and belief, on occasion includes the right to review in whole or in part the repair estimates and compensation paid for repairs by other insurers in connection with the repairs performed by those facilities. (*Id.* ¶¶ 161-164.)

Fourth, it is typical in the industry for claims adjusters to compare rates with their counterparts at other insurers, and the Insurers engage in regular communications about their prevailing rates and the compensation that is paid to repair facilities. (*Id.* ¶ 165.)

Fifth, the Insurers regularly communicate about repair estimating protocol and compensation to repair facilities at various industry meetings and conferences which occur throughout the year, sponsored by Information Providers, industry organizations and the like. (*Id.* ¶¶ 166-168.)

As a result of all of the foregoing, Defendant Insurers and Conspirator Insurers, which comprise approximately 70% of the auto insurance market in the United States and account for and control approximately 70% of the market for insured collision repairs, are able to fix and maintain prevailing rates for hourly labor rates and “paint and materials” reimbursement across the country, and repair facilities are paid the same or nearly the same rates. As a result, repair

compensation to Plaintiffs and the Classes has been – and remains –artificially suppressed. (*Id.* ¶ 169.)

G. Plaintiffs' Suppressed Compensation

To further demonstrate their standing to assert RICO claims against the Defendant Insurers predicated on their injury to business or property, Plaintiffs attached representative examples of their shortfalls in compensation on repairs performed. Those examples identify the repair order and specific Defendant Insurer claim number, the dates that estimates and estimate supplements – and repair orders and invoices – were prepared, the payments made toward repair compensation, the source of the payment, the total amount due based on each Plaintiff's repair orders, and the amount and itemization of the shortfall in compensation for repairs. In connection with each repair, Plaintiffs presented each Defendant Insurer with repair orders that explicitly detailed the charges for repairs and the basis for those charges. Defendant Insurers prepared estimates and estimate supplements that contained the misrepresentations and omissions described in the FAC concerning the compensation for repair rates and procedures. In particular, in connection with each of the repairs, Defendant Insurers represented to Plaintiffs that Plaintiffs' charges for the repairs were not in accordance with prevailing rates. In connection with each of these repairs, the shortfall failed to compensate or fully compensate Plaintiffs. (*Id.* ¶¶ 258-276.)

H. Fraudulent Concealment and Tolling of Applicable Statutes of Information

Finally, the FAC sufficiently alleges facts showing fraudulent concealment such that the applicable statutes of information are tolled. Plaintiffs allege that each Defendant Insurer (and Conspirator) concealed from Plaintiffs and the members of the Classes the fraudulent conduct establishing artificial prevailing rates for insured repairs and suppressing compensation for those repairs, and further that each Defendant Insurer (and Conspirator) prevented Plaintiffs and the members of the Classes from knowing or discovering the methods by which the artificial

prevailing rates for insured repairs were established and by which compensation for those repairs was suppressed. (*Id.* ¶ 287.) The efforts to conceal the aforementioned were designed to avoid detection. (*Id.* ¶ 288.) Plaintiffs did not know, nor could reasonably have known, that they sustained injuries caused by Defendant Insurers' respective uniform policies, patterns and practices, and the facts necessary to establish Plaintiffs' claims were intentionally concealed from Plaintiffs for the purpose of obtaining delay on the Plaintiffs' part in filing a complaint predicate on the claims. (*Id.* ¶ 290-2.)

III. ARGUMENT

A. Rule 12(b)(6) Standard

In ruling on a motion to dismiss, the Court must view the complaint in the light most favorable to the Plaintiff, *see, e.g., Jackson v. Okaloosa County, Fla.,* 21 F.3d 1531, 1534 (11th Cir.1994), and must limit its consideration to the pleadings and any exhibits attached thereto. FED. R. CIV. P. 10(c); *see also GSW, Inc. v. Long County, Ga.,* 999 F.2d 1508, 1510 (11th Cir.1993). The Court will liberally construe the complaint's allegations in the Plaintiff's favor. *Jenkins v. McKeithen,* 395 U.S. 411,421 (1969). However, "conclusory allegations, unwarranted factual deductions or legal conclusions masquerading as facts will not prevent dismissal." *Davila v. Delta Air Lines, Inc.,* 326 F.3d 1183, 1185 (11th Cir.2003).

In reviewing a complaint on a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6), "courts must be mindful that the Federal Rules require only that the complaint contain 'a short and plain statement of the claim showing that the pleader is entitled to relief.' " *U.S. v. Baxter Intern., Inc.,* 345 F.3d 866, 880 (11th Cir.2003) (citing FED. R. CIV. P. 8(a)). This is a liberal pleading requirement, one that does not require a plaintiff to plead with particularity every element of a cause of action. *Roe v. Aware Woman Ctr.for Choice, Inc.,* 253 F.3d 678, 683 (11th Cir.2001).

However, a plaintiff's obligation to provide the grounds for his or her entitlement to relief requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do. *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 554–555, 127 S.Ct. 1955, 167 L.Ed.2d 929 (2007). The complaint's factual allegations "must be enough to raise a right to relief above the speculative level," *Id.* at 555, and cross "the line from conceivable to plausible." *Ashcroft v. Iqbal*, 556 U.S. 662, 129 S.Ct. 1937, 1950–1951, 173 L.Ed.2d 868 (2009).

B. Plaintiffs' RICO Claims Are Sufficiently Pled

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, Plaintiffs 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); *State Farm Mut. Auto Ins. Co. v. Altamonte Springs Diagnostic Imaging, Inc.*, 2011 WL 6450769 *6 (M.D.FL. Dec. 21, 2011) (J. Presnell); *see also Hemi Grp., LLC v. City of New York, N.Y.*, 559 U.S. 1, 9 (2010).

Plaintiffs have satisfied their burden of pleading viable RICO claims.

1. Plaintiffs Have Pled Viable RICO Enterprises

A RICO 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). An association in fact enterprise reaches a group of persons associated together for the common purpose of engaging in a course of conduct, and is proved by evidence of "an ongoing organization, formal or informal", as well as evidence "that the various associates function as a continuing unit." *U.S. v. Turkette*, 452 U.S., 576, 580, 583 (1981); *U.S. v. Goldin Indus., Inc.*, 219 F.3d 1271, 1275 (11th Cir. 2000) (same). In *Boyle v. U.S.*, 129 S.Ct. 2237 (2009), the Supreme Court clarified the attributes of an association in fact enterprise. *Boyle* held that the RICO statute defined "enterprise" broadly, such that the "enterprise" element of a 1962(c) claim can be satisfied by showing "three structural features: a purpose, relationship among those associated with the enterprise, and longevity sufficient to permit those associates to pursue the enterprise's purpose." *Id.* at 2244-45; *State Farm Mut. Auto Ins. Co. v. Kugler*, 2011 WL 4389915 *5 (S.D.FL. Sept. 21, 2011).

Plaintiffs have pled 7 distinct RICO association in fact enterprises, consisting of Defendant Insurers and the Information Providers with which they collaborate. The State Farm association in fact enterprise is comprised of State Farm, together with its Information Providers and State Farm's DRP facilities.

Each of these RICO Enterprises satisfies the 3 enterprise elements under *Boyle*, given that each has: (i) a purpose; (ii) relationships among those associated with the enterprise; and (iii) longevity sufficient to permit the associates to pursue the enterprise's purpose.

a. Purpose of the RICO Enterprises

There are only 3 Information Providers in the United States, and they sell their estimating programs to both insurers and collision repair facilities (i.e., DRP and non-DRP). Given the framework and control of the repair industry effectuated by insurance companies (including, especially, the Defendant Insurers), all repair estimates and invoices are prepared using an estimating program from the Information Providers, and compensation to collision repair facilities nationwide is grounded in the estimating programs of the Information Providers, i.e., the repair facilities are required to use the estimating Information Provider programs to perform their work because it is the only means by which insured repairs are paid. (FAC at 5, 46, 50-59) The Information Provider estimating programs are, therefore, held as the definitive, objective standard for damage appraisal and repair, including the time, scope and extent of repairs and the manner in which the repairs are to be performed and accomplished. (FAC at 5, 46, 50-59, 90-130)

In fact, the information providers furnish Defendant insurers with the framework and tools to suppress compensation to repair facilities. Indeed, the information provider estimating programs consistently designate times to perform repair procedures that are understated; bundle required repair procedures to significantly understate the time necessary to perform the procedures in a professional and competent manner; impose formulas for calculating times for repair procedures that are arbitrary and understated, which do not reflect the labor time necessary to perform the procedures in a professional and competent manner; and collapse and combine repair procedures to achieve what is known as “overlap” or “redundancy”, in order to reduce the time – and cost – in repair estimates. Further, the information providers have written their programs so that any time a repair estimate contains additional or supplemented repair procedures that are required in the judgment and discretion of the repair professional, and/or

contains a deviation from any of the designated labor times, those entries are highlighted for audit by Defendant insurers, enabling Defendant insurers to avoid appropriately compensating non-direct repair facilities for work that the insurers contend is subsumed by bundled procedures – or because the purported prevailing standard in the industry is not to charge for these necessary added procedures or enhancements in time. The information providers also furnish Defendant insurers with "scrubber" programs, which audit repair estimates from non-direct repair facilities (and, in fact, direct repair facilities as well) to likewise avoid appropriately compensating non-direct repair facilities for repair procedures or costs that do not comport with what Defendant insurers each contend are the industry prevailing rates and standards for repair – and Defendant insurers refuse to pay for repairs other than at the so-called industry prevailing rates and standards. (FAC at 6, 50-59, 112-130)

In addition, the Information Providers are purportedly the objective, independent information storehouse for the collision repair industry. Each information provider collects and synthesizes the repair data from the Defendant Insurers (and other insurers) that use its estimating programs, and this data is then furnished to the respective Defendant Insurers (and other insurers) for all insured repairs covered by that particular insurer, and for all insured repairs in the aggregate covered by the other insurers utilizing that Information Provider's estimating program. This repair data, however, is heavily biased because it is predicated on repairs by the Defendant Insurers' (and other insurers') direct repair facilities; it does *not* properly incorporate data from repair facilities, like Plaintiffs and the members of the respective classes, that are not on the Defendant Insurers' (or other insurers') direct repair programs. Thus, although this data is promulgated as representative of industry prevailing rates, it is, in fact, a feedback loop of the

fixed rates that the insurers set with their respective direct repair facilities, which have been "laundered" through the so-called independent information providers. (FAC at 7, 50-59, 62-71)

The 7 RICO Enterprises, partnerships between the respective Defendant Insurers and their Information Providers, are continuous, ongoing organizations associated for the common purposes of: (1) establishing and promulgating the prevailing rate for damage repairs to vehicles covered by the respective Defendant Insurers, including (a) hourly labor rates; (b) reimbursement for "paint and materials"; (c) the time, scope and extent of compensable repair procedures; and (d) parts prices; and (2) establishing and promulgating the standards for damage appraisal and repair, including the time, scope and extent of repairs and the manner in which the repairs are to be performed and accomplished. (FAC at 186)

Neither the Defendants Insurers nor their Information Provider conspirators could effectuate or accomplish the purposes of the respective RICO Enterprises without the sharing of data and collaboration between and among them. Defendant Insurers control the compensation to the collision repair industry, which is based on the industry prevailing rates and repair standards promulgated by the Information Providers, which, in turn, derives, in large (or exclusive) part, from Defendant Insurers' fixed prevailing rates and the estimating standards and guidelines set in collaboration or consultation with the insurers. The Defendant Insurers and Information Providers benefit from the respective RICO Enterprises, which enable Defendant Insurers to artificially suppress compensation for collision repairs, and which also enable the Information Providers to maintain their position as the exclusive sellers and suppliers of data and estimating programs to the collision repair industry, including the very repair facilities like Plaintiffs and the members of the classes which utilize and depend on the Information Provider programs and data to perform repairs. (FAC at 187, 193-236)

In addition, the RICO Enterprises have engaged in a pattern of racketeering to artificially suppress compensation to repair facilities, including Plaintiffs and the members of the proposed Classes, that are not part of each Defendant Insurer's DRP networks, by falsely establishing and representing the prevailing rates for collision repairs, as well as the standards for damage repair, including the time, scope and extent of repairs and the manner in which the repairs are to be performed and accomplished. Accordingly, the RICO Enterprises are engaged in the common purpose of defrauding the collision repair facilities. (FAC at 188, 193-236)

b. **Relationships among the Associates in the RICO Enterprises**

Each of the respective RICO Enterprises has an existence and structure distinct from its members. All of the Defendant Insurers are separate corporate entities, as are the Information Providers. And, with respect to the State Farm Enterprise, the State Farm Select Service facilities likewise are separate and distinct from State Farm. Further, each member of the respective RICO Enterprises has an existence separate and apart from the pattern of racketeering activities of the RICO Enterprises, and each member of the respective RICO Enterprises engages in operations that are distinct from their activities on behalf of the RICO Enterprises. Defendant Insurers all issue automotive insurance – as well as other lines of insurance. The Information Providers not only license and/or sell product packages to insurers and repair facilities, including, without limitation, programs to prepare estimates for vehicle damage repairs as well as claims and operational management programs, but they also license and/or sell additional analytics programs concerning other types of claims and business. With respect to the State Farm Enterprise, State Farm's Select Service facilities are engaged in the business of performing automotive repairs for insured and non-insured vehicles. (FAC 189-190)

And, as described, supra, each member of the respective RICO Enterprises is reliant and dependent upon the other member(s), and each is essential to the operation of the RICO Enterprises in establishing, promulgating and representing repair rates and standards. Further, each member of the RICO Enterprises has conducted or participated in the affairs of the RICO Enterprises, directly or indirectly, has facilitated the unlawful racketeering activities of the RICO Enterprises, and has a well-defined role in the RICO Enterprises. (FAC at 191)

c. **Continuous Existence of the RICO Enterprises**

At all material times, the respective RICO Enterprises all had an ongoing and continuous existence sufficient to pursue the purpose of each of the RICO Enterprises. In each of the RICO Enterprises, there was interdependence between and/or among the members in pursuing the unlawful purpose of the respective RICO Enterprises, which could not have been accomplished without the participation of each member. Each of the RICO Enterprises has been ongoing for periods exceeding two years, and is continuing. Further, as described herein, each member of the respective RICO Enterprises was aware of the purpose of the RICO Enterprises to establish and promulgate prevailing rates and standards for insured repairs, which were artificially suppressed and resulted in reduced compensation for those repairs. (FAC 193-236, 239-242)

Defendant Insurers do not challenge the continuity of the RICO Enterprises.

d. **Plaintiffs Have Sufficiently Alleged that the RICO Enterprise Members are Participating in the Conduct of the Enterprises**

To be liable 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). Thus, the person "must participate in the operation or management of the enterprise itself". *Id*. at 185. "[A]n 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, Inc. v. Andrews-Bartlett & Assocs., Inc.*, 62 F.3d 967, 977, 978-79 (7th Cir. 1995) ("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….'"); *State Farm v. Mut. Auto Ins. Co. v. Kugler*, 2011 WL 4389915 at *6 (S.D. Fla. Sept. 21, 2011) (same). "The word 'participate' makes clear that RICO liability is not limited to those with primary responsibility for the enterprise's affairs, just as the phrase 'directly or indirectly' makes clear that RICO liability is not limited to those with a formal position in the enterprise, but *some* part in directing the enterprise's affairs is required." *Reves*, 507 U.S. at 184 (emphasis in original).

Here, Defendant Insurers and the Information Providers have, at the very least, played "some part" in directing the operation and/or management of the RICO Enterprises to falsely establish the purported prevailing rates and repair standards, which artificially suppresses the compensation to collision repair facilities like Plaintiffs and proposed Classes.

As Plaintiffs have alleged:

(1) Defendant Insurers and Conspirator Insurers each pay millions (or tens of millions) of dollars per year for Information Provider products. Information Provider revenue for estimating products also derive from repair facilities. Reportedly, 60% of estimating revenue comes from repair facilities and insurers account for 40% of the revenue. However, given that Defendant Insurers and Conspirator Insurers mandate that their DRP facilities use the same Information

Provider estimating programs, Defendant Insurers and Conspirator Insurers create a secondary revenue stream for Information Providers through the insurers' respective DRP facilities, and thus account for and control a significant portion of that additional 60% in repair facility revenue for the Information Providers. And, generally, if a repair facility is a DRP facility for multiple insurers – which frequently is the case – that facility will license estimating programs from multiple Information Providers. Given the number of DRP facilities, the Defendants Insurers and Conspirator insurers account for almost 75% of the Information Providers' revenue. Thus, the Defendant Insurers have great financial influence (FAC at 57)

(2) Defendant Insurers regularly meet and consult with the Information Providers at Defendant Insurers' facilities, including repair testing and training facilities, to discuss and collaborate on estimating methods and repair standards. Audatex, Mitchell and CCC all have facilities near State Farm's headquarters, as well as employee representatives on State Farm's and other of Defendant Insurer's sites. Further, the Information Providers regularly visit Tech-Cor, Allstate's repair testing and training facility, as well as Allstate's headquarters. (FAC at 59).

(3) The Information Providers all sponsor conferences and annual events, attended by all Defendant Insurers, at which the parties discuss the Information Provider programs, estimating processes and protocol, methods for improving "accuracy" and "cost containment" – and this specifically includes compensation paid to repair facilities by Defendant Insurers, current pricing and severity data that the Information Providers promulgate as prevailing industry data, but which is derived from Defendant Insurers' claims data tied to repairs performed only by Defendant Insurers' DRP facilities and from estimates for repairs prepared by Defendant Insurers (that do not reflect – let alone accurately reflect – the repair invoices from Plaintiffs and

proposed Classes), and future pricing trends and implementation of cost-savings measures for Defendant Insurers' claim repairs. Personnel for Defendant Insurers and the Information Providers often move between the two. For example, Audatex presently employs former officer and executive level personnel from Defendant Insurers in advisory and consulting positions, including State Farm, Allstate and Progressive. (FAC at 59, 166-167)

(4) Defendant Insurers request and/or require that Information Providers find ways to reduce severity on insured claim repairs by modifying the estimating programs that they sell not only to Defendant Insurers but also the Plaintiffs and the collision repair facilities in the proposed Classes whose compensation and, if one accepts Defendant Insurers' position – the entire methodology and manner of repairs, is, given the control of the industry asserted by Defendant Insurers, tied directly to the Information Provider programs. This includes: (i) reducing time for labor operations (by re-doing time studies until the desired time is achieved or simply shaving time arbitrarily from required operations); (ii) collapsing and combing ("bundling") labor operations – and finding more redundancy (known as "overlap") in order to remove times for necessary labor operations; (iii) omitting or truncating necessary labor operations; and/or (iv) requiring that labor operations be entered manually by repair facilities preparing estimates, enabling Defendant Insurers and Conspirator Insurers to challenge and suppress compensation for these operations or the time ascribed to them, as described at length below. (FAC at 60, 69-70)

(5) The data that is incorporated into CCC's, Audatex's and Mitchell's estimating programs to develop the falsely portrayed "industry" prevailing rates for – at a minimum – labor (for body, frame and mechanical work and refinishing), paint and materials reimbursement, compensable repairs in terms of time, scope and procedures, all comes from Defendants Insurers

(and other insurers, including conspirator insurers), ensuring that the rates are nothing but a feedback loop of fixed and suppressed rates imposed by Defendant Insurers (and other insurers, including conspirator insurers). (FAC at 69-70**)**

(6) Each Defendant Insurer in collaboration with the respective Information Providers, establishes and maintains artificial prevailing rates and standards for repairs, including, without limitation: (1) hourly labor rates; (2) reimbursement for "paint and materials"; (3) the time, scope and extent of compensable repair procedures; and (4) parts prices. These prevailing rates were and are established through pre-determined arrangements with the Defendant Insurer's network of DRP facilities, which have agreed (willingly or not) to abide by Defendant Insurer's prevailing rates, estimating profile with the Information Provider, and company estimating protocol, as well as the Information Provider's estimating program that Defendant Insurer is able to exploit in promulgating the time, scope and extent of compensable repair procedures, based on, among other things, the manner in which the Information Provider estimating program is written and designed, as well as the Information Provider's determination of labor times and procedures as described above. The repair estimates prepared by Defendant Insurer's DRP facilities, as well as those prepared by Defendant Insurer for its DRP facilities or for repairs performed by non- DRP facilities, serve as the industry repair data maintained by Defendant Insurer's Information Provider, upon which the purported prevailing rates are based. (FAC 193-236)

(7) The Information Provider in each RICO Enterprise, respectively, aggregates, maintains and provides data that it promulgates as representative of industry prevailing rates for hourly labor rates, reimbursement for "paint and materials" and parts prices. In addition, to make their estimating program more amenable to insurer exploitation, the Information Provider:

(i) reports time studies supporting designated labor times that are outdated, incomplete or improperly extrapolated to procedures involving unrelated vehicles, parts and equipment; (ii) re-works time studies so that Information Provider is able to report results that are satisfactory to the Defendant Insurer (and other insurers) (i.e., results which reduce the labor times designated for repair procedures); (iii) bundles numerous repair procedures and tasks to significantly understate the labor time necessary to perform the procedures in a professional and competent manner; (iv) imposes formulas for calculating labor times for procedures that are arbitrary and understated, which do not reflect the labor time necessary to perform the procedures in a professional and competent manner; (v) collapses and combines procedures to achieve greater overlap to reduce labor times and costs in repair estimates; and (vi) commonly shifts necessary repair procedures to "Not Included" or discretionary categories, enabling the Defendant Insurers (and other insurers) to avoid compensating repair facilities for their work as unnecessary or not competitive. (FAC 112-130, 193-236)

(8) Further, the Information Providers have written their estimating program so that any time a labor time is changed or a procedure is added per the program or manually input as a "Not Included" or based on the repairer's judgment, those entries are highlighted for audit by the Defendant Insurer (and other insurers). (FAC 112-130, 193-236)

(9) Further, the Information Providers provide scrubber programs to the Defendant Insurers, enabling the Defendant Insurers to search repair estimates prepared using the Information Provider's estimating program and remove or highlight specific procedures and labor times (as well as hourly labor rates, reimbursement rates for "paint and materials" and parts prices) that do not comport with, or deviate from the defendant Insurer's estimating profile or company protocol. (FAC 112-130, 193-236)

(10) When negotiating or dealing with non- DRP facilities that are performing repairs on vehicles covered by the Defendant Insurers, the Defendant Insurers represent that deviations in hourly labor rates, reimbursement for "paint and materials", the time, scope and extent of compensable repair procedures that are contained in non- DRP repair estimates, and/or parts prices, do not constitute the prevailing rates in the industry and/or that no other repair facilities (in the Defendant Insurer's artificially drawn geographic regions) charge the hourly labor rates, reimbursement rates for "paint and materials", for the time, scope and extent of compensable repair procedures, and/or the parts prices in question. In addition, the Defendants Insurers conceal the foundation and basis for the purported prevailing rates and the manner in which such prevailing rates are determined and maintained, in forcing and coercing non- DRP facilities to accept artificially suppressed compensation for the repairs performed.

(11) The Defendant Insurers and the Information Providers promulgate together the Information Provider data as "industry" data, and the repairs standards in the Information Provider estimating programs and the "industry" standard, and the Information Provider products are sold to, and mandated for use by, all collision repair facilities, including Plaintiffs and the proposed Classes.

With respect to the State Farm Enterprise, in addition to all of the foregoing, State Farm's Select Service (DRP) facilities are "vital" participants in the State Farm Enterprise, without which the scheme and acts of racketeering could not be accomplished. *All* Select Services facilities enter into uniform, written contracts with State Farm – outlining uniform rights and obligations, are required to satisfy the same standards and undergo the same training, utilize the State Farm estimating profile and company estimating protocol, use similar repair methodologies, participate in State Farm's on-line survey to establish State Farm's prevailing

rates, afford State Farm with the most competitive pricing for all repair compensation, and abide by State Farm's uniform compensation.

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. By the same token, as described above, the Select Service facilities are vital to State Farm's establishment and maintenance of its prevailing rates in order to artificially suppress compensation for repairs.

These "lower rung-participants" are "vital" to the State Farm Enterprise, *MCM Partners*, 62 F.3d at 977, 978-79, and "enable" the State Farm Enterprise "to meet its goals." *State Farm Mut. Auto Ins. Co. v. Weiss*, 410 F.Supp.2d 1146, 1157 (M.D. Fla. 2006). Further, with respect to the State Farm Select Service facilities, "there is no need for a plaintiff to prove that each conspirator had contact with all other members. Indeed a RICO enterprise may be shown through proof of a hierarchical structure and without evidence that the lower level members of the enterprises collaborated directly with each other." *Coleman v. Commonwealth Land Title Ins. Co.*, 2013 WL 4675713 at *6 (E.D.Pa. Aug. 30, 2013) (citing *U.S. v. Friedman*, 854 F.2d 535, 562-63 (2d Cir. 1988). And, "it is well established that one conspirator need not know the identities of all his co-conspirators, nor be aware of all of the details of conspiracy in order to be

found to have agreed to participate in it." Id. at *6 (quoting, *U.S. v. De Peri*, 778 F.2d 963, 975 (3d Cir. 1985).

Further, to the extent that State Farm argues that including the DRP facilities as members in the State Farm Enterprise serves an impediment because they are merely competing facilities engaged in similar types of transactions with State Farm – nothing more, that argument has been squarely rejected. *See, e.g., Negrete*, 2011 WL 4852314 at *7 (citing *In re Nat. Western Life Ins. Deferred Annuities Litig.*, 635 F.Supp.2d 1170 (S.D. Cal. 2009). In Negrete, the court denied summary judgment to RICO defendant Allianz, which directed its enterprise members "through a variety of contractual provisions and company rules". Id. at *5, *7.

In short, it is clear that each State Farm Select Service facility understood the nature and import of their conduct in abiding, and the function that they were performing to further State Farm's goal of establishing what it purports to be prevailing rates for certain categories of repair compensation, including, without limitation, labor rates and reimbursement for paint and materials, which accounts for at least 50% of all repair compensation. (FAC at 131-148)

Defendant Insurers contend that the RICO Enterprises (1) have no existence distinct from the Defendant Insurers' own affairs and from the alleged racketeering acts; and (2) that Defendant Insurers and the Information Providers, which are in a customer-supplier relationship, are merely pursuing their own affairs, rather than those of the RICO Enterprises, and do not share a common purpose. But these arguments miss the mark.

Defendant Insurers place great significance on *D.M. Robinson Chiropractic v. Encompass Ins. Co. of America*, 2013 WL 1286696 (N.D. Ill. March 28, 2013). In that case, data provider (Mitchell) supplied an auto insurer (several Allstate entities) with a software program (DecisionPoint) to assist the insurer in paying medical claims arising from policyholder auto

accidents. Ingenix, a third party unrelated to Mitchell, was the actual database of pricing information used in reimbursing the medical claims. Mitchell's software program simply permitted insurers like Allstate to interface with the Ingenix data in setting reimbursement of those medical claims. Plaintiffs claimed that Allstate utilized Mitchell's software to set certain pricing benchmarks in order to underpay claims. *Id*. at *2-4. The court found that Mitchell and Allstate were in a standard customer-supplier relationship, and Mitchell's sole motive was encouraging Allstate to use its product for Mitchell's own financial gain, distinct from any interest that Allstate had in using the software. *Id*. at *9-*11. Accordingly, the court held that plaintiffs had failed to adequately allege an association in fact RICO enterprise because the members of the enterprise did not share a common purpose. In particular, the court noted that plaintiffs had not adequately alleged that defendants shared a common purpose to defraud policyholders. *Id*. at *11. Plaintiffs argued that Mitchell was a "lower-rung participant" acting at the direction of "upper management" within a RICO enterprise (relying on *MCM Partners, Inc. v. Andrews- Bartlett & Assocs., Inc.*, 62 F.3d 967, 978 (7th Cir. 1995)). But the court distinguished Mitchell's activities from those of the enterprise members in *MCM Partners* who were found to have participated in the enterprise's activities, because, unlike the members in *MCM Partners*, "Mitchell had *no direct dealings* with [p]laintiffs or other victims of the alleged RICO enterprise." *D.M. Robinson*, at *8 (emphasis added).

Notably, in the court's prior decision addressing an earlier complaint (*M.W. Widoff v. Encompass Ins. Co. of America*, 2012 WL 769727 (N.D. Ill. March 2, 2012)), the court stated that "[i]t would suffice that [Allstate] and Mitchell acted in concert to fulfill a purpose perhaps to increase their profits by using the Ingenix database to defraud their customers (*Pa. Chiropractic Ass'n v. Blue Cross Blue Shield Ass'n*, 2010 WL 1979569 *8 (N.D. Ill. May 17, 2010))." *Id*. at

*6. Plaintiffs then amended their complaint to include Ingenix as a member of the enterprise, but Ingenix's only alleged involvement was "verifying" pricing information to Allstate. *Id.* at *9. With respect to Mitchell, plaintiffs alleged that Mitchell "tailored" DecisionPoint so that Allstate could underpay claims, the court found that Mitchell was simply a vendor – without a role in Allstate's medical reimbursement decisions or financial benefit that was tied to Allstate's underpayment of claims. *Id*. at *10.

This action stands in stark contrast to *D.M. Robinson*. First, the Information Providers in this case, CCC, Audatex and Mitchell, all sell their programs directly to the collision repair facilities, including the Plaintiffs and the proposed Classes, which are being defrauded. Second, the Information Providers here promulgate (in collaboration with the Defendant Insurers) the so-called prevailing rates and repair standards by which the Plaintiffs and other collision repair facilities are being defrauded. In *D.M. Robinson*, Mitchell's software program merely permitted Allstate to interface with Ingenix, which was the entity that promulgated the medical pricing for insurance reimbursement. Mitchell provided none of the data upon which Allstate's alleged fraud was predicated. Third, the Information Providers unquestionably have common purposes underlying their RICO Enterprises. Each is invested in in the shared purpose of establishing the so-called prevailing rates and repair standards, i.e., (1) establishing and promulgating the prevailing rate for damage repairs to vehicles covered by the respective Defendant Insurers, including (a) hourly labor rates; (b) reimbursement for "paint and materials"; (c) the time, scope and extent of compensable repair procedures; and (d) parts prices; and (2) establishing and promulgating the standards for damage appraisal and repair, including the time, scope and extent of repairs and the manner in which the repairs are to be performed and accomplished. Fourth, the members of the RICO Enterprises mutually benefit from this purpose – the Defendants

Insurers through strict cost containment and control of insured collision repairs; the Information Providers by maintaining their role as the independent arbiters of collision repair data and standards in order to maintain their nationwide market dominance and sell their product to all stakeholders in the industry, including the collision repair facilities that are being defrauded. Neither can operate without the data, standards and knowledge shared between the Defendant Insurers (and other insurers) and the Information Providers – indeed the underlying repair information upon which the Information Providers base their rate information and repair estimating standards derives from Defendant Insurers DRP claims data, and the repair data and standards can only be promulgated in collaboration.[3] Further, through the RICO enterprises, Defendant Insurers, in collaboration with the Information Providers, are able to fraudulently establish and misrepresent to Plaintiffs and the proposed Classes the so-called industry prevailing rates for: (1) labor; (2) "paint and materials"; (3) parts; and (4) the time, scope and extent of compensable repair procedures – another common purpose which is indeed enabled by the Information Providers who, notwithstanding the guidance provided in the written manuals, construct their estimating programs to eliminate necessary time and procedures from repairs, provide "scrubbers" to the Defendant Insurers to eliminate necessary time and procedures from the repairs that the Information Providers proclaim is necessary, and represent to the collision repairs facilities to which they sell their programs, including Plaintiffs, that the data, including rates, costs and repair procedures are accurate and representative of the entire market when the date excludes collision repair facilities that do not serve as DRP facilities. In *D.M. Robinson*, Mitchell was not involved in any way with Allstate's medical claim reimbursement. *Id*. at 10.

[3] In D.M. Robinson, there was no allegation that Allstate provided any data to Mitchell or that Allstate collaborated with Mitchell on its program in the manner alleged here. *Id. passim*.

As a result, the Information Providers are not simply pursuing their own self-interests based on the conduct alleged here.[4] (FAC 5-7. 46, 50-59, 62-71, 90-130)

Predicated on the acts alleged in the Complaint, the Defendant Insurers, through the RICO Enterprises and in collaboration with the Information Providers, have defrauded collision repair facilities like Plaintiffs and the proposed Classes. This constitutes violative conduct under section 1962(c), which is that the RICO person has used the RICO enterprise to further an illegal scheme. *See, e.g., Cedric Kushner Promotions, LTD. v. Don King, 533 U.S. 158, 163 (2001)*; *Managed Care*, 298 F.Supp.2d at 1273 (the RICO Enterprise is the vehicle through which the unlawful pattern of racketeering is committed); *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.")[5]

And, to the extent that Defendant Insurers argue in their Joint Motion that "the shared goal of financial profit by each party conducting its own business, does not quality as a common purpose under RICO" (Jt Motion at 20, relying on D.M. Robinson at *9), that mischaracterizes the holding of *D.M. Robinson*, the claims in this action, and the law. Rather, the court in *D.M. Robinson* held that the financial profit achieved by each member conducting its own affairs could not qualify as a common purpose. *Id.* Defendants Insurers' Joint Motion cites no authority for

[4] It is notable that the Decision Point product sold by Mitchell to Allstate in *D.M. Robinson* is medical billing software that has nothing to do with the claims, products or facts in this action, demonstrating that Mitchell (like CCC and Audatex), and its standard business activities, are clearly entities distinct from the RICO Enterprises and the RICO conduct alleged here. In other words, *D.M. Robinson* shows a standard commercial relationship between Mitchell and Allstate which is distinct from, and in contrast to, Mitchell's role as a member of 2 RICO Enterprises in this case, and the pattern of racketeering – on behalf of those RICO Enterprises – which they enabled and in which they engaged. Interestingly, the Allstate companies use CCC as their Information Provider for repair estimating products and data at issue in this case (rather than Mitchell).

[5] To the extent that Defendants Insurers' imply that the *enterprise* must be "criminal", that is incorrect. (Jt. Motion at 18; GEICO at 10) RICO applies to both legitimate and illegitimate enterprises. *See, e.g., Turkette*, 452 U.S. at 580; *Allstate Ins. Co. v. St. Anthony's Spine & Joint Institute, P.C.*, 691 F.Supp.2d 772, 789 (N.D.Ill. 2010). (Indeed, the case that GEICO cites, Spadaro v. City of Miramar, 855 F.Supp.2d 1317, 1348 (S.D. Fla. 2012), was a prisoner's action.)

the proposition that the shared financial profit of the members of the RICO Enterprises – either through the enterprise as a whole or (by virtue of the individual members' participation) does not qualify and a common purpose. And, in fact, *Mohawk Indus*. expressly holds to the contrary ("[C]ommon purpose of making money was sufficient under RICO. Because the complaint clearly alleges that the members of the enterprise stand to gain sufficient financial benefits from Mohawk's widespread employment of harboring of illegal workers, the plaintiffs have properly alleged a 'common purpose' [under] RICO.") *Mohawk Indus.*, 465 F.3d at 1284-85.

Further, operation of an enterprise could even include a participant's acquiescence to losing money, so long as the member is advancing the enterprise's goals. *See MCM Partners*, 62 F.3d at 979, 971 (Scheme alleged had a purpose of maintaining a monopoly on forklift rentals, which benefited the "upper management" of the scheme, but resulted in the "lower-rung" defendants having to pay above-market prices as customers of the forklift rental services. Seventh Circuit held that "lower-rung" defendants, who were coerced into following orders, could qualify as participants in the operation of the enterprise, despite the fact that the enterprise's success *would result in losses, rather than profits*, for these participants).[6]

Again, the symbiosis between the Defendant Insurers and the Information Providers is indisputable, as they collectively develop the standards, rates and data for compensation in the collision repair industry, predicated upon the "laundered" feedback loop of fixed compensation set by Defendant Insurers through their DRP claims data and repair estimates prepared under Defendants' Insurers' strict estimating profiles and uniform company protocol, as well as the time, scope and extent of compensable repair procedures developed through coordinated efforts.

[6] And further, a RICO enterprise need not have any economic motive for engaging in a pattern of racketeering activity, *Scheidler v. National Organization for Women, Inc.*, 537 U.S. 393 (2003)
.

Estimating programs from the Information Providers are the mandated standard for collision repair compensation. Further, this cannot be considered a mere "commercial relationship" between Defendant Insurers given that the Information Providers directly sell their products to the defrauded collision repair facilities. And, the "commercial relationship" between Defendant Insurers and the Information Providers is not at all related to the common purpose of the RICO Enterprises to (falsely) establish the so-called prevailing rates and industry repair standards. Rather, the purported garden variety customer – supplier relationship between Defendant Insurers and the Information Providers concerned the purchase of estimating programs to create repair estimates for insured claims. None of the respective members of the RICO Enterprises could have accomplished the fraudulent scheme without the others. *See, e.g., In re Insurance Brokerage Antitrust Litigation*, 61 F.3d 300, 378 (3d Cir 2010) ("if defendants band together to commit [violations] they cannot accomplish alone … then they cumulatively are conducting the association in fact *enterprise's* affairs and not [simply] their *own* affairs.") (alterations and emphasis in original).

For these reasons, *United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund v. Walgreen Co.*, 719 F.3d 849 (7th Cir. 2013), a case upon which Defendant Insurers rely so heavily, is likewise unavailing and readily distinguishable. In that case, Walgreen filled drug prescriptions with medications purchased from Par (a pharmaceutical manufacturer), and they were alleged to have formed a RICO enterprise. Walgreen overcharged the plaintiff health benefits fund and other insurers by switching drug prescriptions to more expensive dosages. *Id*. at 850-852. Par was alleged to have facilitated Walgreen's ability to switch drugs (and thereby made more itself). *Id*. Plaintiff fund argued that each needed the other to fulfill the scheme, as Walgreen did not manufacture drugs and Par did not fill

prescriptions. The court rejected the theory, finding that Walgreen could simply have switched the dosages and drugs itself, or simply purchased the more expensive dosages and drugs from another manufacturer. *Id*. at 855-56. The court contrasted the case with *Insurance Brokerage*, where the members of the RICO enterprise were charged with fixing a purported competitive bidding processes – cooperation that fell outside the bounds of the parties' normal commercial relationship, just as Defendant Insurers and the Information Providers are alleged to have falsely promulgated collision repair industry rates and standards in this case. *Id*.

A RICO enterprise "need not possess even an ascertainable structure." *U.S. v. Goldin,* 219 F.3d 1271, 1275 (11th Cir. 2000). "[T]he existence of an enterprise is proved by evidence of an ongoing organization, formal or informal, and by evidence that the various associates function as a continuing unit…. [T]he definitive factor in determining the existence of a RICO enterprise is the existence of an association of individual entities, however lose or informal, that furnishes a vehicle for the commission of two or more predicate crimes, that is, the pattern of racketeering activity requisite to the RICO violation." *Mohawk Indus.*, 465 F.3d at 1284.

Further, in clarifying the attributes of an association in fact enterprise, the Supreme Court saw "no basis in the language of RICO" for requiring any particular type of organizational structure. *Boyle* 129 S.Ct. at 2245. Indeed, an association in fact enterprise need not have a hierarchical structure or a "chain of command"; decisions may be made on an ad hoc basis and by any number of methods…. Members of the group need not have fixed roles; different members may perform different roles at different times…. While the group must function as a continuing unit and remain in existence long enough to pursue a course of conduct, nothing in RICO exempts an enterprise whose associates engage in spurts of activity punctuated by periods of quiescence…." *Id.* at 2245-46.

Further, it is unnecessary to require proof of a structure "beyond that inherent in the pattern of racketeering activity" because "the evidence used to prove a pattern of racketeering activity and the evidence establishing an enterprise 'may in particular cases coalesce.'" *Turkette*, 452 U.S. at 583. Thus, "proof of a pattern of racketeering activity may be sufficient in a particular case to permit the jury to infer the existence of an association-in-fact enterprise." *Boyle*, 129 S.Ct. at 2247; *In re Insurance Brokerage Antitrust Litig.*, 618 F.3d at 368.

Under these teachings, the RICO Enterprises alleged by Plaintiff here are sufficient. Indeed, in a somewhat analogous setting, an association in fact enterprise consisting of, among others, health insurers and their data vendors, engaged in a "fraudulent scheme based upon the failure to disclose a plethora of automated processing techniques to diminish, delay or deny payments" to providers. *In re Managed Care Litigation*, 298 F.Supp.2d 1259, 1275, 1278 (S.D.FL. 2003) (overarching "common purpose" among defendants to develop payment processes to underpay health claims, fostered by sharing guidelines, software packages, and trade information). The following cases likewise illustrate the point:

Employer and third-party temp agencies and recruiters conspired to violate federal immigration laws and harbor illegal workers, thereby permitting them to depress wages paid to legal workers. Mohawk Indus., 465 F.3d at 1282, 1284 ("The plaintiffs' complaint alleges that the recruiters and Mohawk share the common purpose of obtaining illegal workers for employment by Mohawk. The complaint further alleges that each recruiter is paid a fee for worker it supplies to Mohawk and that Mohawk has made various incentive payments to employees and other recruiters for locating workers that Mohawk eventually employs and harbors. Furthermore, the acts of racketeering activity committed by Mohawk have the same or similar objective: the reduction of wages paid to Mohawk's hourly workforce." What is clear

from the complaint is that each member of the enterprise is allegedly reaping a large economic benefit from Mohawk's employment of illegal workers.") (internal quotation marks removed). Significantly, the Eleventh Circuit has stated that it is not required that the common purpose of the enterprise be the *sole* purpose of each and every member of the enterprise. And, it may often be that different members of the RICO enterprise will enjoy different benefits from the commission of predicate acts. This is insufficient to defeat a civil RICO claim. Rather, all that is required is that the enterprise have *a* common purpose. *Mohawk Indus.*, 465 F.3d at 1286-87.

Insurance Brokerage, 618 F.3d at 377 (bid-rigging enterprise between insurance broker and various insurers, "suggests an interrelationship among the insurers (sometimes through sham bids) – mediated through the broker – in pursuit of achieving greater business and profits by deceiving insurance purchasers.")

Common purpose between insurer and field marketing organizations through misleading materials to increase sales of insurer's products. *Negrete v. Allianz Life Ins. Co. of N. America*, 2011 WL 4852314 at *8 (C.D. Cal. Oct. 13, 2011) (Relationship between insurer and agencies involved "more than mere sales", given insurer's control over the agencies through training, marketing materials and commissions. "Common purpose element does not require the enterprise participants to share all of their purposes in common" (citing *Odom v. Microsoft Corp.*, 486 F.3d 541, 552 (9th Cir. 2007) and *In re Nat. Western Life Ins. Deferred Annuities Litig.*, 635 F.Supp.2d 1170, 1172 (S.D. Cal. 2009)).

See Coleman, 2013 WL 4675713 at *6-*7 (upholding enterprise comprised of title company and its various title agents, as well as multiple bilateral enterprises between the title company and the respective title agencies, where the title company and its agents functioned as a continuing unit for the purpose of overcharging on title insurance. "Commonwealth Land

directed the title agents in a common scheme to further a common purpose, collecting fees Commonwealth Land was not entitled to receive.")[7]

Lastly, to the extent that Defendant Insurers argue or imply that the members of the respective RICO Enterprises are not distinct from the RICO Enterprises, that issue is easily dispatched. Each member of the respective RICO Enterprises has an existence separate and apart from the pattern of racketeering activities of the RICO Enterprises, and each member of the respective RICO Enterprises engages in operations that are distinct from their activities on behalf of the RICO Enterprises. Defendant Insurers all issue automotive insurance – as well as multiple lines of insurance products. The Information Providers not only license and/or sell product packages to insurers and repair facilities, including, without limitation, programs to prepare estimates for vehicle damage repairs as well as claims and operational management programs, but they also license and/or sell numerous additional analytics programs concerning other types of claims and businesses. With respect to the State Farm Enterprise, State Farm's Select Service (DRP) facilities are engaged in the business of performing automotive repairs for insured and non-insured vehicles. (FAC at 190)

2. <u>Plaintiffs Have Sufficiently Alleged a Pattern of Racketeering Activity Through Predicate Acts</u>

RICO "racketeering activity" includes specific predicate acts as defined in 18 U.S.C. § 1961(1). In order to successfully allege a "pattern" of racketeering activity, Plaintiff must allege the commission of 2 or more predicate acts within a 10 year period that are related to each other and which amount to or pose a threat of continued criminal activity. *H.J. Inc. v. Northwestern*

[7] Defendant Insurers' reliance on *Crichton v. Golden Rule Ins. Co.*, 576 F.3d 392 (7th Cir.2009) is misplaced. That case involved the sale of insurance products by the issuer through a federation that "was merely a conduit for the sale of Golden Rule's insurance." There, the parties were merely conducting Golden Rule's affairs in a "garden-variety" marketing arrangement. The federation played no role in the misrepresentations concerning the sale of the products. *Id*. at 399-400.

Bell Tel. Co., 492 U.S. 229, 240 (1989); *Jackson v. Bellsouth Telecommunications*, 372 F.3d 1250, 1264 (11th Cir. 2004). In this case, Plaintiffs allege wire fraud (18 U.S.C. § 1343) and extortion (18 U.S.C. § 1951) as the predicate acts. Though Defendant Insurers challenge the predicate acts alleged and whether they constitute RICO violations, they do *not* challenge that Plaintiffs have alleged a pattern under RICO, *i.e.*, relatedness and continuity of the alleged predicate acts. *H.J. Inc.*, 492 U.S. at 240.[8]

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). Extortion under the Hobbs Act "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). Fear of "economic loss" indisputably qualifies. *See, e.g.*, *Brokerage Concepts, Inc. v. U.S. Healthcare, Inc.*, 140 F.3d 494, 521 (3d Cir. 1998). Plaintiffs have sufficiently alleged both.

a. <u>Plaintiffs Have Sufficiently Plead the Conduct Regarding the 7 Corporate Defendant Insurers and the Predicate Acts under Rules 8(a) and 9(b)</u>

Before addressing the substantive aspects of the predicate acts, it is necessary to quell some confusion manufactured by the Defendant Insurers, contending that Plaintiffs have improperly "lumped" or grouped Defendant Insurers together in a "shotgun" pleading. These arguments, designed to distract the court, raise two distinct issues. The first is that the conduct alleged in the Complaint applies generically to all Defendant Insurers (purportedly failing to give them fair notice under Fed. R. Civ. P. 8(a)) and the second is that Plaintiffs have not sufficiently

[8] "Continuity is both a closed- and open-ended concept, referring either to a closed period of repeated conduct, or to past conduct that by its nature projects into the future with a threat of repetition. *Id*. at 241.

alleged which of the Defendant Insurer affiliates engaged in the conduct at issue (which purportedly implicates concerns under Rule 8(a) as well as Rule 9(b) on pleading fraud with particularity). Both of these are false issues.

First, notwithstanding that there are approximately 80 companies named as defendants in this action, they are all affiliates of the 7 Defendant Insurers. Thus, in reality, there are 7 defendants in this case. Further, it is patently clear from the Complaint that it was necessary to provide factual background for the manner in which the industry operates, and describe the conduct that applies to *all* of the Defendant Insurers and the conduct in which they *all* engage to suppress repair compensation. Indeed, Defendant Insurers do not deny the gist of the conduct in suppressing repair compensation; their contention is that it is based on market competitive forces. More importantly, Defendant Insurers cannot dispute that the Complaint contains particular allegations and distinct counts with respect to each and every Defendant Insurer, and Plaintiff have pled that each of the Defendant Insurers formed an association in fact RICO enterprise with their respective Information Providers. And, as discussed below, Plaintiffs have introduced exemplary transactions with each of the Defendant Insurers to demonstrate the conduct of each. Accordingly, Plaintiffs have not improperly "lumped" Defendant Insurers together in a "shotgun" pleading. *See, e.g., Lockheed Martin Corp. v. Boeing Company*, 314 F.Supp.2d 1198, 1207 (M.D. Fla. 2004) (particularized allegations denoting defendants' conduct); *Hepp v. Paul Revere Life Ins. Co.*, 2014 WL 3865389 *7 (M.D. Fla. Aug. 5, 2014) (same).[9]

[9] It rings hollow for Defendant Insurers to contend that the Complaint is a shotgun pleading and that they have been "lumped" together when they do not dispute, among other things, that they all have DRP programs, their motivation is to refer as many repair claim as possible to these DRPs to control costs, that they all use the Information Provider programs, that the so-called prevailing rate is based exclusively on their DRP data, that they use the Information Providers' data (or, for State Farm – in part – survey data) as the prevailing rates and repair standards.

Second, each of Defendant Insurers are each engaged in systematic, corporate-wide protocol and practices dictated by corporate parents and officials, in uniformly dealing with collision repair claims across the country – and in perpetrating their fraudulent conduct – and are, therefore, jointly and severally liable. (FAC at 24-30, 192, *passim*) Indeed, Defendant Insurers do not (and cannot) dispute that the Plaintiffs engaged in requisite transactions with the Defendant Insurers. Further, as discussed below, Plaintiffs attached as exhibits approximately 5 dozen exemplary transactions with the 7 respective Defendant Insurers, which contained, among other things, the dates, times and places that the events alleged occurred, the dealings that comprise each transaction, including the Defendants Insurers' repair order numbers and claims numbers, the dates of the Defendant Insurers' repair estimates and supplement estimates and the dates of the Plaintiffs' repair invoices, the payments made by the Defendants Insurers and the dates of payments, the total amount for repairs due to Plaintiffs and the shortfall in compensation paid (all of which was previously communicated to the respective Defendant Insurers at the time of transactions), and a detailed list of all items of shortfall (i.e., procedures, time, etc., scope, parts) which the Defendant Insurers claimed did not comport with prevailing rates.

For the Defendants to contend that they are not aware of which insurer affiliate the Plaintiffs transacted with is simply misleading. The same is true for the records and dates pertaining to every single repair of which they have been apprised. Rendering the Defendant Insurers' argument even more disingenuous is the fact that, more often than not, Defendant Insurers' repair estimates prepared by their claims adjusters and supervisors do not specify which insuring affiliate is underwriting and/or adjusting the claim, and refer to the company family by a generic name (not by any incorporated name). For example, "Nationwide Insurance" or "Nationwide *Enterprise*" (emphasis added), "State Farm Insurance Companies" or "State

Farm", "Progressive", "GEICO" (FAC at ¶ 192)[10] This, of course, is unsurprising, given that each has company-wide, uniform claims adjustment and repair estimating standards and guidelines, dictated by management. In addition, the payments are variously made by generic corporate operating accounts, with the same frequency as insuring affiliate accounts, and sometimes, the payments are made by insuring affiliates that are different from the insuring affiliate identified on the estimates. *Id*. Of course, this is much ado about nothing, and a way for the Defendant Insurers to mislead the Court. Defendant Insurers have all of these records and are keenly aware of which company and which affiliate transacted with the Plaintiffs on each and every occasion, and can identify the specific claims adjusters and supervisors who communicated with Plaintiffs.[11]

Defendants also argue that Plaintiffs have improperly grouped Defendant Insurers together with their affiliates. The affiliates are necessarily "grouped" because they are all part of intra-corporate conspiracy. Each Defendant Insurer has company-wide, systematic and uniform claims management practices, and operates as a single, integrated enterprise for claims adjustment and administration purposes; all affiliates operate pursuant to company-wide estimating protocol that is mandated from the top. (FAC ¶¶ 24-30.) Defendants are aware of their involvement with their respective affiliates, but Plaintiffs cannot know all of the precise inner workings of each intra-corporate conspiracy without discovery. The general pleading requirement that defendants' roles be distinguished, however, is "not necessary. . . when such

[10] The "21st Century" entity identified in the repair transactions is defendant 21st Century Indemnity Insurance Company, which is a Farmers affiliate (Complaint at 28). Significantly, the estimates prepared by 21st Century refer plaintiff Crawford's (and all other facilities that are not Farmers DRPs) to "www.TheShopofChoice.com/Farmers", which is a "Farmers Insurance" run site, and certain estimates transmitted to Crawford's were sent by and from "Farmers Ins."

[11] Should the Court deem it appropriate and necessary, Plaintiffs stand ready to provide copies of exemplar estimates and supplements, and payment records, from the Defendant Insurers in order to demonstrate this point.

information is uniquely within the defendant's knowledge. . . or when defendants are related corporate entities who can themselves determine their individual roles without significant difficulty." *United States v. Kellogg Brown & Root Servs., Inc.*, No. 4:12-cv-4110-SLD-JAG, 2014 WL 4948136 at *10 (C.D. Ill. Sept. 30, 2014) (quoting *Viacom, Inc. v. Harbridge Merch. Servs., Inc.*, 20 F.3d 771, 778 (7th Cir. 1994) and *Jepson Inc. v. Makita Corp.*, 34 F.3d 1321, 1329 (7th Cir 1994)); *see also Dorsey v. Rockhard Labs, LLC,* No. CV 13-07557, 2014 WL 4678969 at *5 (C.D. Cal. Sept. 19, 2014) (refusing to find complaint deficient "merely because [plaintiff] has not differentiated between the two related corporate entities at this stage.")

Courts thus recognize that it is unfair to impose a heightened obligation on plaintiffs at the pleading stage when defendants are in unique possession of specific facts. *Hill v. Morehouse Med. Assocs., Inc.*, No. 02–14429, 2003 WL 22019936 at *3 (11th Cir. Aug. 15, 2003) ("9(b)'s heightened pleading standard may be applied less stringently. . . when specific factual information about the fraud is peculiarly within the defendant's knowledge or control") (quotation omitted); *Lawrence Holdings, Inc. v. ASA Intern., Ltd.*, No. 8:14-cv-1862-T-33EAJ, 2014 WL 5502464 (M.D. Fla. Oct. 30, 2014) (same); *Kindred Hosp. East, LLC v. Fox-Everett, Inc.*, No. 3:12-cv-307-J-37MCR, 2012 WL 5467516 at *4 (M.D. Fla. Oct. 4, 2012) (same); *see also Power v. GMAC Mortg. Corp.*, No. 06-c-4983, 2007 WL 723509 at *3 (N.D. Ill. Mar. 7, 2007) (it is "unreasonable to expect [plaintiff] to know the details of the relationship between [the co-conspirators] at this point such that greater specificity would be warranted at this point.")

Nor do courts stringently apply Rule 9(b) when related corporate affiliates are on notice of their respective involvement. *Jepson*, 34 F.3d at 1329 (assuming that plaintiff's omission of facts regarding each defendant's role in alleged scheme could be overlooked, "given that the three corporate defendants in this case are related corporations that can most likely sort out their

involvement without significant difficulty"); *Cima v. Wellpoint Healthcare Networks, Inc.*, No. 05-cv-4127-JPG, 2006 WL 1914107 at *21 (S.D. Ill. July 11, 2006) (citing *Jepson* and rejecting defendants' Rule 9(b) argument when plaintiff had made "allegations against related corporate entities"); *U.S. ex rel. Trombetta v. EMSCO Billing Servs., Inc*., 96 C 226, 2002 WL 34543515 (N.D. Ill. Dec. 5, 2002) ("To the extent any residual ambiguity remains, the moving defendants, which consist of closely related corporations and their sole owner and CEO, 'can most likely sort out their involvement without significant difficulty.'") *See also Storto Enters., Inc. v. Exxonmobil Oil Corp*., CIV. WDQ-10-1630, 2011 WL 231877 (D. Md. Jan. 24, 2011) ("A plaintiff need not particularize its pleadings to each defendant when the defendants are related corporations who "can most likely sort out their involvement without significant difficulty") (quoting *Jepson*). Plaintiffs therefore need not plead each individual affiliate's specific role in the scheme beyond the allegations plead here.

The cases Defendants cite which criticize the absence of specific allegations as to separate defendants are readily distinguishable because they address the more typical situation where defendants are in fact wholly separate entities. *Brooks v. Blue Cross & Blue Shield of Fla., Inc.*, 116 F.3d 1364, 1381 (11th Cir. 1997) (plaintiffs referred to separate insurer defendants together as the "Group Health Insurance Defendants" and complaint was "devoid of specific allegations with respect to the separate Defendants")[12]; *Ambrosia Coa & Constr. Co. v Pages Morales*, 482 F.3d 1309, 1317 (11th Cir. 2007) (defendants were individual persons as well as corporate entities; complaint alleged that certain defendants defrauded plaintiff and referred to certain paragraphs that described fraud of other defendants; complaint did "not discuss the nature of each defendant's participation in the scheme"); *West Coast Roofing & Waterproofing, Inc. v.*

[12] Notably, *Brooks* was decided at the summary judgment stage. *Id.*

Johns Manville, Inc., 287 Fed. App'x 81, 86 (11th Cir. 2008) (defendants were three separate corporations; complaint failed to identify specific false statements made by each defendant); *Magluta v. Samples*, 256 F.3d 1282, 1284 (11th Cir. 2001) (complaint asserted constitutional claims relating to conditions of confinement against fourteen federal officials but made "no distinction among the fourteen defendants charged, though geographic and temporal realities make plain that all of the defendants could not have participated in every act complained of.")

Consequently, at this stage of the proceedings, where Plaintiffs have had no opportunity for discovery, the allegations of company-wide conduct should be sufficient to withstand challenge.

b. Plaintiffs Have Sufficiently Pled Wire Fraud

Through the RICO Enterprises, Defendants Insurers, in collaboration with the Information Providers, are able to fraudulently establish and misrepresent to Plaintiffs and the proposed Classes the so-called industry prevailing rates for: (1) labor (including body, frame and mechanical work, as well as refinishing work); (2) paint and materials reimbursement; (3) parts; and (4) the time, scope and extent of compensable repair procedures, i.e., what the Defendant Insurers say are compensable repair procedures, and the appropriate time allotted to repair procedures. These prevailing rates are, in fact, simply the rates that Defendant Insurers require their respective DRP facilities to accept for labor, paint and materials, and parts, and for preparing repair estimates in accordance with each insurer's estimating profile and company-wide estimating protocol, which outline the fixed limits for the time, scope and cost of compensable repairs paid by each insurer.

These fixed, pre-determined rates and repair standards with DRP facilities are the sole foundation for the Information Provider estimating programs and industry data and, given the

Information Providers standing as the *purported* independent, objective arbiters of industry data – on which *all* collision repair facilities, including Plaintiffs and the proposed Classes have been forced to rely, each of the Defendant Insurers can and do misrepresent to Plaintiffs and the proposed Classes that deviations in hourly labor rates, reimbursement for "paint and materials", the time, scope and extent of compensable repair procedures, and/or parts prices do not constitute the prevailing rates in the industry and/or that no other repair facilities (DRP and non-DRP alike) charge those rates or for those repair procedures or for the amount of time that is necessary to perform the repairs in a professional, competent manner. Further, each of the Defendant Insurers conceals the foundation and bases for their purported prevailing rates and the manner in which such prevailing rates are determined and maintained, as well as the way in which repair invoices are reviewed and analyzed for deviations that allegedly do not comport with so-called industry prevailing rates in requiring repair non-DRP facilities like Plaintiff and the proposed Classes to accept suppressed compensation for the repairs performed.

Notably, this data, through various mechanisms, is shared and exchanged by Defendant Insurers (and other insurers) and the Information Providers. However, collision repair facilities like Plaintiffs and the proposed Classes (i) do not have access to this information, (ii) do not have means to verify or challenge the accuracy of the information, (iii) do not have any knowledge of, or means to access, each of the Defendant Insurers' internal estimating profiles and guidelines with artificial cost controls, (iv) do not have any means to know how or why the estimating programs work decidedly to their disadvantage, and (v) do not have any knowledge of, or means to access, the additional tools that the Information Providers furnish to Defendant Insurers to ensure that their artificial cost controls are enforced.

Plaintiffs have pled wire fraud with the requisite "particularity" and "circumstances constituting the fraud". *American Dental Assn.*, 605 F.3d at 1291. Plaintiffs attached as exhibits to the Complaint (FAC at Exhibits "E" and "F") 59 representative transactions with the 7 respective Defendant Insurers, which outline in detail the dates, times and places that the events alleged occurred, the dealings that comprise each transaction, including the Defendants Insurers' repair order numbers and claims numbers, the dates of the Defendant Insurers' repair estimates and supplement estimates and the dates of the Plaintiffs' repair invoices, the payments made by the Defendants Insurers and the dates of payments, the total amount for repairs due to Plaintiffs and the shortfall in compensation paid (all of which was previously communicated to the respective Defendant Insurers at the time of transactions), and a detailed list of all items of shortfall (i.e., procedures, time, etc., scope, parts) which the Defendant Insurers claimed did not comport with prevailing rates. Again, Defendant Insurers have all of these records and are keenly aware of which company and which affiliate transacted with the Plaintiffs on each and every occasion, and can identify the specific claims adjusters and supervisors who communicated with Plaintiffs.

As an initial matter, Plaintiffs pleading a long-running RICO fraudulent scheme (or long-running fraudulent conduct in general, including under false claims act cases and the like) need not pled every single fraudulent transaction. *See, e.g., In re Managed Care Litig.*, 298 F.Supp.2d at 1279; *Lawrence Holdings*, 2104 WL 5502464 at *11; *Goldberg v. Rush University Med. Ctr.*, 929 F.Supp.2d 807, 821-22 (N.D. Ill. 2013); *Mason v. Medline Indus., Inc.*, 731 F.Supp.2d 730, 734-35 (N.D. Ill. 2010); *Allstate v. Balle*, 2012 WL 907466 *2-*3; Allstate v. Linea Latina, 781 F.Supp.2d 837, 845 (D. Minn. 2011).

As alleged by the Plaintiffs, these transactions were representative examples, that were based on Plaintiffs' reasonable rates and charges for required repairs, that there was shortfall in compensation based on, among other things, all labor rates, refinishing time and operations, additional required labor operations, times added or increased for procedural operations, discrepancies between repairing and replacing body parts, and paint and materials reimbursement, that Defendants Insurers on each occasion, represented to Plaintiffs that their charges were not in accordance with prevailing rates for all categories of compensation, and Defendant Insurers presented repair estimates and supplements (prepared with Information Provider programs) that purported to show the rates and required repair procedures and standards that were in accordance with so-called prevailing rates. **(**FAC at 258-276; Exhs "E" and "F")[13] Further, the Defendant Insurers used the interstate wires to, among other things, create, transmit and receive repair estimates, communications concerning the repairs and/or process payments for the repairs, as well as materials and information to establish, exchange, process and promulgate the prevailing rates, estimating profiles and company estimating protocol, including, without limitation, with the Information Providers. (FAC at 247, 265, 274)[14]

> As outlined in the Complaint, Defendant Insurers' racketeering activity included
>
> (1) preparing repair estimates and repair estimate supplements – and causing their DRP facilities to prepare repair estimates and repair estimate supplements – using their respective estimating profiles with CCC, Audatex and/or Mitchell and company estimating protocols, which constrained the time, scope and extent of compensable repair procedures, hourly labor rates, reimbursement for "paint and materials" and/or parts prices;

[13] The reference in the Complaint to facts and information within Defendant Insurers' possession concerned their internal documents and data pertaining to the claims alleged, as well as the transactions that occurred with absent class members, which clearly warrants and requires discovery.

[14] Further, to the extent that Defendant Insurers argue that the wire communications have to contain misrepresentations or omissions – though they plainly do in this case – that is a misconception of the RICO claims standards. The wires need only be incidental to the fraudulent scheme, which they were as well. *Schmuck v. U.S.*, 489 U.S. 705, 715 (1989); *American Dental Assn.*, 605 F.3d at 1292.

> (2) using scrubber programs from CCC, Audatex and/or Mitchell – or any independent audit program such as Performance Gateway – to review repair estimates and repair estimate supplements to constrain the time, scope and extent of compensable repair procedures, hourly labor rates, reimbursement for "paint and materials" and/or parts prices;
>
> (3) establishing, promulgating, reporting, and falsely representing the prevailing rates for the time, scope and extent of compensable repair procedures, hourly labor rates, reimbursement for "paint and materials" and/or parts prices, as well as concealing and omitting the invalid bases for these falsified prevailing rates;
>
> (4) entering into agreements with DRP facilities to establish and maintain prevailing rates for the purpose of suppressing compensation for the time, scope and extent of compensable repair procedures, hourly labor rates, reimbursement for "paint and materials" and/or parts prices; and

None of this was known to Plaintiffs. (Complaint at 193-236, 246-256, 258-276, *passim*). As discussed above in demonstrating the Information Providers participation in the conduct of the RICO Enterprises, *supra*, they fostered and participated in Defendant Insurers' predicate acts. (*See also* FAC at 112-129, 193-236, *passim*)

1. **Plaintiffs' Reliance and Defendants' Intent**

As discussed below, Plaintiffs asserting 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). Clearly, here, Plaintiffs have established that Defendant Insurers' conduct led directly to their injuries, which is the applicable standard. *Anza v. Ideal Steel Supply Corp.*, 547 U.S. 451, 461. In any event, and to the extent necessary, Plaintiffs have sufficiently alleged reliance. Defendant Insurers contend that Plaintiffs knew what their own rates were and believed that they were reasonable. Therefore, according to Defendant Insurers, Plaintiffs knew that Defendant Insurers' suppressed rates were not reasonable but knowingly accepted them and cannot be deemed to have

reasonably relied on Defendant Insurers' alleged misrepresentations and omissions. This argument is not only cynical, it misconstrues this action.

Again, none of the conduct alleged herein was known to Plaintiffs and the proposed Classes, and was designed to misrepresent and conceal materials facts to suppress repair compensation paid to them. Indeed, the point is not that the Plaintiffs knew that there was a discrepancy in compensation. Rather, the point is that Defendant Insurers, through collaboration with the Information Providers, were able to misrepresent to Plaintiffs what the purported prevailing rates were (for all categories of repair compensation), how the rates and repair standards are determined, that Plaintiffs' charges were not in accordance with purported prevailing rates, that other repair facilities (both DRP and non-DRP) did not charge what Plaintiffs charge, that the Information Provider programs are designed to permit Defendant Insurers (and other insurers) to implement strict cost controls in suppressing repair compensation in terms of time, scope and extent of repair procedures – and that the Information Providers furnish scrubbers for the same purposes. And, with respect to State Farm, in addition to the foregoing, it was also able to misrepresent to Plaintiff the manner in which it established it rates and repair standards using strict control over its DRP program, including the statistically invalid and fraudulent survey process. All of these facts were clearly material to Plaintiffs performing collision repair services.

Defendant Insurers' knowing and intentional misrepresentations, concealment and omissions of material facts concerning the prevailing rates were made for the purpose of deceiving Plaintiffs and proposed Classes to accept artificially suppressed compensation for insured repairs. Defendant Insurers knew or recklessly disregarded the fact that their misrepresentations, concealment and omissions were material, and that non-DRP facilities like

Plaintiffs would incur a loss in the form of suppressed compensation for insured repairs based on their fraudulent conduct in maintaining artificial prevailing rates for insured repairs. (FAC at 246-256, 258-276)

And, though not necessary to state a violation of the wire fraud statute, Plaintiffs and the proposed Classes relied to their detriment on the material misrepresentations, concealment and omissions concerning the prevailing rates and standards for compensation of insured repairs (in conjunction with the Information Providers), as demonstrated by, among other things, the fact that they accepted suppressed compensation for the insured repairs performed. Plaintiffs and the proposed Classes had no reasonable means of verifying, testing or discovering the accuracy (or lack thereof) of Defendant Insurers' representations of their purported prevailing rates – and standards for compensation of repairs. Not only are Plaintiffs and the proposed Classes not privy to the rates charged by and paid to other repair facilities, or the manner in which rates are determined but, in fact, Defendant Insurers expressly warn repair facilities against rate comparisons, lest they lead to concerted prices. As a result of Defendant Insurers' conduct, Plaintiffs and the proposed Classes have been injured in the form of suppressed compensation and reimbursement for collision repair services. *See In re Managed Care Litig.*, 298 F.Supp.2d 1278-79 (fraudulent scheme based upon failure to disclose a plethora of automated processing techniques to diminish, deny or delay payments to healthcare providers for services, including misrepresentation of rates and the basis for those rates).[15]

[15] Defendant Insurers' cases are inapposite. In American Dental Assn., there was no evidence of collaboration between *unrelated* insurers – only parallel conduct, and there were no misrepresentations or inaccuracies alleged to the providers regarding providers' compensation. American Dental Assn, 605 F.3d at 1291-92; American United Life Ins. Co. v. Martinez, 480 F.3d 1043 (11th Cir 2007) (no allegations that defendants assisted policyholder in filing fraudulent life insurance application and no duty to disclose); Mid-State Fertilizer Co. v. Exch. Nat'l Bank of Chicago, 693 F.Supp.666 (N.D. Ill. 1988) (on summary judgment, defendant's loan payment crediting process was not material – and plaintiffs renewed the loan); Green Leaf Nursery v. E.I. DuPont De Nemours & Co., 341 F.3d 1292 (11th Cir. 2006) (alleged misrepresentations by opposing party in the course of settling a litigation); Smith v. Bank of America, 2014 WL 897032 at *7 (M.D. Fla. Mar. 6, 2014) (plaintiff knew of bank's possession of original

Based on the foregoing, Plaintiffs have satisfied their pleading standards for fraud under RICO by alleging (1) statements, documents and misrepresentations made, (2) the time, place and persons responsible for the statements, (3) the content and manner in which the statements misled the Plaintiffs, and (4) what Defendant Insurers gained by the alleged fraud. In addition, Plaintiffs have sufficiently alleged Defendant Insurers' intent, and to the extent necessary, their reliance on Defendant Insurers' misrepresentations and omissions of material fact, resulting in substantial suppression of repair compensation. *See American Dental Assn.*, 605 F.3d at 1290-91. Indeed, Defendant Insurers candidly admit their conduct. In June 5, 2014 testimony before the Rhode Island Senate Committee on Judiciary in opposition to Rhode Island Senate Bill No. 2834, which proposed creating new classifications and licensure of repair facilities based on certification of standards, quality and equipment, and which, in turn, would require new labor rate classifications and higher rates for more qualified facilities, counsel for the Property Casualty Insurance Association of America (Stephen Zubiago of Nixon Peabody LLP) – representing, among others, GEICO, Liberty Mutual and Nationwide –stated: "We sell the insurance, we pay the bills, we'd like to make the decisions with respect to what the rates are." (FAC at 64)

c. **Extortion**

"Extortion" is defined as 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)(2). The terms "fear" includes the fear of economic loss. *Brokerage Concepts*, 140 F.3d at 521; *United States v. Bornscheuer*, 563 F.3d 1228, 1236-37 (11th Cir.

promissory note in challenging regarding validity of debt); Reynolds v. E. Dyer Dev. Co., 882 F.2d 1249, 1253 (7th Cir. 1989) (no damage by reason of defendants' purported misrepresentations regarding property because plaintiffs knew of soil problems and instructed builder to fix the problem as recommended and proceed with building the house).

2009); *DeFalco v. Bernas*, 244 F.3d 286, 313 (2d Cir. 2001); *U.S. v. Crockett*, 979 F.2d 1204, 1212 (7th Cir. 1992).

Defendant Insurers, in violation of 18 U.S.C. § 1951, extorted Plaintiffs and the proposed Classes through wrongful use of fear of economic loss, in that Plaintiffs and the members of the Classes would not be able to perform the insured repairs unless they accepted the suppressed compensation paid by Defendant Insurers, and, in addition, that Defendant Insurers would respectively steer future repairs away from Plaintiffs and the proposed Classes unless they accepted the suppressed compensation paid by Defendant Insurers. As a result, Plaintiffs and the proposed Classes were coerced or forced to accept suppressed compensation for insured repairs predicated on fear of economic harm, i.e., if the repair facilities wanted to do business with Defendant Insurers. (FAC at 248, 250, 255)

Defendant Insurers argue that they did not obtain any property from the Plaintiffs and, even if they did, they did not do so by "wrongful" means – only "hard bargaining" which is not actionable. Defendant Insurers are wrong on both counts.

In *Scheidler*, the Supreme Court found that "property" under the Hobbs Act constituted "something of value" that defendants "could exercise, transfer, or sell." *Id.* at 405. Further, it is beyond dispute that services constitute "property." *See, e.g., In re Managed Care Litig.*, 298 F.3d 1279-80.

Plaintiffs performed repairs services for Defendant Insurers' insureds and vehicles covered by their insurance policies for which they were obligated to pay. As Defendant Insurers contend, their obligation to pay for repairs is defined under their policies. The value of the services performed by Plaintiffs is "something of value" that defendants "could exercise, transfer, or sell", in that it relieved Defendant Insurers of their obligations to their insureds under

the policies. *Scheidler*, 537 U.S. at 405. Accordingly, Defendant Insurers obtained Plaintiffs' property.

With respect to the manner in which the property was obtained, Defendant Insurers argue that "the use of economic fear in business negotiations between private parties is not 'inherently' wrongful," and that they merely engaged in "hard bargaining". *Brokerage Concepts*, 140 F.3d at 523. The difference between hard bargaining and extortion under the Hobbs Act is that a defendant's conduct will not be actionable if he had a "lawful claim to the property." *Id*. at 524.

> Congress included the word 'wrongful in the Hobbs Act because not every threat of economic harm is *wrongful*. . . . Whether or not it is a shameful fact, it is nevertheless a fact that threats of economic harm are used every day as tools in the business world; only a few of them are extortionate. This is the holding of *United States v. Enmons*, 410 U.S. 396 (1973), wherein the Supreme Court said: The term "wrongful," which on the fact of the statute modifies the use of each of the enumerated means of obtaining property- actual or threatened force, violence, or fear- would be superfluous if it only served to describe the means used. For it would be redundant to speak of "wrongful violence" or "wrongful force" since, as the Government acknowledges, any violence or force to obtain property is "wrongful." Rather, "wrongful" has meaning in the Act only if it limits the statute's coverage as to those instances where the obtaining the property would itself be "wrongful" because the alleged extortionist has no lawful claim to that property.

United States v. Waters, 850 F. Supp. 1550, 1560 (N.D. Ala. 1994) (quoting *United States v. Enmons*, 410 U.S. 396, 398-402 (1973)).

Here, as described at length, Defendant Insurers had no "lawful" right to obtain Plaintiffs' services by virtue of fraudulently misrepresenting the basis for their compensation – and then obtaining their repair services at suppressed rates. Further, economic fear is "wrongful" under the Hobbs Act if the plaintiff had a pre-existing statutory right to be free from defendant's demand. *See George Lussier Enters., Inc. v. Subaru of New England, Inc.*, 393 F.3d 36, 50 (1st Cir. 2004). Numerous states, including Pennsylvania and North Carolina where the Plaintiff businesses are located, have "anti-steering" laws. *See, e.g.*, 31 Pa. Code § 146.8 (b) and (d); 31

31 Pa. Code § 62.3(b)(3); N.C. Gen. Stat. § 58-3-180(a), (b) and (b1); N.C. Gen. Stat. § 58-33-76 (a). Likewise, these statutes and others speak to the fairness, equity and impartiality that Defendant Insurers' claims adjusters are required to employ in preparing damage appraisals and repair estimates. Accordingly, Defendant Insurers' threats to steer existing repair services being performed by Plaintiffs on behalf of insureds and other vehicle owners as well as threats to steer future repairs – unless Plaintiff accepted the suppressed repair compensation, are not insulated by a "lawful claim to the property". [16]

Lastly, Plaintiffs have clearly alleged Defendant Insurers' intent in its conduct, as well as Plaintiffs' state of mind, sufficient at the pleading stage. *See, e.g.*, *United States v. Haimowitz*, 725 F.2d 1561, 1572 (11th Cir. 1984) (defendant's intent); *Sutherland v. O'Malley,* 882 F.2d 1196, 1202 (7th Cir. 1989) (victim's belief; defendant's use of power); *Defalco,* 244 F.2d at 213 (victim's state of mind). Thus, Defendant Insurers wrongfully obtained Plaintiffs' property, rendering their conduct extortionate.

3. <u>RICO Injury</u>

"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). Plaintiffs have sustained injury to business or property as a result of the Defendant Insurers' acts, consisting of under-compensation for collision repair work and services on vehicles covered by insurance, including the suppression of hourly labor rates, suppression of compensation for "paint and materials", suppression of compensation for parts, and suppression of compensation for the time, scope and extent of the repair procedures performed. (FAC at 175, *passim*)

[16] *Mendez Internet Management Services Inc. v. Banco Santander De Puerto Rico*, 621 F.3d 10, 13, 15-16 (1st Cir. 2010) is inapposite. There, the bank, under suspicion of plaintiff's money-laundering activities and under the imprimatur of the Patriot Act, denied plaintiff accounts to sell Iraqi dinars.

It is beyond dispute that depressed compensation and the failure to provide appropriate compensation for services performed is a RICO injury. *See, e.g., In re Managed Care Litigation*, 298 F.Supp.2d at 1279-80 (defrauded of rightful monetary payments; claims processing mechanisms to deny, diminish and delay payments for services performed); *Mohawk Indus.*, 456 F.3d at 1286-88 (depressed wages; and "legal entitlement to business relations unhampered by schemes prohibited by the RICO predicate statutes"); *Mendoza v. Zirkle Fruit Co.*, 301 F.3d 1163, 1168-72 (9th Cir. 2002) (same). Further, being deprived of the opportunity to earn greater profits likewise is a RICO injury. *See, e.g, In re Nat. Western Life Ins. Deferred Annuities Litig.*, 268 F.R.D. 652, 666 (S.D. Cal. 2010) (deferred annuities subjected to reduced credited rate of return deprived holders of greater profits than they earned); *Negrete*, 2001 WL 4852314 at *9 (same); *Chesapeake Employers' Ins. Co. v. Eades*, 2105 WL 58637 *7 (N.D. Ga. Jan. 5, 2015) (seeking damages for workers' compensation premiums that could have been charged to insured). Further, lost business opportunities also qualify as RICO injury. *See Bridge*, 553 U.S. *passim*; *BCS Services, Inc*, 637 F.3d at 756-57.

It cannot reasonably be questioned that Plaintiffs have suffered a RICO injury based on Defendant Insurers' conduct.

4. **Plaintiff's Injuries Were By Reason of Defendant Insurers' RICO Violations**

To satisfy their pleading standard, Plaintiffs' need to show that their injuries were "by reason of" Defendant Insurers' RICO violations, which means that: (1) the injuries were sufficiently direct so that Plaintiffs have standing to sue and (2) proximate cause. *Mohawk Indus.*, 456 F.3d at 1287 (citing, *Anza v. Ideal Steel Supply Corp*., 547 U.S. 451 (2006)); *see also Hemi Grp., LLC v. City of New York, N.Y.*, 559 U.S. 1, 9 (2010).

In alleging wire fraud, Plaintiffs "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*, 553 U.S. at 661. Rather, there need only be "some direct relation between the injury asserted and the injurious conduct alleged" – "causation". *Id*. at 654, 658 (causation shown where plaintiff's damages are "foreseeable and natural consequence" of RICO fraud scheme). This is because, as the Supreme Court has held, no first party reliance is required; Plaintiffs injuries can be caused by misrepresentations made to, and fraudulent conduct directed toward, third parties. *Bridge*, *passim* (fraudulent tax lien bids to municipality caused injury to competitors); *BCS Services, Inc. v. Heartwood 88, LLC*, 637 F.3d 750, 756-57 (7th Cir. 2011) (same).

As alleged, Plaintiffs and the proposed Classes were the victims directly injured by Defendant Insurers' fraudulent and extortionate conduct. Artificial suppression of compensation for labor rates, the cost of "paint and materials" and parts, and repair procedures is an injury suffered by repair facilities rather than insureds and vehicle owners, who have received the full benefit of the repairs to their vehicles. (FAC at 178)

Alternatively, as alleged, Plaintiffs and the members of the Classes were injured as a direct and proximate consequence of Defendant Insurers' conduct regarding the repairs services performed by Plaintiffs and the members of the Classes covered by, and/or in connection with, first party and third party insurance claims, i.e., in the context of any representation to policyholders or third party vehicle owns about the prevailing, customary or reasonable rates that Defendant Insurers claim is the guidepost in determining compensation for repairs. (FAC at 178)

Plaintiffs and the members of the Classes were paid compensation by Defendant Insurers for their repair work and services predicated on material misrepresentations and omissions concerning prevailing rates, market values and industry standards as described herein and/or Defendant Insurers' extortionate conduct, and Plaintiffs and the members of the Classes 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 Defendant Insurers' conduct. The injuries sustained by Plaintiffs and the members of the Classes were caused by overt acts in furtherance of the Defendant Insurers' respective conspiracies in violation of 18 U.S.C. § 1962(c), including the misrepresentation of the prevailing rates for repairs and the artificial suppression of compensation for repair work and services performed on vehicles covered by Defendant Insurers, as well as Defendant Insurers' extortionate conduct. (FAC at 180-181) Further, *none* of the shortfall in compensation was paid by any other source, including insureds and/or vehicle owners. (FAC at 267, 275)

Accordingly, there is no more "direct" or "immediate" victim of the Defendant 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. Along the same lines, Defendant Insurers' conduct was the direct and proximate cause of Plaintiffs' (and the proposed Classes') injuries, and that includes the event of suppression of repair compensation that resulted from reliance by insureds and third party vehicle owners on statements made to them by Defendant Insurers regarding the so-called prevailing rates 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.

Plaintiffs have sustained injuries "by reason of" Defendant Insurers' conduct and, therefore, have standing to assert their RICO claims.[17]

5. Defendant's Contentions Based on So-Called Market Forces, Public Policy and Business Justifications

Defendant Insurers make several arguments that are grounded in so-called market competition, public policy or business justification to challenge Plaintiffs' claims. It is more useful, however, to examine – and counter – the arguments in consolidated fashion, rather than in the sections, *supra*, addressing the elements of Plaintiffs' claims.

Defendant Insurers' Joint Motion contends, as discussed in part above, that Plaintiffs are aware of their rates, business costs and margins, and, if the compensation paid by Defendant Insurers was unacceptable, Plaintiffs could have declined the work or charged the customer the difference. Or, Plaintiffs could have accepted the lower compensation at the risk of losing the work. Defendant Insurers' Joint Motion relies (as do the motions of State Farm and GEICO) upon *Quality Auto Body, Inc. v. Allstate Ins. Co.*, 660 F.2d 1195, 1204, 1206 (7th Cir. 1981) to argue that the overarching response to Plaintiffs' claims is that suppressed repair compensation simply demonstrates competitive market forces at work, and that the thousands of collision repair facilities like Plaintiff and the proposed Classes should effectively accept their fate – or go into a different line of work. In short, *Quality Auto Body* was decided over 30 years ago when Defendant Insurers like Allstate and State Farm denied that they had DRP programs that set fixed compensation – which they, of course, now embrace, and was an entirely different case. *Quality Auto Body* did not involve a fraudulent scheme with the Information Providers to misrepresent what the purported prevailing rates and repair standards and methodologies are in

[17] Defendant Insurers' argument that Plaintiffs lack standing under Fed. R. Civ. P. 12(b)(1) is incorrect. As demonstrated herein, Plaintiffs are the parties who suffered lost compensation, and who are the most direct victims of Defendant Insurers' conduct.

the industry – and how they are determined, with software estimating programs sold by purported independent arbiters that inaccurately reflect proper repair procedures but which collision repair facilities have been forced to rely upon in order to be compensated for the repair services – or simply to perform essential repair services that Defendant Insurers claim are unnecessary or un-compensable – in total disregard for the very customers/policyholders they claim to benefit through alleged "cost savings". *Quality Auto Body*, however anachronistic it might be, was a different case concerning purported competitive market forces that cannot be applied here in the way that Defendant Insurers suggest.[18]

In any event, Defendant Insurers' argument in the Joint Motion is cited for the proposition that their misrepresentations about prevailing rates and repair standards could not have been the "but for" cause of Plaintiffs' receiving less in repair compensation. In their view, Plaintiffs had a choice – and exercised it to accept less.

With respect to the first option, Defendants Insurers would like nothing more than to have Plaintiff and the proposed Classes "decline the work". That way, Defendant Insurers could steer more repairs to their DRP facilities, where they can impose – by agreement – their cost control measures. The problem though, is that collision repair facilities must sell their repairs to insurers, which cover and pay for between approximately 75% and 90% of all automotive damage repairs annually, and Defendant Insurers (and the 3 other conspirator insurers identified in the Complaint) account for approximately 70% of that figure. Thus, the collision repair facilities do not have a choice as to whether to participate in the sale of their repair services to Defendant Insurers. Rather, they face a Hobson's choice: Sell into a rigged market or do not sell at all – and go out of business. (FAC at 65) With respect to the second option – charging the

[18] Indeed, all of this time later, how does threatening the quality and comprehensiveness of repairs through imposed price structures "rebound to the benefit of competition and consumers." *Quality Auto Body*, 660 F.2d at 1204.

customer the difference is *not realistic*, as this Court noted on the record in a prior hearing in this MDL (6:14-md-2557).

> Judge Presnell: Yeah, but I think their point is that if they don't lower their price to State Farm's price, they won't have any business to deal with.
>
> Mr. Fenton: That's – well, they can charge their customer for the difference, Your Honor.
>
> Judge Presnell: Well, *but realistically, that's not the way this market works*.

See A&E Auto Body, Inc. v. 21 Century Centennial Ins. Co., Transcript of Hearing on Motions to Dismiss, Nov. 14, 2014, page 95, lines 11-17 (emphasis added).

And, of course, as demonstrated by Plaintiffs in Exhibits "E" and "F" to the Complaint, the shortfalls the result from Defendant Insurers' suppressed compensation is often thousands of dollars. Accordingly, neither proposed option is realistic, equitable and cannot defeat causation under RICO. Indeed, collision repair facilities like Plaintiffs and the proposed Classes have customer bases that they need to service to sustain their business.

GEICO contends that control and suppression of repair compensation permits GECIO to: (1) deliver "cost-effective premium rates" to its policyholders; (2) maintain its market share; and (3) effectuate its policy of paying all shops the same rate for quality repairs. GEICO contends that belies any criminal intent in its RICO conduct. With respect to the first point, savings on premiums, there is no evidence that Defendant Insurers have pointed to that demonstrates that there is a direct correlation (or any correlation) between suppressed repair compensation and premium savings. In fact, for example, notwithstanding the fact that the frequency and severity of insured repairs have remained relatively stable and consistent, auto insurance premiums have generally experienced steady and significant increases. Thus, while Defendant Insurers (and Conspirator Insurers) have paid stable and consistent repair compensation on an annual basis, the

insurers have increased premiums – and simply retained the majority of the savings as internal profit. (FAC at 80). Further, Defendant Insurers' argument that Plaintiffs could charge the customer the difference in repair costs simply cannot be reconciled with the pretext of passing "cost-savings" onto the policyholders.

With respect to the other points, GEICO's market share does not insure to the benefit of its policyholders. Rather, it benefits GEICO's corporate account, and ability to access capital – and, indirectly, GEICO's shareholders. GEICO simply does not explain how this factor makes its conduct acceptable. GEICO's last point is a somewhat stunning admission: They pay the same rate of compensation to all shops for so-called quality repairs. The way to ensure quality is not to suppress compensation, which acts to jeopardize the quality of repairs. (FAC at 79) None of GEICO's arguments excuse its conduct in misrepresenting the prevailing rates and repair standards.

State Farm argues that Plaintiffs' claims lack particularity, because Plaintiffs do not allege was the prevailing rate should be. That misses the point. Collision repairs are a service performed by highly skilled professionals, who each have and demonstrate particular levels of expertise, certification, training, equipment, capacity and quality of workmanship, and compensation should be set based on skill and competition – in addition to the repairs that are necessary. Like other professionals – and contrary to artificial and uniform prevailing rates that Defendant Insurers and Conspirator Insurers have been able to establish through means that have little to do with free market competition or value, the services of automotive repair professionals should be based on factors such as quality, experience, training and facility capabilities, and the compensation for these services should be based, at least in part, on these factors. Defendant Insurers' and Conspirator Insurers' use of leverage to control the flow of repairs to maintain

suppressed labor rates focuses solely on achieving the greatest cost savings, but is counter to the obligation that vehicles must properly be restored to pre-loss condition, and risks the quality of the repairs. Accordingly, Defendant Insurers (and conspirator insurers) have affected the market so that the pay the same or similar labor rates to all repair facilities in each geographic region, irrespective of quality, experience, training, equipment and/or certification. (FAC at 63, 79) Indeed, State Farm argues that there is no obligation or duty for insurers to pay higher rates based on a repair facility's expertise. (State Farm at 13) This demonstrates the utter lack of consequence to State Farm of repair quality and performance.

State Farm also argues, because State Farm's payment obligations are to their policyholders rather than repair facilities, and controlled by insurance policy provisions, the "causal chain" between Plaintiffs' injuries and the conduct is broken. According to State Farm, Plaintiffs lack standing. (State Farm at 20-21) As discussed above, State Farm's argument flies in the face of the tenets of *Bridge*, *BCS Services* and myriad cases explaining how proximate cause and directness of injury under RICO is determined and is fatally flawed. Even accepting, *arguendo*, State Farm's premise, however, demonstrates that State Farm's conduct is fraudulent because it is the misrepresentation of the prevailing rate that is actionable. State Farm argues that its policies define its payment obligations for collision repairs, which is based on the so-called prevailing rate. However, State Farm's policies do not provide that the so-called prevailing rate upon which State Farm's obligation to pay for a loss is based solely on DRP facilities, which, in turn, is nothing but the rate – and worse, repair standards – that State Farm itself fixes and then imposes upon its DRP facilities (along with a strict most favored nation provision). This stands the policy provision on its head.

6. RICO Conspiracy

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." Plaintiffs must allege "that the conspirators agreed to participate directly or indirectly in the affairs an enterprise through a pattern of racketeering activity." *In re Managed Care Litig.*, 298 F.3d 1280. "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." *American Dental Assn.*, 605 F.3d 1293 (citations omitted).

As discussed at length herein, by virtue of their conduct, each of the Defendant Insurers conspired – as defined above, with their respective Information Providers and, specific to State Farm, with their Select Service DRP facilities as well, to defraud and extort, in violation of 18 U.S.C. § 1962(c), Plaintiffs and proposed Classes for their money and property 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, Defendant 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; *In re Managed Care Litig.*, 298 F.3d 1280-81.

C. Unjust Enrichment

Given that the unjust enrichment claims by Plaintiffs are state law claims, this Court should look to the analysis that the Northern District of Illinois, as the transferor court, would have performed. *See Van Dusen v. Barrack*, 376 U.S. 612, 639 (1960); *Boardman Petroleum, Inc. v. Federated Mut. Ins. Co.*, 135 F.3d 750, 752 (11th Cir. 1998) ("[W]hen a case is transferred from one forum to another [under § 1404(a)], the transferor court's choice-of-law rules apply to the transferred case even after the transfer occurs."). Under Illinois law, "the local law of the state where the injury occurred should determine the rights and liabilities of the parties, unless Illinois has a more significant relationship with the occurrence and with the parties." *See Hardly Able Coal Co. v. Int'l Harvester Co.*, 494 F. Supp. 249, 250 (N.D. Ill. 1980) (quotation omitted).

To determine whether one state's substantive law (unjust enrichment) applies in a multi-state action, the court must engage in the following analysis. First, the court must determine whether there is an actual conflict between the laws of the relevant states. *Phillips Petroleum Co. v. Shutts*, 472 U.S. 797, 817 -18 (1985). This necessarily involves looking at each state's elements of unjust enrichment to determine whether there is a true or actual conflict. *Id*. at 816-17. A conflict exists when the application of one state's law over another will make a difference in the outcome. Ill. Law & Practice, Conflict of Laws § 2 n.18 (citing *McGrew v. Pearlman*, 710 N.E.2d 125, 128 (Ill. App. Ct. 1999) ("There is a conflict if the difference in the laws will result in a difference in outcome.")). If there is no true conflict (a so-called "false conflict"), the court can safely apply its own unjust enrichment claim in the case. *Id*. "Ordinarily, Illinois follows

the Restatement (Second) of Conflict of Laws in making choice of law decisions." *Hall v. Sprint Spectrum LP*, 876 N.E.2d 1036, 1041 (Ill. App. Ct. 2007) (citation omitted). Section 187(2) of the Restatement (Second) of Conflict of Laws provided, in pertinent part:

> (2) The law of the state chosen by the parties to govern their contractual rights and duties will be applied . . . unless either
>
> (a) The chosen state has no substantial relationship to the parties or the transaction and there is no other reasonable basis for the parties' choice, or
>
> (b) Application of the law of the chosen state would be contrary to a fundamental policy of a state which has a materially greater interest than the chosen state in the determination of the particular issue and which, under the rule of § 188, would be the state of the applicable law in the absence of an effective choice of law by the parties."

Hall, 876 N.E.2d at 1041 (quoting Restatement (Second) of Conflict of Laws § 187(2) (1971)). "The public policy of a State must be sought in its constitution, legislative enactments[,] and judicial decisions." *Id*. (quoting *Roanoke Agency, Inc. v. Edgar*, 461 N.E.2d 1365, 1371 (Ill. 1984)).

Plaintiffs do not waive, and expressly preserve, their right to raise the application of conflicts of laws and choice of laws as necessary at the appropriate juncture but submit that, for the purposes of Defendant Insurers' motions to dismiss, under the law of Pennsylvania (plaintiff Crawford's), North Carolina (plaintiff K&M) or Illinois (the transferor forum), they have pled a viable cause of action for unjust enrichment.

In Pennsylvania, to establish unjust enrichment, a party must show "benefits conferred on defendant by plaintiff, appreciation of such benefits by defendant, and acceptance and retention of such benefits under such circumstances that it would be inequitable for defendant to retain the benefit without payment of value." *Stoeckinger v. Presidential Fin. Corp. of Del. Valley*, 948 A.2d 828, 833 (Pa. Super. Ct. 2008). *See Mitchell v. Moore*, 729 A.2d 1200, 1203 (Pa. 1999)

("To sustain a claim of unjust enrichment, a claimant must show that the party against whom recovery is sought either 'wrongfully secured or passively received a benefit that it would be unconscionable to retain.")

In North Carolina:

> The mere fact that one party was enriched, even at the expense of another, does not bring the doctrine of unjust enrichment into play. There must be some added ingredients to invoke the unjust enrichment doctrine. Indeed, as we recently explained, there are five elements to a *prima facie* claim for unjust enrichment: First, one party must confer a benefit upon the other party . . . . Second, the benefit must not have been conferred officiously, that is it must not be conferred by an interference in the affairs of the other party in a manner that is not justified in the circumstances . . . . Third, the benefit must not be gratuitous. . . . Fourth, the benefit must be measurable. . . . Last, the defendant must have consciously accepted the benefit. Thus, in order to prevail on a claim of unjust enrichment, a plaintiff must show that "property or benefits were conferred on a defendant under circumstances which give rise to a legal or equitable obligation on the part of the defendant to account for the benefits received. However, "[t]he recipient of a benefit voluntarily bestowed without solicitation or inducement is not liable for their value."

Butler v. Butler, 768 S.E.2d 332, 336 (N.C.Ct. App. 2015) (citations and quotations omitted); *See also JPMorgan Chase Bank, Nat'l Ass'n v. Browning*, 750 S.E.2d 555, 559 (N.C.Ct. App 2013) (same).

In Illinois, unjust enrichment "is a condition that may be brought about by unlawful or improper conduct as defined by law, such as fraud, duress or undue influence, or alternatively, it may be based on contracts which are implied in law." *See Assn. Ben. Services v. Caremark Rx, Inc*., 493 F.3d 841, 855 (7th Cir. 2007); *Salatech, LLC v. Balt, Inc.*, 20 N.E.3d 796, 808 (Ill. App. Ct. 2014). Unjust enrichment must entail a defendant receiving the benefit of the enrichment. *Blythe Holdings, Inc. v. DeAngelis*, 750 F.3d at 656 (2014)

Plaintiffs performed repairs services for Defendant Insurers' insureds and vehicles covered by their insurance policies for which they were obligated to pay. Defendant Insurers

contend that their obligation to pay for repairs is defined under the policies. The value of the services performed by Plaintiffs relieved Defendant Insurers of their obligations to their insureds under the policies. Further, by virtue of the conduct outlined in the Complaint and herein – riddled with fraud, duress and impropriety, Defendant Insurers were unjustly benefitted by paying artificially suppressed compensation for the repair services – and it would be inequitable for them to have benefitted without "payment of value."

Further, even assuming, *arguendo*, a benefit was not conferred directly upon Defendant Insurers (though it was), that is not the proper measure of a claim for unjust enrichment. Rather, it is the relationship between the plaintiff's detriment and the defendant's benefit that guides the analysis. *See Suessenbach Family Ltd. Partnership v. Access Midstream Partners, L.P.*, 2015 WL 1470863 * (M.D. Pa. Mar. 31, 2015) (parent company benefitted from subsidiary's inflated royalty deductions to the plaintiff's detriment); *In re TFT-LCD (Flat Panel) Antitrust Litig.*, 2011 WL 4501223 (N.D. Cal. Sept. 28, 2011) (indirect purchasers' unjust enrichment claims against manufacturers for inflated consumer prices). Defendant Insurers have clearly benefitted at the expense of the Plaintiffs and the proposed Classes.

D. <u>Fraud</u>

Like their claim of unjust enrichment, Plaintiffs do not waive, and expressly preserve, their right to raise the application of conflicts of laws and choice of laws as necessary at the appropriate juncture but submit that, for the purposes of Defendant Insurers' motions to dismiss, under the law of Pennsylvania (plaintiff Crawford's), North Carolina (plaintiff K&M) or Illinois (the transferor forum), they have pled a viable cause of action for fraud.

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*, No. 1259 C.D. 2013, 2014 WL 346589, at *8 (Pa. Commonw. Ct. Jan. 30, 2014) (citing *Blumenstock v. Gibson*, 811 A.2d 1029, 1034 (Pa. Super. Ct. 2002); *See also DeArmitt v. New York Life Ins. Co.*, 73 A.3d 576, 481 (Pa. Super. Ct. 2013) (same).

In North Carolina, to show a cause of action for common law fraud, a 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 Pharmaceutical Prods., Inc.*, 598 S.E.2d 570, 582 (N.C.Ct. App. 2004); *See also Freese v. Smith*, 428 S.E.2d 841, 844 (N.C.Ct.App. 1993) (same).

In Illinois, to state a cause of action for common law fraud, a plaintiff must plead "(1) a false statement of material fact; (2) knowledge or belief by the defendant that the statement was false; (3) an intention to induce the plaintiff to act; (4) reasonable reliance upon the trust of the statement by the plaintiff; and (5) damage to the plaintiff resulting from this reliance." *Phillips v. DePaul University*, 19 N.E.3d 1019, 1036 (Ill. App. Ct. 2014) (quoting *Avon Hardware Co. v. Ace Hardware Corp.*, 998 N.E.2d 1291 (Ill. App. Ct. 2013); *See also JPMorgan Chase Bank, N.A. v. East-West Logistics, L.L.C.*, 9 N.E. 104, 121 (Ill. App. Ct. 2014) (same and adding "Intentional concealment of a material fact is the equivalent of a false statement of material fact. Where a person has a duty to speak, his failure to disclose material information constitutes fraudulent concealment.").

As discussed at length herein, Defendants Insurers fraudulent schemes and conduct to artificially establish prevailing rates and repair standards – which they imposed, with the Information Providers, upon Plaintiffs and the proposed Classes – were clearly material facts. Further, for the reasons outlined herein under the RICO claims, Plaintiffs have alleged (1) false statements and omissions of material facts; (2) known to Defendant Insurers to be false; (3) that were made for the purpose of inducing Plaintiffs and the proposed Classes to rely on the statements and omissions – and such reliance was reasonable and justifiable; and (5) as a result, Plaintiff and the proposed Classes were injured, in that they were paid – and forced to accept – suppressed compensation for repair services. Accordingly, Plaintiffs have sufficiently pled a claim for fraud.

E. **Equitable tolling/Fraudulent Concealment**

Plaintiffs have sufficiently alleged fraudulent concealment so as to equitably toll the applicable statutes of limitation, by alleging that each Defendant Insurer intentionally concealed from Plaintiffs and the members of the Classes the fraudulent conduct establishing artificial prevailing rates for insured repairs and suppressing compensation for those repairs. (FAC ¶¶ 287-290.)

As an initial matter, a "statute of limitations bar is an affirmative defense, and plaintiff[s] [are] not required to negate an affirmative defense in [their] complaint." *La Grasta v. First Union Sec., Inc.,* 358 F.3d 840, 845 (11th Cir. 2004) (quotation omitted). "Thus, at the motion-to-dismiss stage, a case may only dismissed on statute of limitations grounds 'if it is apparent from the face of the complaint that the claim is time-barred.'" *Latonik v. Fla. Dept. of Highway Safety & Motor Vehicles,* No. 6:14-cv-1793, 2014 WL 7010737 at *2 (M.D. Fla. Dec. 11, 2014) (quoting *La Grasta*) (refusing to find claims time-barred at motion-to-dismiss stage); *see also*

Corcel Corp., Inc. v. Ferguson Enterprises, Inc., No. 12-80896, 2014 WL 2612326 (S.D. Fla. June 11, 2014) (same as to RICO claims); *Bocciolone v. Solowsky,* No. 08-20200-civ, 2009 WL 936667 at *6 (S.D. Fla. Apr. 6, 2009) (same); *State Farm Mut. Auto. Ins. Co. v. Kugler,* No. 11-80051, 2011 WL 4389915 at *13 (S.D. Fla. Sept. 21, 2011) (denying motion to dismiss RICO and state law claims, noting "perimeters of [four year] limitations period are appropriately defined by reference to the delayed discovery doctrine. . . and the doctrine of equitable tolling" and refusing to resolve on motion to dismiss).

In *Rotella v. Wood*, 528 U.S. 549 (2000), while clarifying that in RICO cases the discovery rule applies upon discovery of the injury, the Supreme Court further confirmed that, "[i]n rejecting pattern discovery as a basic rule, we do not unsettle the understanding that federal statutes of limitations are generally subject to equitable principles of tolling, and where a pattern remains obscure in the face of a plaintiff's diligence in seeking to identify it, equitable tolling may be one answer to the plaintiff's difficulty. . . ." *Rotella*, 528 U.S. at 560 (citation omitted). "Unlike the discovery rule, which determines the time of the initial commencement of a limitations period, '[e]quitable tolling functions to stop the statute of limitations from running where the claim's accrual date has already passed." *Forbes v. Eagleson*, 228 F.3d 471, 486 (3d Cir. 2000) (quotation omitted).

Consistent with *Rotella*, the Eleventh Circuit recognizes that the "principle of equitable tolling is germane to RICO cases," although it is "the exception, not the rule". *Ward v. Dickinson Financial Corp. II, Inc.*, No. 7:14-cv-8, 2015 WL 1020151 at *11 (M.D. Ga. Mar. 9, 2015) (quoting *Pacific Harbor Capital, Inc. v. Barnett Bank, N.A.*, 252 F.3d 1246, 1252 (11th Cir. 2001)). Similarly, in the Seventh Circuit, "[t]he doctrine of equitable tolling may be applied to the statute of limitations for a civil RICO action. . . Equitable tolling may toll a statute of

limitations where, despite a plaintiff's due diligence, he cannot 'obtain vital information bearing on the existence of his claims.'" *Jones v. Burge,* No. 11-cv-4143, 2012 WL 2192272 at *4 (N.D. Ill. June 13, 2012) (quoting *Bontkowski v. First Nat. Bank of Cicero*, 998 F.2d 459, 462 (7th Cir. 1993)). "Among the circumstances warranting equitable tolling are situations where 'the defendant has actively misled the plaintiff respecting the plaintiff's cause of action,' *i.e.* fraudulent concealment." *Forbes*, 228 F.3d at 486. "[I]f the defendant conceals *any* element of the offense, including but not limited to, the injury itself, the four-year period will be tolled." *Mathews v. Kidder, Peabody & Co., Inc*., 260 F.3d 239, 256 n.26 (3d Cir. 2001) (emphasis in original).

Active misleading and fraudulent concealment are precisely what Plaintiffs plead here, and equitable tolling therefore applies to all of Plaintiffs' claims.

With respect to Plaintiffs' common law claims, "[t]he applicable limitations periods for federal causes of action founded on diversity jurisdiction are found pursuant to state law." *Ducat Florida, LP v. Wells Fargo Bank, N.A.,* No. 12-23683-civ, 2013 WL 6667028 at *4 (S.D. Fla. Oct. 24, 2013) (citing *Veltmann v. Walpole Pharm., Inc.,* 928 F.Supp. 1161, 1164 (M.D. Fla.1996).) Similarly, state law governs the determination of when a common law claim accrues. *Id.* Under each of the relevant four states' laws, the discovery rule operates to toll the statutes of limitation for the common law claims. Specifically, in Illinois, the "discovery rule postpones the start of the period of limitations until the injured party knows or reasonably should know of the injury and knows or reasonably should know that the injury was wrongfully caused." *Haskins v. Midwest Air Traffic Control Serv., Inc.,* No. 12-cv-04584, 2014 WL 6980574 at *2 (N.D. Ill. Dec. 10, 2014) (citing *Khan v. Deutsche Bank AG,* 365 Ill. Dec. 517 (2012)); *see also Lewandowski v. Jelenski,* 401 Ill.App.3d 893, 897 (Ill. App. Ct. 2010) (discovery rule applies to

unjust enrichment claims). Similarly, for Florida actions "founded upon fraud," the state's delayed discovery rule tolls actions "from the time the facts giving rise to the cause of action were discovered or should have been discovered with the exercise of due diligence." *Mayor's Jewelers, Inc. v. Meyrowitz*, No. 12–80055–CIV, 2012 WL 2344609 at *4 (S.D. Fla. June 20, 2012); Fla. Stat. § 95.031(2)(a). *See also* N.C.G.S.A. § 1-52(9) (under North Carolina law, for relief on the ground of fraud or mistake, "the cause of action shall not be deemed to have accrued until the discovery by the aggrieved party of the facts constituting the fraud or mistake"); *Fine v. Checcio,* 870 A.2d 850, 858 (Pa. 2005) (under Pennsylvania law, the discovery rule tolls the statute of limitations until such time as the tort and the existence of the tortfeasor should reasonably have been discovered); *Ruddy v. Mt. Penn Borough Mun. Auth.,* No. 1120 C.D. 2013, 2014 WL 1852002 at *2 (Pa. Cmwlth. 2014) (applying discovery rule to toll statute of limitations as to unjust enrichment claim).

Thus, here, where Defendant Insurers cannot claim that the statutes of limitation for fraud and unjust enrichment under any of the potentially applicable state laws bars Plaintiffs claims, the Court should not engage in a factual-intensive inquiry at the pleading stage to ascertain when the discovery rule cut-off might apply.

IV. CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that the Court deny the motions to dismiss by all defendants in their entirety, and grant Plaintiffs such other and further relief as the Court deems just and proper.

Dated: April 24, 2015.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this ___ day of April, 2015, I electronically filed the foregoing with the Clerk of the Court by using the CM/ECF system which will send a Notice of Electronic Filing to all counsel of record that are registered with the Court's CM/ECF system.

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