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IN THE SUPREME COURT OF FLORIDA

VERON CARAVAKIS,

Plaintiff/Petitioner,

vs. CASE NO. SC02-198

ALLSTATE INDEMNITY COMPANY,

Defendant/Respondent.

ON REVIEW FROM THE DISTRICT COURT OF APPEAL, SECOND DISTRICT
DCA Case No.: 2D00-4027

ANSWER BRIEF OF DEFENDANT/RESPONDENT ALLSTATE INDEMNITY COMPANY

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TABLE OF CONTENTS

TABLE OF CONTENTS i

TABLE OF AUTHORITIES iii

STATEMENT OF THE CASE AND FACTS 1

SUMMARY OF ARGUMENT 4

ARGUMENT 6

Issues On Appeal

1. THE SECOND DISTRICT PROPERLY DENIED CERTIORARI REVIEW, BECAUSE THERE WAS NO CLEARLY ESTABLISHED PRINCIPLE OF LAW ON THE SUBSTANTIVE STANDING ISSUE, SO THE CIRCUIT COURT COULD NOT HAVE "DEPARTED FROM THE ESSENTIAL REQUIREMENTS OF LAW" OR CAUSED A "MISCARRIAGE OF JUSTICE" 6

A. The Parties Agree About The Correct Standard For Certiorari Review, And The Second District Correctly Applied That Standard 6

B. The Second District Correctly Ruled That No Controlling Precedent Existed Regarding The Substantive Standing Issue, And That, Absent Such Precedent, The Circuit Court Could Not Have Violated A Clearly Established Principle Of Law 7

C. The Circuit Court Did Not "Misapply" The Law, And Caravakis' Theories Regarding The "Correct" Law Do Not Support His Claim That He Suffered Any Injury .. 8

1. Caravakis Suffered No Injury Simply Because The Disputed Amounts Of His Medical Bills Were Not Paid Within 30 Days 9

2. Allstate's Policy Does Not Indemnify Against Liability, As Opposed To Loss 12

3. Caravakis Was Neither Denied Access To The Courts Nor Deprived Of Any Right To A Jury Trial 14

II. IF THIS COURT DECIDES TO REACH THE MERITS OF THE CIRCUIT COURT DECISION, THE CIRCUIT COURT CORRECTLY AFFIRMED THE COUNTY COURT RULING THAT CARAVAKIS LACKED STANDING TO SUE ALLSTATE OVER A DISPUTED MEDICAL BILL WHEN HE PAID NOTHING FOR THE MEDICAL BILL, HIS MEDICAL PROVIDER DID NOT PURSUE HIM IN ANY WAY FOR THE UNPAID BALANCE, AND HIS INSURANCE POLICY'S DEFENSE AND INDEMNIFICATION PROVISION FULLY PROTECTED HIM FROM ANY PROVIDER COLLECTION ACTIVITY 16

A. The Circuit Court's Interpretation Of Allstate's Policy Language Is Wholly Consistent With The Florida No-Fault Law 16

B. Caravakis' Inability To Show Injury, *Not* Allstate's Insurance Policy, Prohibits Him From Bringing This Lawsuit 24

C. The Overwhelming Number Of Cases Directly On Point Show The Circuit Court Correctly Ruled That Caravakis Suffered No Injury, And Therefore Lacked Standing To Bring This Lawsuit 24

CONCLUSION 31

CERTIFICATE OF SERVICE 32

CERTIFICATE OF COMPLYING WITH FONT REQUIREMENTS 33

TABLE OF AUTHORITIES

CASES

AIU Ins. Co. v. Daidone,
760 So.2d 1110, 1112 (Fla. 4th DCA 2000) 10, 11

Caloosa Property Owners Ass'n v. Palm Beach Cty. Bd. of Com'rs,
429 So.2d 1260, 1266-67 (Fla. 1st DCA 1983) 15

Caravakis v. Allstate Indem. Co.,
806 So.2d 548 (Fla. 2d DCA 2001) 1, 7

Chiles v. Thornburgh,
865 F.2d 1197, 1209-1211 (11th Cir. 1989) 24

Derius v. Allstate Indem. Co.,
723 So.2d 271 (Fla. 4th DCA) 11, 22

Dunmore v. Interstate Fire Ins. Co.,
301 So.2d 502 (Fla. 1st DCA 1974) 10, 11, 19

Dunn v. State Farm Mut. Automobile Ins. Co.,
8 Fla. L. Weekly Supp. 132a (Fla. 6th Cir. Ct. Oct. 27, 2000)
.... 25

Fla. Dep't of Agric. & Consumer Servs. v. Miami-Dade County,
790 So.2d 555, 558 n.4 (Fla. 3d DCA 2001) 24

Gaines v. McArthur,
254 So.2d 8 (Fla. 3d DCA 1971) 13

Gloria v. Allstate County Mutual Insurance Company,
No. SA-99-CA-676-PM (W.D. Tex. Sept. 29, 2000)
(Appendix 1) 12, 25, 26

Government Employees Ins. Co. v. Gonzalez,
512 So.2d 269 (Fla. 3d DCA 1987) 20

Griffith v. State Farm Mut. Automobile Ins. Co.,
8 Fla. L. Weekly Supp. 411b (Fla. 6th Cir. Ct. Jan. 31, 2001)
.... 25

Haines City Community Development v. Heggs,
658 So.2d 523, 528 (Fla. 1995) 6

Ivey v. Allstate Insurance Company,
774 So.2d 679, 682 (Fla. 2000) 4, 6, 7

Kaklamanos v. Allstate Ins. Co.,
796 So.2d 555 (Fla. 1st DCA 2001) 8, 12, 13

Kinnard v. Allstate Ins. Co.,
No. 992-00812 (Mo. Cir. Ct. Nov. 15, 1999) 28

Kochinski v. State Farm Fire and Cas. Co.,
7 Fla. L. Weekly Supp. 807a (Fla. Hillsborough Cty. Ct.
Sept. 20, 2000) 25

LaMothe v. Auto Club Ins. Assoc.,
214 Mich. App. 577, 543 N.W.2d 42, 43 (1995) 27, 28

Lasky v. State Farm Ins. Co.,
296 So.2d 9 (Fla. 1974) 18

McGill v. State Farm Mutual Auto. Ins. Co.,
207 Mich. App. 402, 526 N.W.2d 12, 13 (1994) 27, 28

McQueen v. Allstate Indemnity Company,
6 Fla. L. Weekly Supp. 85
(Fla. Broward Cty. Ct. Dec. 7, 1998) 25

Mitch v. State Farm Mut. Auto. Ins. Co.,
Case No. 99-4033 (Fla. Pinellas Cty. Ct.
Oct. 29, 1999) 24

Nationwide Mut. Fire Ins. Co. v. Pinnacle Medical, Inc.,
753 So.2d 55 (Fla. 2000) 18, 22, 23

Noah v. Government Employees Ins. Co.,
No. SA-00-CA-018 (W.D. Tex. Apr. 9, 2001) 12, 26, 27

Ny v. Metro. Property & Casualty Ins. Co.,
1998 WL 603 28

Ostrof v. State Farm Mut. Auto. Ins. Co.,
200 F.R.D. 521 (D. Md. 2001) 12, 28, 29

State Farm Mut. Auto. Ins. Co. v. Lee,
678 So.2d 818 (Fla. 1996) 10

Stilson v. Allstate Insurance Company,
692 So.2d 979, 982 (Fla. 2d DCA 1997) 6, 7

United Auto. Ins. Co. v. Rodriquez,
808 So.2d 82 (Fla. 2001) 2, 4, 11, 14

OTHER

Md. Ins. Code § 19-508 12

Section 21, Fla. Const. 15

Section 627.736(1), Fla. Stat. 2, 18

Section 627.736(2), Fla. Stat. 10

Section 627.736(4)(b), Fla. Stat. 4

Tex. Ins. Code art. 5.06-3(d) 12

STATEMENT OF THE CASE AND FACTS

I. Nature Of The Case

This matter is on review from a Second District Court of Appeal decision denying a petition for writ of certiorari and refusing to review a decision by the circuit court sitting in its appellate capacity. The opinion below is reported at Caravakis v. Allstate Indem. Co., 806 So.2d 548 (Fla. 2d DCA 2001).

II. Statement Of The Case And Facts

Defendant/respondent, Allstate Indemnity Company ("Allstate"), generally agrees with plaintiff/petitioner Veron Caravakis' ("Caravakis") Statement of the Case and Facts. However, Caravakis fails to fully state the basis for the county and circuit courts' rulings that Caravakis lacked standing to bring suit. Both courts reasoned that Caravakis suffered no injury as a result of Allstate's decision not to pay all his medical bills in full.

As the circuit court explained, citing numerous decisions from Florida and other jurisdictions, the "prevalent view" is that no breach of contract occurs, and the insured suffers no damages, "when the insurer pays the amount it determines to be reasonable for a submitted expense and further agrees to defend and indemnify the insured if he or she is pursued for any balance from such a determination." (Circuit Court Order at 2, 3; DCA R 104, 105.) (citations omitted).

Allstate also disagrees with Caravakis' statement that

Allstate "unilaterally reduced" his medical bills to the extent it suggests Allstate paid nothing toward the bills or had no basis for its payment decision. Caravakis established neither contention in the record below. Moreover, this Court's recent decision in United Auto. Ins. Co. v. Rodriguez, 808 So.2d 82 (Fla. 2001), negates Caravakis' suggestion that an insurer must pay *all* medical bills, as opposed to only reasonable and necessary medical expenses. See Part I.B.1, infra.

Caravakis was insured under an Allstate auto policy which provided Personal Injury Protection ("PIP") coverage. (DCA R 15,18.) Under the plain terms of his insurance contract and § 627.736(1), Fla. Stat., Allstate was obligated to pay only 80% of reasonable expenses for necessary medical services incurred as the result of a motor vehicle accident.

Also, Caravakis' policy included Allstate Florida Amendatory Endorsement AIU63-4, which provides:

> **Unreasonable or Unnecessary Medical Expenses**
>
> If an insured person incurs medical expenses which ***we*** deem to be unreasonable or unnecessary, ***we*** may refuse to pay for those medical expenses and contest them.
>
> If the insured person is sued by a medical services provider because ***we*** refuse to pay medical expenses which ***we*** deem to be unreasonable or unnecessary, ***we*** will pay resulting defense costs and any resulting judgment against the insured person.

(DCA R 27, 31, 180, and Caravakis' Brief at 2.) So, Allstate

promised to defend and indemnify Caravakis should any medical provider pursue him for unpaid amounts if Allstate determined that a medical charge was unreasonable or unnecessary. (DCA R 27, 31, 180, and Caravakis' Brief at 2.)

As the circuit court noted, it is undisputed that, of the $2,114 Caravakis' medical provider billed, Allstate covered $2,027, eighty percent of which it timely paid. (Circuit Court Order at 2; DCA R 104.) As the circuit court stated, "the record shows that [Allstate] did comply with its statutory and contractual obligations when it timely paid Appellant's medical provider eighty percent for all reasonable and necessary medical services." (Id. at 3; DCA R 105.)

Caravakis had every opportunity to submit evidence showing he suffered injury sufficient to confer standing. Yet, Caravakis produced no evidence that: a) he paid out-of-pocket for his unpaid medical bills; b) his medical provider pursued him in any way for any balance due; or c) Allstate's payment decision otherwise harmed him. (Circuit Court Order at 3; DCA R 105.) Nor did Caravakis submit any evidence that Allstate breached its promise to defend and indemnify him should his medical provider pursue collection activity (which did not occur). (Id.)

SUMMARY OF THE ARGUMENT

The Second District correctly denied certiorari review and refused to reach the merits of the circuit court's grant of summary judgment to Allstate based on Caravakis' lack of standing. In so ruling, the Second District applied the correct standard for certiorari review -- recently reaffirmed by this Court in Ivey v. Allstate Insurance Company, 774 So.2d 679, 682 (Fla. 2000) -- that district courts should grant certiorari *only* when the circuit court decision violates "a clearly established principle of law." As the Second District correctly recognized, no controlling precedent existed on the substantive standing issue, so it had no authority to issue a writ of certiorari.

Instead of citing any controlling precedent, Caravakis argues that the circuit court misapplied Fla. Stat. § 627.736(4)(b), which provides that insurers must pay PIP benefits within 30 days, and Art. I, Sections 21 and 22 of the Florida Constitution, which provide for the right of access to courts and a trial by jury. None of these arguments has merit. Caravakis incorrectly presumes that insurers must pay *all* PIP claims within 30 days. This Court recently rejected that very argument, holding that even if a PIP claim is not paid within 30 days, an insurer may still contest it. Rodriguez, 808 So.2d at 87. The PIP statute requires payment *only* of reasonable and necessary medical expenses. So, only those bills

must be paid within 30 days; unreasonable and unnecessary bills need not be paid within 30 days or at all.

Also, Caravakis ignores the fact that, absent standing to bring suit, he could not have been deprived of any right of access to court or a jury trial. Contrary to Caravakis' contention, the circuit court did not violate any clearly established precedent or "misapply the law."

Even if this Court decides to reach the merits here, it should affirm the circuit court's decision. In his arguments on the merits, Caravakis fails to even discuss the substantive standing issue. Instead, he argues that the way the circuit court interpreted Allstate's policy's defense and indemnification provision violates the Florida No-Fault Law; Allstate's policy does not prohibit a PIP suit; and the circuit court's interpretation of the defense and indemnification provision violates public policy.

Even if correct, these contentions would not confer standing because Caravakis suffered and can suffer no injury from the conduct he alleges. Indeed, Caravakis utterly fails to address, much less distinguish, the overwhelming number of cases from Florida and other jurisdictions holding that plaintiffs lack standing under identical circumstances.

ARGUMENT

I. THE SECOND DISTRICT CORRECTLY DENIED CERTIORARI REVIEW, BECAUSE THERE WAS NO CLEARLY ESTABLISHED PRINCIPLE OF LAW ON THE SUBSTANTIVE STANDING ISSUE, SO THE CIRCUIT COURT COULD NOT HAVE "DEPARTED FROM THE ESSENTIAL REQUIREMENTS OF LAW" OR CAUSED A "MISCARRIAGE OF JUSTICE".

A. The Parties Agree About the Correct Standard For Certiorari Review, And The Second District Correctly Applied That Standard In Denying Review.

Much of Caravakis' initial argument is superfluous. It details the history of common law writ of certiorari, but Allstate agrees with Caravakis about the correct standard for certiorari review. (Caravakis' Brief at 10-13.)

Specifically, "[t]he proper inquiry under certiorari review is limited to whether the circuit court afforded procedural due process and whether it applied the correct law." Ivey, 774 So.2d at 682 (citing Haines City Community Development v. Heggs, 658 So.2d 523, 528 (Fla. 1995)). Certiorari is not proper to correct "simple legal error." Id. (quoting Stilson v. Allstate Insurance Company, 692 So.2d 979, 982 (Fla. 2d DCA 1997)).

As Caravakis notes, this Court has repeatedly held that a district court should grant a petition for writ of certiorari only where the circuit court decision resulted in "violation of a clearly established principle of law resulting in a miscarriage of justice." Heggs, 658 So.2d at 529 (citation and internal quotation

omitted). The Second District correctly applied this standard when it denied Caravakis' petition for review. Caravakis v. Allstate Indemnity Company, 806 So.2d 548, 549-50 (Fla. 2d DCA 2001).

B. The Second District Correctly Ruled That No Controlling Precedent Existed Regarding The Substantive Standing Issue, And That, Absent Such Precedent, The Circuit Court Could Not Have Violated A Clearly Established Principle Of Law.

As the Second District correctly ruled, "when established law provides no controlling precedent, the circuit court cannot be said to have violated a clearly established principle of law." Caravakis, 806 So.2d at 549-50. See also Ivey, 774 So.2d at 682-83 (same principle); Stilson, 692 So.2d at 982 (absent controlling precedent, court could not conclude that trial or circuit court violated a "clearly established principle of law").

There was no controlling authority on the substantive standing issue here -- i.e., whether an insured may sue an insurer for failing to pay a medical bill when: 1) the insured never paid the bill, 2) the medical provider never pursued the insured for payment, and 3) the insurer agreed to defend and indemnify the insured in the event the provider did engage in collection activity. As the Second District observed, at the relevant time *no* Florida appellate cases addressed the Allstate policy provision, much less how it applied to facts like the ones presented here. See Caravakis, 806 So.2d at 550.

Indeed, Caravakis has yet to cite any controlling authority on this issue. The only on point Florida appellate court decision he

cites is Kaklamanos v. Allstate Ins. Co., 796 So.2d 555 (Fla. 1st DCA 2001). Kaklamanos, of course, was decided *after* the circuit court decided this case, and has now been consolidated with Caravakis' case for review by this Court. So, Kaklamanos certainly was not controlling when the Second District ruled. Moreover, for all the reasons in the merits brief Allstate submitted to this Court in Kaklamanos, that case was incorrectly decided and should be quashed.

Put simply, no controlling contrary precedent existed when the circuit court ruled that Caravakis had no standing to bring this action. Accordingly, the circuit court could not have violated any clearly established principle of law, and the Second District correctly denied Caravakis' petition for certiorari on this ground.

C. The Circuit Court Did Not "Misapply" The Law, And Caravakis' Theories Regarding The "Correct" Law Do Not Support His Claim That He Suffered Any Injury.

Instead of citing controlling precedent on the standing issue, Caravakis merely cites provisions from the Florida PIP statute and Constitution which he claims the circuit court "misapplied." First, he argues he was "damaged" by Allstate's failure to pay the disputed medical expenses within 30 days, as required by the PIP statute. See Fla. Stat. § 627.736(4)(b); Caravakis' Brief at 13-14, 19-20. Second, Caravakis argues that Allstate's policy is one indemnifying against liability, as opposed to loss, so he was harmed simply because he "receive[d] bills." (Id. at 17-19.)

Third, Caravakis argues he was injured because he was denied access to the courts and a right to trial by jury. (Id. at 20-21.)

According to Caravakis, the circuit court misapplied the law by failing to recognize his "injury" under these theories, which resulted in a "miscarriage of justice" sufficient to justify certiorari review. As shown below, however, none of these theories has any merit.

1. Caravakis Suffered No Injury Simply Because The Disputed Amounts Of His Medical Bills Were Not Paid Within 30 Days.

Caravakis argues he "suffered damages," and so has standing, because Allstate did not pay all his medical bills in full within 30 days. The fundamental flaw in Caravakis' "30-day" theory is his mistaken presumption that insurers must pay the full amount of *all* medical bills within 30 days. Yet, this Court expressly rejected that very argument in Rodriquez, 808 So. 2d at 87. This Court explained that, while "the plain language of the [PIP statute] provides that an insurer is subject to specific penalties for an 'overdue' payment: ten percent interest and attorneys' fees, *[n]othing in the statute provides that once a payment becomes overdue the insurer is forever barred from contesting the claim.*" Id. (emphasis added).

In other words, if a claim is not paid within 30 days, that does not automatically entitle the insured to PIP benefits. To the contrary, the PIP statute expressly provides that insurers are obligated to pay claims *only* for medical treatment that is

reasonable and necessary. See § 627.736(2), Fla. Stat.

The cases Caravakis cites to support his "30-day" theory are no help to him. Caravakis relies on Kaklamanos, which was not in existence at the time of the circuit court's decision, is now on review before this Court, and was incorrectly decided.

Caravakis also relies on State Farm Mut. Auto. Ins. Co. v. Lee, 678 So.2d 818 (Fla. 1996). (Caravakis' Brief at 14.) But in Lee, this Court merely held that the statute of limitations for failure to pay PIP benefits begins to run when the insurer breaches its obligation to pay, and that breach occurs once 30 days pass "and no benefits were paid on the claim, *assuming they were properly due*[.]" Lee, 678 So.2d at 821 (emphasis added). Nothing in Lee suggests that insureds can bring suit even if they have suffered no injury. To the contrary, the limitations period begins to run only if the unpaid benefits are "properly due." Id. Or, in other words, "if [PIP] benefits are not due, they cannot be 'overdue'." AIU Ins. Co. v. Daidone, 760 So.2d 1110, 1112 (Fla. 4th DCA 2000).

Here, of course, Allstate disputes that the relevant medical expenses are due at all. And nothing in the record indicates that Caravakis' medical provider disagrees.

Finally, Caravakis cites Dunmore v. Interstate Fire Ins. Co., 301 So.2d 502 (Fla. 1st DCA 1974), for the proposition that there "is no provision in the statute to toll [the 30-day] time

limitation," and that the "burden is clearly upon the insurer to authenticate the claim within the statutory time period. To rule otherwise would render the recently enacted 'no-fault' insurance statute a 'no-pay' plan -- a result we are sure was not intended by the legislature." (Caravakis Brief at 14.)

Dunmore is distinguishable because the insurer there paid nothing for Dunmore's medical bills within 30 days, even though it did not dispute Dunmore's entitlement to PIP benefits. 301 So.2d at 502. See, e.g., Daidone, 760 So. 2d at 1112 (distinguishing Dunmore on the ground that there was no dispute in that case that benefits were owed). By contrast, here, Allstate paid the overwhelming majority of Caravakis' bills within 30 days, but disputed Caravakis' entitlement to PIP benefits for the small amount it did not pay.

Nothing in Dunmore suggests that, just because 30 days have passed, an insurer must provide PIP benefits for unreasonable or unnecessary bills it would not otherwise have to pay. As this Court emphasized in Rodriguez, Allstate had every right to dispute Caravakis' bills. See Rodriguez, supra; see also Derius v. Allstate Indem. Co., 723 So.2d 271 (Fla. 4th DCA), rev. denied, 719 So.2d 892 (Fla. 1998) ("an insurer is not liable for any medical expense to the extent that it is not a reasonable charge for a particular service or if the service is not necessary").

Indeed, Caravakis never explains how the passage of 30 days

could possibly have injured him when he has not paid the disputed bills, his medical provider never pursued him for the balance, and, in all events, his Allstate policy's defense and indemnification provision fully protects him from any collection activity.

Notably, like the Florida statute, the Texas and Maryland PIP statutes require insurers to pay benefits within 30 days. Tex. Ins. Code art. 5.06-3(d) ("[a]ll payments of benefits prescribed under this Act shall be made periodically as the claims therefor arise and within thirty (30) days after satisfactory proof thereof"); Md. Ins. Code § 19-508 (same). Even so, Texas courts have dismissed claims identical to Caravakis' because the plaintiffs failed to allege actual injury. See Gloria v. Allstate County Mutual Insurance Company, No. SA-99-CA-676-PM (W.D. Tex. Sept. 29, 2000) (Appendix 1); Noah v. Government Employees Ins. Co., No. SA-00-CA-018 (W.D. Tex. Apr. 9, 2001) (Appendix 2). And a Maryland court found a named plaintiff not a member of the class he sought to represent for the same reason. Ostrof v. State Farm Mut. Auto. Ins. Co., 200 F.R.D. 521 (D. Md. 2001).

This case is no different. The circuit court did not "misapply the law" by failing to apply Caravakis' erroneous 30-day theory.

2. Allstate's Policy Does Not Indemnify Against Liability, As Opposed To Loss.

Again relying heavily on Kaklamanos, Caravakis next argues that the circuit court "misapplied the law" by failing to recognize

that Allstate's policy is one indemnifying against liability, as opposed to loss. Based on this theory, Caravakis argues he "suffered damages" simply because he received medical bills, "owes money" and "remains liable" for those bills. (Caravakis' Brief at 17-19.)

Caravakis' argument is flawed for the same reasons as the First District's decision in Kaklamanos. Like the First District, Caravakis cites no authority for his claim that the PIP portion of his policy provides indemnity against liability. Caravakis also relies on language from Gaines v. McArthur, 254 So.2d 8 (Fla. 3d DCA 1971), for his distinction between the types of indemnification, but omits the discussion immediately thereafter:

> Whether a contract is one of indemnity against liability or against loss must necessarily depend upon its terms and the intent of the parties. Contracts of indemnity are, however, strictly construed, *unless it clearly appears otherwise, the contract will be held to be against loss.*

Gaines, 254 So.2d at 10 (quoting Case Comment, 24 Calif. L. Rev. 193 (1936) (emphasis added)).

In other words, just as the First District did, Caravakis ignores Florida's presumption that a contract of indemnity is one against loss, not against liability. Given this presumption, and the fact that nothing in the contract "clearly appears otherwise," the PIP portion of Allstate's policy must be read to insure against loss, not liability. (DCA R 27, 31, 180, and Caravakis' Brief at 2.)

Even if Allstate's policy were a policy of indemnity against

liability, however, that would not confer standing upon Caravakis. Caravakis still must suffer damages to have standing. That an expense or a debt is incurred, or that liability for payment attaches, does not create actual injury particularly here, where Caravakis paid nothing for the "debt," and where even if his medical provider were to pursue him for the "debt," his policy's defense and indemnification provision would fully protect him.

Significantly, even under Caravakis' theory, he could not possibly suffer any injury here because the "debt" is for bills the insurer disputes as unreasonable or unnecessary. Caravakis states that the PIP statute "makes Allstate an '*indemnitor against liability' for reasonable and necessary medical expenses.*" (Caravakis' Brief at 18 (emphasis added)). So, as even Caravakis has argued, Allstate clearly is *not* an indemnitor against liability for unreasonable or unnecessary medical expenses. To the contrary, the PIP statute gives Allstate the right to contest such expenses. Rodriguez, supra. In any event, even if the "debt" is someday found to be due, Allstate, not Caravakis, would defend him and pay it, so not only has Caravakis suffered no current injury, he also can have no possible injury in the future.

3. Caravakis Was Neither Denied Access To The Courts Nor Deprived of Any Right To A Jury Trial.

Caravakis' argument that the circuit court's ruling was a "miscarriage of justice" because it denied him access to the courts and deprived him of the right to a jury trial (Caravakis' Brief at

21) also fails, because Caravakis again ignores the standing requirement.

The Florida constitutional right of access to courts does not open Florida courts to *all* persons who want to file suit. Rather, the courts are "open to every person *for redress of any injury*." Art. I, § 21, Fla. Const. (emphasis added); Caloosa Property Owners Ass'n v. Palm Beach Cty. Bd. of Com'rs, 429 So.2d 1260, 1266-67 (Fla. 1st DCA 1983)(Art. I, § 21 "provides that Florida courts shall be open to every person for redress of any injury").

So, the circuit court did not rob Caravakis of his "day in court." Rather, he is not entitled to a day in court because he cannot show he suffered any actionable injury and so has no standing. If a plaintiff cannot establish subject matter jurisdiction because he cannot demonstrate standing, that does not amount to a denial of access to the courts or the right to a jury trial. If it did, the standing requirement would simply cease to exist.

In sum, no miscarriage of justice occurred here. There was no denial of access to court or to a jury trial. The circuit court violated no controlling precedent on standing, nor did it misapply the law.

II. IF THIS COURT DECIDES TO REACH THE MERITS OF THE CIRCUIT COURT DECISION, THE CIRCUIT COURT CORRECTLY AFFIRMED THE COUNTY COURT RULING THAT CARAVAKIS LACKED STANDING TO SUE ALLSTATE OVER A DISPUTED MEDICAL BILL WHEN HE PAID NOTHING FOR THE MEDICAL BILL, HIS MEDICAL PROVIDER DID NOT PURSUE HIM IN ANY WAY FOR THE UNPAID BALANCE, AND HIS INSURANCE POLICY'S DEFENSE AND INDEMNIFICATION PROVISION FULLY PROTECTED HIM FROM ANY PROVIDER COLLECTION ACTIVITY.

The Second Circuit correctly rejected Caravakis' petition for certiorari review and refused to reach the merits of this case. If this Court decides to reach the merits, however, the circuit court's decision should be affirmed.

Even when arguing the merits, Caravakis fails to address the substantive standing issue on which the county court's decision was based. He instead argues: 1) the circuit court's interpretation of Allstate's defense and indemnification provision violates the Florida No-Fault Law; 2) Allstate's policy does not prohibit a PIP suit by Caravakis; and 3) the circuit court's interpretation of the policy's defense and indemnification provision violates Florida public policy. As shown below, these arguments are unfounded.

A. The Circuit Court's Interpretation Of Allstate's Policy Language Is Wholly Consistent With The Florida No-Fault Law.

Caravakis claims that the way the circuit court interpreted Allstate's defense and indemnification provision violates the PIP statute. (Caravakis' Brief at 23-29.) He utterly fails to support this argument.

First, Caravakis contends that if an insurer "imposes any

additional restrictions or requirements on its insureds than are required through the [PIP] statute," the policy must be enforced as if it complied with the statute regardless of the policy's terms. (Id. at 23-24.) This argument is a red herring because, far from imposing restrictions on its insureds, Allstate's defense and indemnification provision provides added protection -- a promise that Allstate will defend and indemnify insureds should medical providers pursue collection activity against them. Obviously recognizing that this provision benefits him, Caravakis states "it is not so much the language of the Allstate amendatory endorsement that is objectionable," but the circuit court's interpretation of it. (Id. at 25.) He then argues, without citing any authority, that the way the circuit court interpreted the amendatory endorsement violates the PIP statute by "prohibiting an insured from filing a PIP suit." (Id.) Yet, it is not the circuit court's interpretation that prohibits him from maintaining his suit; rather, as the circuit court recognized, it is Caravakis' own failure to show he suffered any actionable injury.

Caravakis next argues that the circuit court interpreted the defense and indemnification provision in a way that violates "an objective of the PIP statute which is to insure prompt payment of PIP claims." (Caravakis' Brief at 25-26.) Essentially, this argument only restates Caravakis' erroneous contention that insurers must pay *all* PIP claims, as opposed to only reasonable and

necessary claims, within 30 days.

None of the cases Caravakis cites requiring prompt payment of PIP claims supports his argument that the circuit court's ruling violated the PIP statute. For instance, Caravakis cites Nationwide Mut. Fire Ins. Co. v. Pinnacle Medical, Inc., 753 So.2d 55 (Fla. 2000), and Lasky v. State Farm Ins. Co., 296 So.2d 9 (Fla. 1974), but neither opinion even remotely suggests that the statute requires payment of *all* PIP claims.

While Lasky discussed the PIP statute's prompt payment objective, it also specifically acknowledged the requirement that medical expenses must be reasonable and necessary. In fact, in Lasky, this Court expressly recognized the wisdom of this requirement:

> We also deem worthy to note that § 627.736(1) and (1)(a) specify as to medical expenses that these must be such as are "reasonable" and that such expenses shall be "for necessary medical, etc." services. Strict observance of these wise legislative predicates applying to the $1,000 level should serve to meet the arguments that the cost to the "rich man" easily exceed such a threshold while the services "that a poor man cannot afford will always be under the threshold." In this day of ever-increasing medical and hospital costs, the $1,000 minimum seems less than illusory.

Lasky, 296 So.2d at 15. Far from requiring "speedy payment" of PIP claims for bills insurers dispute as unreasonable or unnecessary, this Court recognized in Lasky that "strict observance" of the reasonableness/necessity requirement benefits, rather than harms,

insureds because it prevents needless depletion of PIP coverage. Id.

Caravakis also cites Dunmore, supra, for the proposition that if PIP insurers could toll the 30-day requirement, that would render the "no-fault" statute a "no-pay" plan. (Caravakis Brief at 27.) Dunmore is distinguishable, as discussed above, because Dunmore's insurer paid nothing for his medical bills within the 30 days (301 So.2d at 502), while Allstate paid most of Caravakis' medical expenses and only declined to pay those few it had the right to dispute under the PIP statute. Accordingly, the "'no-pay' plan" argument is factually and legally untenable.

Instead of using facts to support his argument, Caravakis speculates that the circuit court's ruling will result in "all PIP disputes [be]ing in the form of a health care provider suing the PIP insured and the insurance carrier stepping in to defend the insured." (Caravakis' Brief at 28.) Supposedly, this would prohibit speedy payment of PIP benefits, because the PIP insured "would have to hope to be sued by his or her medical provider." (Id.) If the provider chose not to sue, Caravakis posits, "not only would there be the inability to obtain speedy payment, there would be an inability to obtain any payment whatsoever." (Id.)

The undisputed facts of Caravakis' own case negate this argument. When, as here, the medical provider does not dispute the insurer's payment decision and, in fact, apparently accepts it, the

insurer obviously need not make any payment, much less a "speedy payment." And, contrary to Caravakis' contention, if an insured or provider cannot obtain payment for an unreasonable or unnecessary medical expense, that certainly does not violate the PIP statute.

Caravakis' reliance on Government Employees Ins. Co. v. Gonzalez, 512 So.2d 269 (Fla. 3d DCA 1987), is equally flawed. Citing Gonzalez, Caravakis claims "the foundation of the legislative scheme is to provide swift and virtually automatic payment so that the injured insured may get on with his life without undue financial interruption." (Caravakis Brief at 28 (quoting Gonzalez).) Unlike Allstate here, however, the insurer in Gonzalez "consistently maintained "it *undoubtedly owed* [$10,000 in PIP benefits] to someone" -- either, the insured or his medical provider, which had a lien for its bill -- but failed to pay benefits for a long time. 512 So.2d at 270 (emphasis added). Under these circumstances, the Gonzalez court imposed attorneys' fees as a penalty for the insurer's delay in paying benefits it agreed were due.

In stark contrast, Allstate has consistently maintained that it does not owe the disputed amounts of Caravakis' medical bills. Also, the medical provider in Gonzalez obtained a lien for Gonzalez' unpaid medical bills, but Caravakis' medical provider has not pursued him (or Allstate) for any unpaid amounts. So, Caravakis suffered no "financial interruption," nor would he even

if his medical provider pursued him for collection, because Allstate's promise to defend and indemnify fully protects him.

Caravakis next argues that the circuit court's interpretation of Allstate's policy violates the PIP statute by "denying a PIP insured the right to have the dispute determined by the trier of fact." (Caravakis' Brief at 28.) This essentially reiterates his baseless argument that he was deprived of the right to a jury trial.

At the outset, no provision in the PIP statute entitles insureds (or insurers) to have a jury decide disputes. Even if such a provision existed, Caravakis still could not present his case to a jury unless and until he established the threshold requirements for standing, which he cannot do.

Notably, instead of alleging facts showing injury, Caravakis wildly speculates that the circuit court's ruling will violate some hypothetical insureds' right to have a jury determine a PIP dispute - particularly, Caravakis claims, "in cases where the healthcare provider decides not to sue the PIP insured and would simply choose to withhold any further treatment and report the indebtedness to a credit agency." (Caravakis' Brief at 28.) Caravakis' conjecture only highlights his lack of standing. The hypothetical insured's provider stopped the insured's treatment. In contrast, Caravakis presented no evidence that his medical provider withheld further medical treatment or even reported any indebtedness he might have

to a credit agency.

Finally, <u>Derius v. Allstate Indem. Co.</u>, 723 So.2d 271 (Fla. 4th DCA 1998), and <u>Pinnacle</u>, <u>supra</u>, also do not support Caravakis' position on the right to a jury. In <u>Derius</u>, the Fourth District merely held that a trial court need not define the term "necessity" when instructing the jury about the necessity of medical expenses. <u>Derius</u>, 723 So.2d at 274. And in <u>Pinnacle</u>, this Court found a mandatory arbitration statute acquiring medical providers (who were assignees of PIP claims) to arbitrate breach of contract claims and awarding the prevailing party attorney fees unconstitutional. Nothing in <u>Derius</u> or <u>Pinnacle</u> suggests that a PIP claimant is entitled to a jury trial, or to bring a lawsuit, absent a threshold showing of injury.

Caravakis tries to use <u>Pinnacle</u> to support another hypothetical scenario regarding possible effects of the circuit court's ruling. According to Caravakis, the circuit court's ruling, like the provision this Court found unconstitutional in <u>Pinnacle</u>, "may encourage healthcare providers to require payment from PIP insureds at the time services are rendered, rather than risk having to file suit against the insured and going up against defense counsel and potential liability for costs and fees through a proposal for settlement." (Caravakis' Brief at 29.) "If this were to occur," Caravakis continues, "the PIP insured would be denied the right to have the issue determined by a jury, due to the

healthcare provider's response to the situation." (Id.)

First, the situation in Pinnacle is not analogous to the hypothetical. The provision in Pinnacle arbitrarily distinguished between medical providers and insureds, subjecting only the medical providers to possible attorneys' fees if the insurer prevailed in arbitration. It was that distinction this Court thought would result in providers' requiring payment for services up front, rather than risk collection through arbitration. Here, of course, there is no such arbitrary distinction.

Second, Caravakis' hypothetical scenario is exactly that -- hypothetical. It does not show any injury to Caravakis himself. Indeed, an equally plausible (and more likely) scenario is that the insured's medical provider accepts the insurer's payment decision -- as Caravakis' medical provider seems to have done. Then, litigating the PIP claim would be pointless, so the PIP insured would certainly not be deprived of any right to a jury trial.

B. Caravakis' Inability To Show Injury, *Not* Allstate's Insurance Policy, Prohibits Him From Bringing This Lawsuit.

Caravakis devotes no less than three pages to arguing that Allstate's defense and indemnification provision contains no language preventing him from filing suit. Accordingly, Caravakis theorizes, the circuit court's ruling was "in direct violation of the policy itself." (Caravakis' Brief at 29-33.) This argument is another red herring. It is Caravakis' lack of standing that preclude his suit here, *not* the policy provision.

Caravakis cites a single county court case, Mitch v. State Farm Mut. Auto. Ins. Co., Case No. 99-4033 (Fla. Pinellas Cty. Ct. Oct. 29, 1999), for the proposition that an insured should not have to wait until the medical provider initiates collection efforts to sue the insurer. Notably, nothing in Mitch supports Caravakis' argument. As the circuit court noted, Mitch "does not cite to any authority and is not the prevalent view." (Circuit Court Order at 3; DCA R 105.) Rather, the prevalent view is that insureds lack standing to sue their insurers in cases just like this one.

C. The Overwhelming Number Of Cases Directly On Point Show The Circuit Court Correctly Ruled That Caravakis Suffered No Injury, And Therefore Lacked Standing To Bring This Lawsuit.

The real substantive issue in this case, which Caravakis avoids, is standing. Without standing, a person may not properly invoke the jurisdiction of the court. See, e.g., Fla. Dep't of Agric. & Consumer Servs. v. Miami-Dade County, 790 So.2d 555, 558 n.4 (Fla. 3d DCA 2001) (citing Chiles v. Thornburgh, 865 F.2d 1197,

1209-1211 (11th Cir. 1989)). To establish standing, a party must show he has suffered an actual or tangibly threatened injury. Id. As the county court correctly ruled, Caravakis failed to show he suffered any injury.

Caravakis never submitted evidence that he paid out-of-pocket for the unpaid amounts of his medical bills, that his medical providers pursued him in any way, or that he would suffer any injury if they did, given the defense and indemnification provision in his policy.

Courts in Florida have repeatedly held that plaintiffs in substantively identical cases lacked standing because they suffered no injury. See, e.g., Griffith v. State Farm Mut. Automobile Ins. Co., 8 Fla. L. Weekly Supp. 411b (Fla. 6th Cir. Ct. Jan. 31, 2001); Dunn v. State Farm Mut. Automobile Ins. Co., 8 Fla. L. Weekly Supp. 132a (Fla. 6th Cir. Ct. Oct. 27, 2000); Kochinski v. State Farm Fire and Cas. Co., 7 Fla. L. Weekly Supp. 807a (Fla. Hillsborough Cty. Ct. Sept. 20, 2000); McQueen v. Allstate Indemnity Company, 6 Fla. L. Weekly Supp. 85 (Fla. Broward Cty. Ct. Dec. 7, 1998). But see Burgess, supra.

And, in cases directly on point, courts in at least five other jurisdictions have ruled the same way:

1. Texas

The United States District Court for the Western District of Texas dismissed plaintiffs' claims in Gloria v. Allstate County

Mutual Insurance Company, No. SA-99-CA-676-PM (W.D. Tex. Sept. 29, 2000), because they failed to allege any injury-in-fact as a result of Allstate's failure to pay their medical bills. (Appendix 1). The Gloria plaintiffs alleged they "suffered damages and liability to the extent of their unpaid bills plus interest," and were "subject to legal liability for the unpaid balance of their bills." Gloria, at 17.

The court ruled that plaintiffs failed to allege injury:

> What plaintiffs have pleaded is the possibility that at some time in the future their "property" will be injured by Allstate's determination of reasonable medical expenses. That the harm is not imminent or actual is particularly obvious in light of plaintiffs' allegations that Allstate's allegedly illegal conduct occurred in 1997 and 1998 and, even though the fact that plaintiffs twice amended their complaint, the amended complaint contains essentially the same general allegations regarding possible injury as the original complaint filed in June 1999. There are no allegations that a health care provider who was not fully reimbursed by Allstate has challenged the determination of what are reasonable expenses, billed plaintiffs for the balance, threatened to sue for the balance, or threatened to resort to a collection agency for payment of the balance.

Gloria, 17-18.

Similarly, in Noah v. Government Employees Ins. Co., No. SA-00-CA-018 (W.D. Tex. Apr. 9, 2001), the court found that the plaintiff lacked standing to sue her insurer for unpaid PIP benefits, because when she filed her lawsuit she had not paid anything to her medical provider, and her fear that the provider might pursue her for unpaid bills in the future was "too

speculative an injury to be the basis of an in-fact injury." Noah, 11. (Appendix 2).

2. Michigan

Several insureds sued their insurers in Michigan, alleging that the insurers wrongfully failed to pay no-fault/medical payments benefits. McGill v. State Farm Mutual Auto. Ins. Co., 207 Mich. App. 402, 526 N.W.2d 12, 13 (1994). The insurers asserted the charges were unreasonable and argued that plaintiffs lacked standing because they had suffered no injury, and, in fact, would never suffer injury in light of defense and indemnification policy provisions like the one in this case. Id.

The court held that the insureds had suffered no injury and, moreover, that no injury could even be threatened in light of the defense and indemnification provisions. Id. at 14. Accordingly, the court affirmed summary judgment for lack of standing. Id.

Relying on McGill, another Michigan court of appeals held that an insured lacked standing to bring suit when an insurer refused to pay allegedly unreasonable medical bills. See LaMothe v. Auto Club Ins. Assoc., 214 Mich. App. 577, 543 N.W.2d 42, 43 (1995), app. denied, 455 Mich. 950, 554 N.W.2d 916 (1996). According to the LaMothe court, there could be no injury because a defense and indemnification provision in the policy, like the one here and in McGill, "remove[d] the insured from jeopardy." Id.

3. **Massachusetts**

A Massachusetts appellate court also found McGill and LaMothe persuasive, holding that where an insurer "issue[s] a binding statement of indemnification," an insured may not bring suit as an "unpaid party." Ny v. Metro. Property & Casualty Ins. Co., 1998 WL 603138, *2-3 (Mass. App. Ct. Sept. 2, 1998). (Appendix 3). The Ny court stressed that the insured could not be injured because he could not possibly suffer any damage, given the indemnification promise.

4. **Missouri**

A Missouri court also decided this issue in Allstate's favor. See Kinnard v. Allstate Ins. Co., No. 992-00812 (Mo. Cir. Ct. Nov. 15, 1999). (Appendix 4). That court dismissed a named plaintiff's individual claim because he failed to allege he had to pay any amount for medical bills Allstate declined to pay in full:

> The pleading fails to state facts indicating how Bush's submission of [medical bills] to Allstate, and Allstate's refusal to pay "in full" gave rise to damages of $13.00. Although Bush allegedly incurred expenses, there is no allegation that he was required to pay amounts, contrary to the terms of the Allstate policy. The mere conclusion that Bush had damages of $13.00 does not show how that sum relates in any way to Allstate's alleged actions. The breach of contract claim of plaintiff Bush is therefore dismissed for failure to state a claim.

Kinnard, at 5-6.

5. **Maryland**

Similarly, in Ostrof v. State Farm Mut. Auto. Ins. Co., 200

F.R.D. 521 (D. Md. 2001), the court ruled that a named plaintiff seeking to represent a class of insureds whose PIP claims State Farm allegedly wrongfully denied was "either not a member of the proposed class or may be subject to a unique defense." The court so ruled because it was "uncontested that he [the plaintiff] has never had to pay his health care providers the amounts that were denied him," and "[n]o suits for the fees are pending against him nor, apparently, are any such suits imminent." Ostrof, 200 F.R.D. 521.

All these cases, like the many Florida circuit and county court cases cited above, support the circuit court's ruling that Caravakis lacked standing. Yet, Caravakis does not even address these cases, much less attempt to distinguish them.

Put simply, insureds lack standing to sue insurers for failing to pay allegedly unreasonable or unnecessary medical expenses in full where, as here, the insurer has expressly agreed to defend and indemnify the insured in the event of any collection activity. If this Court reverses the circuit court's decision, as Caravakis requests, such a ruling would effectively remove one of the most fundamental requirements for access to courts -- standing. PIP lawsuits will flood the courts, which would contravene the legislative intent of the PIP statute.

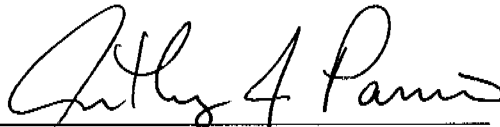
Notably, when it revised the Florida PIP statute, the Florida Legislature found that the statute "is intended to deliver

medically necessary and appropriate medical care quickly and without regard to fault, and *without undue litigation or other associated costs*," and that this intent has been frustrated "at significant cost and harm to consumers by, among other things, fraud, medically inappropriate over-utilization of treatments and diagnostic services, inflated charges, and other practices" described in the Florida Grand Jury "Report on Insurance Fraud Related to Personal Injury Protection." See 2001 Fla. Laws ch. 271, 2001 Fla. SB 1092 (citing Second Interim Report of the Fifteenth Statewide Grand Jury). Reversing the circuit court's decision would only encourage such groundless lawsuits. Accordingly, if this Court reaches the merits of this case, it should affirm the circuit court's decision.

CONCLUSION

For all the foregoing reasons, defendant/respondent, Allstate Indemnity Company, respectfully requests this Court to affirm the Second District Court of Appeal's decision denying certiorari review and, if the Court reaches the merits of this case, to affirm the circuit court's decision upholding summary judgment in Allstate's favor based on plaintiff/petitioner Veron Caravakis' lack of standing.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the above and foregoing "Answer Brief of Defendant/Respondent Allstate Indemnity Company" has been furnished to **TONY GRIFFITH, ESQUIRE**, Tanney, Eno, Tanney, Griffith & Ingram, P.A., 2454 McMullen Booth Road, Building C, Suite 501-A, Clearwater, Florida 33759, and **DAVID B. SHELTON, ESQUIRE**, and **CANDY L. MESSERSMITH**, ESQUIRE, Rumberger, Kirk & Caldwell, Post Office Box 1873, Orlando, Florida 32802-1873 (Counsel for Amicus, National Association of Independent Insurers), by First Class U.S. Mail this 21st day of June, 2002.

ANTHONY J. PARRINO

CERTIFICATE OF COMPLYING WITH FONT REQUIREMENTS

I HEREBY CERTIFY that the foregoing "Answer Brief of Defendant/Respondent Allstate Indemnity Company" has been prepared in Courier New 12-point font as required by Fla. R. App. P. 9.210(a)(2).

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APPENDIX

1. Gloria v. Allstate County Mutual Insurance Company, No. SA-99-CA-676-PM (W.D. Tex. Sept. 29, 2000)

2. Noah v. Government Employees Ins. Co., No. SA-00-CA-018 (W.D. Tex. Apr. 9, 2001)

3. Ny v. Metro. Property & Casualty Ins. Co., 1998 WL 603138, *2-3 (Mass. App. Ct. Sept. 2, 1998)

4. Kinnard v. Allstate Ins. Co., No. 992-00812 (Mo. Cir. Ct. Nov. 15, 1999)

Appendix Part 1

FILED

SEP 29 2000

CLERK, U.S. DISTRICT COURT
WESTERN DISTRICT OF TEXAS
BY ________ DEPUTY CLERK

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

PETER GLORIA and DAVID PEREZ, Plaintiffs, vs. ALLSTATE COUNTY MUTUAL INSURANCE COMPANY and ALLSTATE PROPERTY AND CASUALTY COMPANY, Defendants.	§ § § § § § § § § § §	CIVIL ACTION NO. SA-99-CA-676-FM

ORDER

Pursuant to the consent of the parties in the above-styled and numbered cause of action to trial by the undersigned United States Magistrate Judge and consistent with the authority vested in the United States Magistrate Judges under the provisions of 28 U.S.C. § 636(c)(1) and Appendix C, Rule 1(I) of the Local Rules for the Assignment of Duties to United States Magistrates, in the Western District of Texas, the following order is entered.

I. JURISDICTION

The Court has jurisdiction under 28 U.S.C. §§ 1331 and 1367.

II. PROCEDURAL HISTORY

Plaintiffs Peter Gloria and David Perez commenced this class action in the 57th District Court of Bexar County, Texas against defendant Allstate County Mutual Insurance Company on June 4, 1999, alleging violations under the Racketeering Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. § 1961, et seq., the Texas Insurance Code art. 21.21, and the Texas

64

EXHIBIT C

Deceptive Practices Act ("DTPA") as well as breach of contract and fraud.[1] Because of the RICO claim, defendant removed the case to the District Court on June 25, 1999.[2] Defendant subsequently moved to dismiss the case because plaintiffs lacked standing.[3] Alternatively, defendant moved to transfer the case, under the first-to-file doctrine, to the Circuit Court of Cook County, Illinois, County Department, Chancery Division, where two substantially similar consolidated cases had previously been filed, or to stay the proceeding pending the outcome of a motion for nationwide class certification in the Illinois cases.[4] The parties then filed and the District Court granted a joint motion to stay proceedings until the Illinois cases were resolved.[5] On March 16, 2000, the District Court denied as moot defendant's motion to dismiss or in the alternative to transfer or stay.[6] Upon notice that the proceedings in Illinois had been resolved,[7] the District Court on April 13, 2000, ordered the stay lifted.[8] Defendant then moved for reconsideration of its motion to dismiss and the District Court Clerk received defendant's motion

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[1] Docket no. 1, attachment (Original Complaint).

[2] Docket no. 1.

[3] Docket no. 2.

[4] Id.

[5] Docket nos. 4 and 6.

[6] Docket no. 7.

[7] See docket no. 10, exhibit 1. On March 21, 2000, the Illinois state court denied the motion for nationwide class certification in the consolidated cases, certifying instead only an Illinois class of Allstate insureds alleging essentially the same complaints as are at issue in this case.

[8] Docket no. 9.

to dismiss and/or strike the class allegations.[9] Plaintiffs responded to these motions and defendant replied.[10]

On May 8, 2000, plaintiffs filed their motion to certify a class action and the District Court Clerk received plaintiffs' first amended complaint which added factual allegations in support of their claims and which abandoned the fraud claim.[11] On May 16, 2000, defendant moved to stay the class certification proceedings pending a ruling on the motions to dismiss.[12] The parties stipulated that defendant's motions to dismiss the original complaint would apply to the first amended complaint.[13]

Plaintiffs' second amended complaint was filed on July 7, 2000,[14] and proceedings on defendant's pending motions to dismiss the original and first amended complaints were ordered stayed pending the filing of a motion to dismiss plaintiffs' second amended complaint.[15] The second amended complaint added defendant Allstate Property and Casualty Company[16] and

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[9] Docket nos. 10 and 13, attachment. Defendant's motion to dismiss or to strike the class action was ordered filed on September 9, 2000.

[10] Docket nos. 14, 15, and 19.

[11] Docket nos. 16 and 15, attachment, respectively. Plaintiffs' first amended complaint was ordered filed on September 5, 2000.

[12] Docket no. 20.

[13] Docket no. 24.

[14] Docket no. 29.

[15] Docket no. 28.

[16] The defendants will be referred to collectively as "Allstate."

antitrust claims pursuant to 15 U.S.C. §§ 1 and 13.[17] On August 2, 2000, Allstate moved to dismiss the second amended complaint pursuant to Federal Rule of Civil Procedure 12(b)(1)[18] and 12(b)(6)[19] and to strike or dismiss the class action allegations pursuant to 12(f).[20] Plaintiffs have responded to these motions[21] and Allstate has replied.[22] On September 5, 2000, the Court entered an order which provided that further consideration of plaintiffs' motion to certify a class would not be undertaken until after resolution of the pending motions to dismiss.[23] On September 12, 2000, the parties filed a stipulation stating that Allstate's motions to dismiss the second amended complaint filed on August 2, 2000, are the motions the Court should address and that all motions to dismiss filed prior to August 2 should be considered moot.[24] The stipulation further provides that the, "Parties agree the Sherman antitrust violations alleged are limited to violations of Section 1" and "that the Robinson-Patman Act does not apply."[25]

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[17] Docket no. 29.

[18] Docket no. 34.

[19] Docket no. 32.

[20] Docket no. 36.

[21] These responses and one joint appendix originally were tendered to the Court with a joint motion to seal. On September 22, 2000, the Court entered an order, docket no. 54, which sealed portions of the responses and appendix and required plaintiffs to file redacted copied for the public record "within seven (7) calendar days" of the date of the Order. The Court has reviewed the unredacted copies -- tendered in the sealed record -- in preparing this Order.

[22] Docket nos. 61, 62, 63.

[23] Docket no. 43.

[24] Docket no. 50.

[25] Id. The Sherman antitrust violation alleged is pursuant to 15 U.S.C. § 1. The abandoned claim was an alleged violation of 15 U.S.C. § 13.

In sum, the pleadings for the Court's consideration are plaintiffs' second amended complaint,[26] Allstate's motions to dismiss pursuant to Rules 12(b)(1), 12(b)(6), and 12(f),[27] and plaintiffs' responses.[28] The claims remaining at issue are those alleging violations of RICO; the Sherman antitrust Act, 15 U.S.C. §1; the Texas Insurance Code art. 21.21; and the DTPA; as well as the claim for breach of contract.

III. FACTUAL BACKGROUND

As will be discussed more completely in Section V, when considering motions to dismiss pursuant to FED. R. CIV. P. 12(b)(1) and (6), the Court is required to construe plaintiffs' factual allegations as true. Rule 12(b)(1) and (6) motions admit all well-pleaded facts in the complaint which it challenges.[29] Thus, in the spirit of Rules 12(b)(1) and (6), the Court sets forth the following narration of facts which are taken as true or admitted. The policy at issue provides:

Plaintiffs allege that at times during 1997 and 1998, they were provided personal injury protection ("PIP") and medical payments ("Medpay") coverage under their Texas personal automobile insurance policies issued by Allstate.[30] Allegedly, the PIP and Medpay coverage entitled plaintiffs to payment of the full amount of their medical expenses.[31] However, plaintiffs

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[26] Docket no. 29.

[27] Docket nos. 34, 32, and 36, respectively.

[28] See note 21 above.

[29] Crowe v. Henry, 43 F.3d 198, 203 (5th Cir. 1995); Warfield v. Fidelity & Deposit Co., 904 F.2d 322, 326 (5th Cir. 1990).

[30] Docket no. 29 at 2.

[31] Id.

also allege that the PIP and Medpay provisions provide that the insureds would be paid their "reasonable expenses" incurred for "necessary medical treatment."[32] The policies at issue provide in relevant part that:

> PART B1-MEDICAL PAYMENTS COVERAGE
>
> INSURING AGREEMENT
>
> A. We will pay reasonable expenses incurred for necessary medical and funeral services because of bodily injury:
>
> 1. Caused by accident and
> 2. Sustained by a covered person.
>
> PART B2-PERSONAL INJURY PROTECTION COVERAGE
>
> INSURING AGREEMENT
>
> A. We will pay Personal Injury Protection benefits because of bodily injury:
>
> 1. resulting from a motor vehicle accident and
> 2. sustained by a covered person.
>
> Our payment will only be for losses or expenses incurred within three years from the date of the accident.
>
> B. Personal Injury Protection benefits consist of:
>
> 1. Reasonable expenses incurred for necessary medical and funeral services.[33]

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[32] Id.

[33] Docket no. 29, exhibit, Texas Personal Auto Policy at 314, 316. The Court notes that unless rejected by the insured, the PIP coverage set forth above is required by the Texas Insurance Code which provides:

> "Personal injury protection" consists of provisions of a motor vehicle liability policy which provide for payment to the named insured in the motor vehicle liability policy and members of the insured's household, any authorized operator or passenger of the named insured's motor vehicle including a guest occupant, up to an amount of $2,500 for each such person for payment of all reasonable

The policy also provides that for each of these coverages the "liability shown in the Declarations for this coverage is our maximum limit of liability."[34]

Plaintiffs allege that at various times during 1997 and 1998, they have submitted medical expenses to Allstate for payment under their PIP coverage.[35] According to plaintiffs' allegations, Allstate wrongfully reduced the medical bills to an amount lower than 100% of the expenses actually charged.[36] Allegedly, Allstate accomplished this reduction by using a computerized cost-containment program which included an inaccurate fee schedule to reduce the medical expenses on a systematic basis.[37] Plaintiffs allege that this conduct was designed to reduce the insureds' PIP and Medpay benefits.[38] Allstate allegedly uses an internal fee schedule code (A1 or other similar code) "which is a designation that a medical charge exceeds the reasonable amount for the procedure in the region where the service was provided."[39]

Plaintiffs further allege that Allstate through the use of a computer data base developed by National Biosystems -- also known as ADP Integrated Medical Solutions, Inc. or IMS -- systematically reduces medical charges to "the 85th percentile" without considering the condition

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expenses arising from the accident and incurred within three years from the date thereof[.] TEX. INS. CODE ANN. art. 5.06-3(b) (Vernon 1981).

[34] Id. at 315, 317. The Declarations showing liability limits are not part of the record.

[35] Docket no. 29 at 2.

[36] Id.

[37] Docket no. 29 at 2.

[38] Id.

[39] Id. at 2-3.

or age of the patient or the special certifications or qualifications of the provider.[40] Plaintiffs contend that Allstate has made such reductions without utilizing any relevant or legitimate data with which to compare medical charges in the region where the services were provided and that Allstate does not consider the usual and customary fees of similar medical providers in the geographic area.[41] Plaintiffs allege Allstate has not disclosed that it relies on a third party service for an internal medical fee schedule by which to evaluate the reasonableness of medical charges.[42]

Allstate allegedly refuses to explain the rationale for the reductions and will not disclose its criteria for determining the reductions.[43] According to plaintiffs' allegations, Allstate's position that a charge is not reasonable or customary may be stated in an explanation of benefits or in a letter sent to the insured.[44] One such letter written to plaintiffs' counsel regarding a claim from plaintiff Peter Gloria provides:

> I recently received a medical bill from CRAIG HONER for treatment your client received following the auto accident that occurred on the date shown above. Based on our review of the information submitted, I have sent a check to the health care provider for an amount less than the billed charges along with an Explanation of Benefits. Enclosed is a copy for your records.[45]
>
> Your client's policy provides benefits for reasonable expenses for necessary

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[40] Id. at 3.

[41] Id.

[42] Id.

[43] Id. at 4.

[44] Docket no. 29 at 4.

[45] The Explanation of Benefits is not part of the record.

medical and funeral services because of bodily injury caused by an auto accident. We review all bills to ensure that the treatment and charges meet these criteria. Based on our review of information available to us, not all of the treatment or charges appear to meet these requirements.

> We are committed to the protection of our customers' interests. The provider may seek further review with us should there be disagreement with our evaluation. In the event that we are unable to reach an agreement with the provider, we intend to defend and, if necessary, indemnify our customer up to policy limits against actions that health care providers may take. We will also consider any other appropriate measures to protect our customer should the health care provider decide to pursue collection efforts for the unpaid portion of the bill that is causally related to the accident.[46]

Plaintiffs allege that this letter is an example of Allstate's intentionally vague and deceptive representations and that insureds are deceived into believing that Allstate is complying with the Texas Personal Automobile Policy and the Texas Department of Insurance when it is not.[47]

Plaintiffs contend they believe, to the best of their knowledge as lay persons, that the treatment by their providers and the resulting charges were necessary and reasonable.[48] Plaintiffs further contend that they agreed to compensate their doctors for all medical treatment rendered to them arising out of their accidents and that they are subject to liability for the unpaid balance of their bills.[49] According to plaintiffs' allegations, Allstate's practice of reducing medical charges "interferes and conflicts with the physician-patient relationship and places the patient in a tug-of-war between the insurance company and the medical provider."[50] Allegedly, Allstate's practice

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[46] Docket no. 29, exhibit letter from Veronica McCullough.

[47] Id. at 5.

[48] Docket no. 29 at 5.

[49] Id.

[50] Id.

also causes Texas insureds to be subject to credit damage.[31]

Specifically, plaintiffs allege that plaintiff Gloria presented Allstate with allegedly reasonable medical charges of $5,849.50 and that Allstate allegedly reduced these charges by $334.40.[32] Gloria admits that he received from Allstate the full PIP coverage of $2,500.[33] Plaintiffs also contend that plaintiff Perez presented Allstate with allegedly reasonable medical charges of $2,241.00 and that Allstate allegedly reduced these charges by $65.[34] Plaintiffs allege that Allstate reduced the presented medical charges because the amounts were unreasonably high for plaintiffs' geographical region which Allstate did not identify.[35]

Plaintiffs have brought this class action, individually and on behalf of all similarly situated Allstate insureds, alleging that Allstate systematically, wrongfully, and improperly reduced medical bills for services provided to the insureds covered under the PIP and Med-Pay provisions of their personal automobile insurance policies.[36] As stated above plaintiffs federal claims allege violations of RICO and of the Sherman antitrust Act; their state claims allege violations of Texas Insurance Code and the DTPA as well as breach of contract.

Allstate has moved to dismiss pursuant to Rule 12(b)(1) arguing that the Court lacks

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[31] Id.

[32] Docket no. 29 at 8.

[33] Id.

[34] Id.

[35] Id.

[36] Docket no. 29 at 1.

jurisdiction because plaintiffs have no standing to bring their claims.[57] In addition, Allstate has moved to dismiss plaintiffs' antitrust claim pursuant to Rule 12(b)(6) arguing that plaintiff has failed to state a claim against Allstate for antitrust violations.[58] Finally, Allstate has moved to strike or dismiss plaintiffs' class action allegations pursuant to Rule 12(f) arguing that plaintiffs' claims are "inherently unsuitable" for a class action.[59]

IV. ISSUES

1. Whether plaintiffs have standing to assert their claims.

2. Whether plaintiffs have state a cause of action for antitrust violations.

3. Whether plaintiffs allegations are inherently unsuitable for class action treatment.

V. STANDARDS FOR MOTIONS TO DISMISS

A. Fed. R. Civ. P. 12(b)(1)

Motions filed under Rule 12(b)(1) of the Federal Rules of Civil Procedure permit a party to challenge the subject matter jurisdiction of the district court to hear a case.[60] Lack of subject matter jurisdiction may be found in one of three instances: "(1) the complaint alone; (2) the complaint supplemented by undisputed facts evidenced in the record; or (3) the complaint supplemented by undisputed facts plus the court's resolution of disputed facts."[61] The burden of

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[57] Docket no. 34.

[58] Docket no. 32.

[59] Docket nos. 36 and 37.

[60] FED.R.CIV.P. 12(b)(1).

[61] Williamson v. Tucker, 645 F.2d 404, 413 (5th Cir.), cert. denied 454 U.S. 897 (1981); see Barrera-Montenegro v. United States, 74 F.3d 657, 659 (5th Cir. 1996).

proof for a Rule 12(b)(1) motion to dismiss is on the party asserting jurisdiction.[62] Accordingly, the plaintiff constantly bears the burden of proof that jurisdiction does in fact exist.[63]

A facial attack on subject matter jurisdiction requires the court to decide if the plaintiff has correctly alleged a basis for subject matter jurisdiction.[64] Such an attack is valid if from the face of the pleadings, the court can determine it lacks subject matter jurisdiction.[65] In examining a Rule 12(b)(1) motion, the district court is also empowered to consider undisputed matters of fact reflected in the record.[66] Ultimately, a motion to dismiss for lack of subject matter jurisdiction should be granted only if it appears certain that the plaintiff cannot prove any set of facts in support of his or her claim that would entitle him or her to relief.[67] "A case is properly dismissed for lack of subject matter jurisdiction when the court lacks the statutory or constitutional power to adjudicate the case."[68]

When a Rule 12(b)(1) motion is filed with a Rule 12(b)(6) motion, the court should always consider the Rule 12(b)(1) jurisdictional attack before addressing any attack on the

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[62] McDaniel v. United States, 899 F.Supp. 305, 307 (E.D. Tex. 1995), aff'd, 102 F.3d 551 (5th Cir. 1996).

[63] Menchaca v. Chrysler Credit Corp., 613 F.2d 507, 511 (5th Cir.), cert. denied 449 U.S. 953 (1980).

[64] Venture I, Inc. v. Orange County, Tex., 947 F.Supp. 271, 276 n. 7 (E.D. Tex. 1996).

[65] Id.

[66] Williamson, 645 F.2d at 413.

[67] Home Builders Ass'n of Miss., Inc. v. City of Madison, Miss., 143 F.3d 1006, 1010 (5th Cir. 1998).

[68] Id. (quoting Nowak v. Ironworkers Local 6 Pension Fund, 81 F.3d 1182, 1187 (2d Cir. 1996)).

merits.[69] This requirement prevents a court without jurisdiction from prematurely dismissing a case with prejudice. The court's dismissal of a plaintiff's case because the court lacks subject matter jurisdiction is not a determination of the merits and does not prevent the plaintiff from pursuing a claim in a court that does have proper jurisdiction.[70] A motion to dismiss pursuant to Rule 12(b)(1) is analyzed under the same standard as a motion to dismiss under Rule 12(b)(6).[71]

B. Fed. R. Civ. P. 12(b)(6)

Under Rule 12(b)(6), Fed. R. Civ. P., plaintiff must state a claim upon which relief can be granted or the complaint may be dismissed with prejudice as a matter of law. A motion to dismiss under Rule 12(b)(6) "is viewed with disfavor and is rarely granted."[72] When considering a motion to dismiss for failure to state a claim, all factual allegations in the complaint must be taken as true and construed favorably to the plaintiff.[73] The United States Supreme Court has elaborated:

Nothing in Rule 12(b)(6) confines its sweep to claims of law which are obviously

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[69] Hitt v. Pasadena, 561 F.2d 606, 608 (5th Cir. 1977) (per curiam).

[70] Id.

[71] Home Builders Ass'n of Miss., 143 F.3d at 1010.

[72] Kaiser Aluminum & Chem. Sales, Inc. v. Avondale, 677 F.2d 1045, 1050 (5th Cir.), cert. denied, 459 U.S. 1105, 103 S.Ct. 729 (1982) (quoted in Capital Parks, Inc. v. Southeastern Advertising & Sales Sys., Inc., 864 F.Supp. 14, 15 (W.D. Tex. 1993), affirmed, 30 F.3d 627 (5th Cir. 1994)).

[73] Fernandez-Montez v. Allied Pilots Assoc., 987 F.2d 278, 284 (5th Cir. 1993). See Capital Parks, Inc., 30 F.3d at 629 ("A court's decision to dismiss for failure to state a claim may be upheld 'only if it appears that no relief could be granted under any set of facts that could be proven consistent with the allegations.' Baton Rouge Bldg. & Constr. Trades Council AFL-CIO v. Jacobs Constructors, Inc., 804 F.2d 879, 881 (5th Cir. 1986).") See also O'Quinn v. Manuel, 773 F.2d 605, 608 (5th Cir. 1985).

> insupportable. On the contrary, if as a matter of law "it is clear that no relief could be proved consistent with the allegations," a claim must be dismissed, without regard to whether it is based on an outlandish legal theory or on a close but ultimately unavailing one.[74]

A complaint should not be dismissed for failure to state a claim unless it appears beyond doubt the plaintiff can prove no set of facts in support of his claim which would entitle him to relief.[75] Conclusory allegations or legal conclusions masquerading as factual conclusions will not suffice to prevent a motion to dismiss.[76] This is a rigorous standard, but subsumed within it is the requirement that a plaintiff state its case with enough clarity to enable the court and the opposing party to determine whether a claim is alleged.[77]

C. Fed. R. Civ. P. 12(f)

Rule 12(f) provides that a party may move to have stricken from pleadings "any insufficient defense or any redundant, immaterial, impertinent, or scandalous matter."[78] As with other Rule 12 motions to dismiss, a Rule 12(f) motion to strike is generally disfavored.[79] When considering a Rule 12(f) motion to strike, the Court construes all factual allegations opposed as

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[74] Neitzke v. Williams, 490 U.S. 319, 327, 109 S. Ct. 1827, 2232 (1989) (quoting Hishon v. King & Spalding, 467 U.S. 69, 73, 104 S. Ct. 2229, 2232 (1984)).

[75] Conley, 355 U.S. at 45-46, 78 S.Ct. at 102.

[76] Jefferson v. Lead Indus. Ass'n, Inc., 106 F.3d 1245, 1250 (5th Cir. 1997); Tuchman v. DSC Communications Corp., 14 F.3d 1061, 1067 (5th Cir. 1994); Fernandez-Montes, 987 F.2d at 284.

[77] Elliott v. Foufas, 867 F.2d 877, 880 (5th Cir. 1989).

[78] FED. R. CIV. P. 12(f).

[79] Kaiser Aluminum, 677 F.2d at 1057.

true.[50]

V. ARGUMENTS AND CONCLUSIONS OF LAW

A. Plaintiffs' standing to bring their federal claims

Plaintiffs have alleged that Allstate violated 18 U.S.C. § 1962(c) by unlawfully participating in an association-in-fact enterprise with IMS through a pattern of racketeering activity in the form of mail and wire fraud, subjecting plaintiffs to liability for unpaid medical bills.[51] Plaintiffs also allege that Allstate violated the antitrust laws, specifically 15 U.S.C. § 1, by conspiring and/or contracting with IMS to illegally fix or restrain the amounts Allstate would pay as reimbursement for health care expenses incurred by its insureds.[52] Relying on Rule 12(b)(1), Defendants have moved to dismiss the RICO and Sherman antitrust claims arguing that plaintiffs failed to invoke the Court's jurisdiction because they lack standing to bring their claims. In particular, Allstate argues that plaintiffs have not alleged any actual or threatened injury resulting from Allstate's alleged conduct.

Standing is jurisdictional under Article III of the Constitution, and plaintiffs lacking standing may not litigate their claims in federal court.[53] The constitutional minimum of standing includes three elements: (1) an injury-in-fact; (2) a causal connection between the injury and the conduct complained of; and (3) the likelihood that the injury will be redressed by a favorable

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[50] See id at 1047, 1060.

[51] Docket no. 29 at 15-17.

[52] Docket no. 29 at 13-15.

[53] Meadowbriar Home for Children v. Gunn, 81 F.3d 521, 529 (5th Cir. 1996).

decision.[84] The party invoking federal jurisdiction bears the burden of establishing these elements.[85] "The litigant must clearly and specifically set forth facts sufficient to satisfy these Article III standing requirements."[86] Each element should be supported in the same manner as any other matter on which the plaintiff has the burden of proof.[87] Thus, "[a]t the pleading stage, general factual allegations of injury resulting from defendant's conduct may suffice, for on a motion to dismiss we 'presume that general allegations embrace those specific facts that are necessary to support the claim.'"[88] However, dismissal is appropriate at the pleadings stage "if the complaint itself shows a bar to relief -- when this happens it is 'beyond doubt' that no set of facts will allow plaintiff to prevail."[89]

"Injury-in-fact" is an invasion of a legal right that is "(a) concrete and particularized, and (b) actual or imminent, not 'conjectural' or 'hypothetical.'"[90] "Particularized" means the injury affects the plaintiff in an individual and personal way.[91] "Allegations of possible future injury do not satisfy the standing requirement of Article III. A threatened injury must be 'certainly

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[84] Lujan v. Defenders of Wildlife, 504 U.S. 555, 560, 112 S.Ct. 2130, 2136 (1992).

[85] Lujan, 504 U.S. at 561, 112 S.Ct. at 2136.

[86] Whitmore v. Arkansas, 495 U.S. 149,155, 110 S.Ct. 1717, 1723 (1990).

[87] Id.

[88] Lujan, 504 U.S. at 561, 112 S.Ct. at 2137 (quoting Lujan v. National Wildlife Federation, 497 U.S. 871, 889, 110 S.Ct. 3177, 3189 (1990)).

[89] Mahone v. Addicks Util. Dist. of Harris County, 836 F.2d 921, 926 (5th Cir. 1988) (citing Clark v. Amoco Prod. Co., 794 F.2d 967, 970 (5th Cir. 1986)).

[90] Lujan, 504 U.S. at 560, 112 S.Ct. at 2136.

[91] Id., 504 U.S. at 561 n.1, 112 S.Ct. at 2136 n.1.

impending' to constitute injury-in-fact."[72]

Even accepting plaintiffs' allegations in the second amended complaint as true, the Court concludes that plaintiffs have failed to state an injury-in-fact. Plaintiffs contend that because of Allstate's allegedly illegal RICO conduct, plaintiffs "have suffered damages and liability to the extent of their unpaid bills plus interest."[73] Plaintiffs also have pleaded that they "are subject to legal liability for the unpaid balance of their bills."[74] What plaintiffs have pleaded is the possibility that at some time in the future their "property" will be injured by Allstate's determination of reasonable medical expenses.[75] That the harm is not imminent or actual is

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[72] Whitmore, 495 U.S. at 158, 110 S.Ct. at 1724-25 (quoting Babbitt v. Farm Workers, 442 U.S. 289, 298, 99 S.Ct. 2301, 2308-09 (1979) (citations omitted)). To have standing under Sherman antitrust and RICO laws, a private plaintiff must be "injured in his business or property." 15 U.S.C. § 15(a) (1997); 18 U.S.C. § 1964(c) (2000). Under the Sherman antitrust laws, a private plaintiff must also establish that the injury is an antitrust injury. Doctor's Hosp. of Jefferson, Inc. v. Southeast Medical Alliance, 123 F.3d 301, 305 (5th Cir. 1997.

[73] Docket no. 29 at 16.

[74] Docket no. 29 at 5.

[75] The parties have cited several state court decisions in support of their arguments. LaMothe v. Auto Club Ins. Ass'n, 543 N.W.2d 42, 44 (Mich. App. Ct. 1995, pet. denied) and McGill v. Automobile Ass'n of Mich., 526 N.W.2d 12, 14 (Mich. App. Ct. 1994), cited by Allstate, support the conclusions reached here. In each of these cases, the insurance company reduced the medical charges to what the company determined was a reasonable rate and agreed to defend, indemnify, and/or protect the insureds from future liability because of the reductions. The Michigan Appeals Court found that because the plaintiffs failed to assert factual allegations of actual or threatened injury, they failed to plead a case or controversy. Plaintiffs rely on Purin v. Allstate, 672 N.E.2d 353, 356 (Ill. App. Ct. 1996, pet. denied) in which the Illinois Appeals Court reversed a finding that the insureds lacked standing. The court concluded the insureds did not have to wait for lawsuits to be filed or collection attempts to be made before there was injury-in-fact. However, the Illinois state law action in Purin is factually distinct from the case at issue because Purin alleged that he paid the balance not paid by Allstate. Id. at 354. In addition, a health care provider, who was not paid the full amount charge for the services provided, was included as a plaintiff. Id.

particularly obvious in light of plaintiffs' allegations that Allstate's allegedly illegal conduct occurred in 1997 and 1998 and, even though the fact that plaintiffs' twice amended their complaint, the amended complaint contains essentially the same general allegations regarding possible injury as the original complaint filed in June 1999. There are no allegations that a health care provider who was not fully reimbursed by Allstate has challenged the determination of what are reasonable expenses, billed plaintiffs for balance, threatened to sue for the balance, or threatened to resort to a collection agency for payment of the balance. Moreover, plaintiffs do not allege that Allstate has failed to fulfill its promise to defend and indemnify plaintiffs in the event of any legal action brought against them or that Allstate failed to protect plaintiffs from collection attempts. As to plaintiff Gloria, the Court is particularly puzzled by the apparent lack of injury. It appears from the second amended complaint that, in addition to making assurances to defend, Allstate paid Gloria the maximum PIP benefits due under the policy. Even if Gloria were correct that Allstate's method of calculating payment is incorrect, Gloria's PIP benefits would still not exceed $2,500. In sum, because plaintiffs have alleged speculative rather than actual or threatened liability for the unpaid balance of their medical bills, plaintiffs lack standing to bring their RICO claims.[96]

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[96] See Price v. Pinnacle Brands, Inc., 138 F.3d 602, 606 (5th Cir. 1998) (because pleadings failed to show tangible financial loss to plaintiffs, "plaintiffs' conclusional allegations, unaccompanied by assertions of even general fact to show injury, fail to satisfy the RICO standing requirement); In Re Taxable Mun. Bond Sec. Litig., 51 F.3d 518, 522 (5th Cir. 1995) (no standing because plaintiff failed to establish eligibility for loan program); see also Maio v. Aetna, Inc., 221 F.3d 472, 475 (3rd Cir. 2000) (no RICO injury when "predicated exclusively on the possibility that future events might occur, rather than on the actual occurrence of those events and their present effect on the value of the health care insurance appellants received"); Mira v. Nuclear Measurements Corp., 107 F.3d 466, 474 (7th Cir. 1997) ("plaintiffs have failed to establish that they or the plan suffered an injury (i.e., economic loss) as a result of the defendant's conduct).

As to plaintiffs' antitrust claims, plaintiffs allege that Allstate's conduct limited reimbursement that would be paid for covered medical services, limited the type of medical services that would be covered, and discouraged insureds from seeking needed medical services that were unaffordable other than through the insurance policy with Allstate.[97] With respect to limiting reimbursement to reasonable charge for necessary medical services, the foregoing discussion of plaintiffs' failure to allege injury-in-fact in their RICO claim applies as well to the antitrust claim. Plaintiffs have not alleged that they suffered an actual or threatened injury because of Allstate's limited reimbursement of medical charges. With respect to plaintiffs' other alleged antitrust injuries -- limiting medical services and discouraging insureds from seeking needed medical service -- plaintiffs generally allege only that Allstate's conduct "interferes and conflicts with the physician-patient relationship and places the patient in a tug-of war between the insurance company and the medical provider."[98] There are no specific factual allegations suggesting that either plaintiff received limited medical services, did not seek medical services, or suffered any conflict or interference in a relationship with their health care provider because of Allstate's conduct. Thus, plaintiffs have failed to allege an actual or threatened injury that would entitle them to bring a Sherman antitrust claim against Allstate.

In sum, plaintiffs have failed to state an injury-in-fact. Although plaintiffs generally allege that they have been injured and suffered damages, their supporting allegations which describe the injury and harm set forth a possible injury they could suffer in the future and not a

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[97] Docket no. 29 at 14.

[98] Id. at 5.

"certainly impending" injury or an actual injury already suffered."[99] Therefore, Allstate's Rule 12(b)(1) motion to dismiss for lack of subject matter jurisdiction is granted, and plaintiffs' federal RICO and Sherman antitrust claims are dismissed.

B. Have plaintiffs stated a Sherman antitrust claim

Allstate has moved to dismiss plaintiffs' Sherman antitrust claim pursuant to Rule 12(b)(6).[100] In particular, Allstate argues that plaintiffs have failed to state an antitrust injury, an essential element of an antitrust claim.[101]

To pursue an antitrust claim, plaintiff must show: "(1) injury in fact, an injury to the plaintiff proximately caused by the defendant's conduct; (2) antitrust injury; and (3) proper plaintiff status, which assures that other parties are not better situated to bring suit."[102] An antitrust injury is an

> injury of the type the antitrust laws were intended to prevent and that flows from that which makes the defendants' acts unlawful. The injury should reflect the anticompetitive effect either of the violation or the anticompetitive acts made possible by the violation. It should in short be "the type of loss that the claimed

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[99] See Lewis v. Casey, 518 U.S. 343, 357, 116 S.Ct. 2174, 2183 (1996) ("That a suit may be a class action ... adds nothing to the question of standing, for even named plaintiffs who represent a class 'must allege and show that they personally have been injured, not that injury has been suffered by other, unidentified members of the class to which they belong and which they purport to represent.'" Citing Simon v. Eastern Ky. Welfare Rights Org., 426 U.S. 26, 40, n. 20, 96 S.Ct. 1917, 1925, n. 20 (1976), quoting Warth v. Seldin, 422 U.S. 490, 502, 95 S.Ct. 2197, 2207 (1975)).

[100] Docket no. 32.

[101] Docket no. 33 at 2-4.

[102] Doctor's Hosp., 123 F.3d at, 305.

violations . . . would be likely to cause."[103]

The Supreme Court in Blue Shield of Virginia v. McCready,[104] discussed allegations that set forth a private cause of action for antitrust violations. The Court explained

> McCready charges Blue Shield with a purposefully anticompetitive scheme. She seeks to recover as damages the sums lost to her as the consequence of Blue Shield's attempt to pursue that scheme. She alleges that Blue Shield sought to induce its subscribers into selecting psychiatrists over psychologists for the psychotherapeutic services they required, and that the heart of its scheme was the offer of a Hobson's choice to the subscribers. Those subscribers were compelled to choose between visiting a psychologist and forfeiting reimbursement, or receiving reimbursement by forgoing treatment by the practitioner of their choice.[105]

The Court further noted that "[a]lthough McCready was not a competitor of the conspirators, the injury she suffered was inextricably intertwined with the injury the conspirators sought to inflict on psychologists and the psychotherapy market."[106]

Assuming for argument's sake that plaintiffs have alleged injury from Allstate's conduct, plaintiffs have not alleged any anticompetitive effect of Allstate's acts or how any anticompetitive acts were made possible by Allstate's conduct. As stated above Plaintiffs' allege that Allstate's conspiracy and/or contract with DMS was a scheme to fix or restrain the amount of reimbursement due for medical services, limit the type of medical services, and discourage the use of needed medical services. These allegations do not specify any specific market that

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[103] Brunswick Corp. v. Pueblo Bowl-O-Mat Inc., 429 U.S. 477, 489, 97 S.Ct. 690, 697 (1977) (quoting Zenith Radio Corp. v. Hazeltine Research, Inc., 395 U.S. 100, 125, 89 S.Ct. 1562, 1577 (1969)) (emphasis added).

[104] 457 U.S. 465, 483, 102 S.Ct. 2540, 2550 (1982).

[105] Id.

[106] McCready, 457 U.S. at 484, 102 S.Ct. at 2551.

Allstate targeted for injury by its relationship with IMS or that plaintiffs were in someway injured by any anticompetitive acts targeted at some market. Plaintiffs do not allege that they were required to forego treatment by any specific health care provider in favor of another. Their allegations merely state that Allstate reviewed their medical expenses and reduced them to what Allstate determined was a reasonable rate. If a health care provider concluded that Allstate's decision was incorrect, it would be free to pursue collection efforts against the policy holder — which Allstate would then defend — or against Allstate directly. Plaintiffs have not alleged either has occurred.

Therefore, because plaintiffs failed to allege an antitrust injury, they have not stated a cause of action under the Sherman Antitrust Act. Allstate's Rule 12(b)(6) motion to dismiss is granted and plaintiffs' Sherman antitrust claim is dismissed.

C. Should plaintiffs' class action allegations related to federal claims be stricken

Defendants have moved under Rule 12(f) to strike plaintiffs' class action allegations arguing that plaintiffs have not pleaded facts sufficient to demonstrate that the prerequisites of Federal Rule of Civil Procedure 23 are met.[197] Rule 23 requires that the representatives must suffer the same injuries as the class members they seek to represent.[198] Because plaintiffs allege only that they wish to represent other similar to them and in light of the Court's conclusion that plaintiffs lack standing to bring the federal claims because they have not alleged injury-in-fact, the proposed class would appear to lack standing as well since "similar" class members would

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[197] Docket nos. 36 and 37 at 2.

[198] Amchem Prod., Inc. v. Windsor, 521 U.S. 591, 625-26, 117 S.Ct. 2231, 2251 (1997) (quoting East Tex. Motor Freight Sys., Inc. v. Rodriguez, 431 U.S. 395, 403, 97 S.Ct. 1891, 1896 (1977)).

not have suffered actual injury.

Conclusory class allegations, such as those pleaded by plaintiffs here, have been deemed suitable for dismissal early in the case.[109] When plaintiffs' allegations are analyzed in light of the prerequisites of Rule 23, plaintiffs have not alleged common issues that predominate. Instead, issues such as whether a particular provider's charge was reasonable and/or necessary for a particular treatment for a particular injury in a particular location must be determined on an individualized basis. Each putative plaintiff would be required to prove entitlement to benefits under the terms of the policy[110] and that the medical expenses were reasonable and the services were necessary.[111] Moreover, even if plaintiffs prove the computerized evaluation of the PIP claims was flawed the parties and the Court still will need to analyze each charge on every claim for reasonableness and necessity. Finally, courts have found that class actions are not appropriate in antitrust or RICO cases when individualized questions of injury predominate.[112]

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[109] See In Re Am. Med. Sys., Inc., 75 F.3d 1069, 1079 (6th Cir. 1996) ("Mere repetition of the language of Rule 23(a) is not sufficient. There must be an adequate statement of the basic fact to indicate that each requirement of the rule is fulfilled."); Cook County College Teachers Union v. Byrd, 456 F.2d 882, 885 (7th Cir.) ("[The Union] was obliged in its complaint to allege facts bringing the action within the appropriate requirements of the Rule"), cert. denied, 409 U.S. 848 (1972); Minority Police Officers Ass'n v. city of South Bend, 555 F.Supp. 921, 924 (N.D. Ind.) ("Specific facts must be alleged sufficient to meet the requirements of the rule, as mere repetition of the rule or loosely defined classwide allegations are insufficient"), aff'd in part, appeal dismissed on other grounds, 721 F.2d 197 (7th Cir. 1983); see also Doctor v. Seaboard Coast Line R.R. Co., 540 F.2d 699, 706-10 (4th Cir. 1976) (denying class certification because plaintiff provided no facts about the existence of alleged class).

[110] Western Alliance Ins. Co. v. Northern Ins. Co., 176 F.3d 825, 828 (5th Cir. 1999).

[111] TEX.INS.CODE art. 5.06-3(b).

[112] See Alabama v. Blue Bird Body, 573 F.2d 309, 327-28 (5th Cir. 1978) (fact that each putative plaintiff had to prove conspiracy in particular geographical area and payment of "supracompetive" price which depended on quality and price of bus precluded antitrust class

In sum, plaintiffs are not adequate class representative because they lack standing and have no cause of action. In addition, their class allegations do not allege facts suggesting that common issues, other than Allstate's allegedly flawed computerized reductions in medical expenses, predominate. Therefore, to the extent the Court has jurisdiction to address plaintiffs' class allegations, when plaintiffs' lack of standing -- and when the purported class would appear to lack standing as well -- Allstate's motion to strike the class allegations is granted as to the federal claims and the class allegations as to the federal claims are stricken.

VI. STATE CLAIMS

Having determined that the Court lacks jurisdiction over plaintiffs' federal claims because plaintiffs lack standing to bring them, the Court must now determine how to dispose of plaintiffs' state law claims. The 28 U.S.C. §1367 provides:

> [I]n any civil action of which the district courts have original jurisdiction, the district courts shall have supplemental jurisdiction over all other claims that are so related to claims in the action within such original jurisdiction that the form part of the same case or controversy under Article III of the United States Constitution.[113]

In this case, the Court dismisses plaintiffs' federal claims for lack of standing, requisite of

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action); Windham v. American Brands, Inc., 565 F.2d 59, 65 (4th Cir. 1977) (crux of antitrust action "is injury, individual injury. While a case may present a common question of violation, the issues of injury and damage remain the critical issues in such a case and are always strictly individualized."), cert. denied, 435 U.S. 968 (1978); In Re Beef Indust. Antitrust Litig., 1986 WL 8890, at * 1 (S. D. Tex. June 3, 1986) ("critical issues of injury and damage are inherently individualized" unless subject to mechanical or formula calculation); Abernathy v. Bausch & Lomb, Inc., 97 F.R.D. 470, 474-75 (N.D. Tex. 1983) (because proof of actual anticompetitive injury in private antitrust cases is highly individualistic, courts generally find antitrust " claims ill-suited for maintenance as class actions") (citations omitted); Kahler v. Firstplus Fin. Inc., 248 B.R. 60, 77 (Bankr. N. D. Tex. 2000) (RICO class action not proper because "each member would have to prove legal causation").

[113] 28 U.S.C. 1367(a).

jurisdiction under Article III. Therefore, because the Court did not have original jurisdiction over plaintiffs' federal claims , it may not exercise the supplemental jurisdiction provided by section 1367. Thus, plaintiffs' state claims, including the allegations for a state class action, under the Texas Insurance Code article 21.21 and the DTPA as well as the claim for breach of contract are dismissed without prejudice to filing in state court.

VII. CONCLUSION

Because plaintiffs lack standing to bring their federal claims such that the Court lacks jurisdiction, Allstate's Rule 12(b)(1) motion[114] is GRANTED and plaintiffs' RICO and Sherman antitrust claims are DISMISSED. Assuming that plaintiffs' second amended complaint alleges injury and standing, Allstate's Rule 12(b)(6) motion to dismiss plaintiffs' Sherman antitrust claim[115] is GRANTED on the ground that plaintiffs have failed to state a claim upon which relief may be granted and their antitrust claim is DISMISSED. As plaintiffs have failed to adequately allege the prerequisites of a federal class action, Allstate's Rule 12(f) motion to strike the federal class action allegations[116] is GRANTED and plaintiffs' class action allegations related to RICO and Sherman antitrust violations are STRICKEN. In light of the Court's disposition of plaintiffs' federal class action allegations, plaintiffs' motion to certify a class action[117] are DISMISSED as moot.

Because no federal claim remains in this lawsuit, plaintiffs' state claims under the Texas

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[114] Docket no. 34.

[115] Docket no. 32.

[116] Docket no. 36.

[117] Docket no. 16.

Insurance Code article 21.21 and the DTPA as well as the claims for breach of contract are DISMISSED without prejudice to re-filing in state court, as may be permitted by state law and procedure. Plaintiffs' class action allegations related to the state claims are also DISMISSED without prejudice to re-filing in state court.

The Clerk shall enter judgment accordingly and providing that each side shall bear its own costs.

IT IS SO ORDERED.

SIGNED and ENTERED this 29 day of September, 2000.

Pamela A. Mathy
United States Magistrate Judge

APPENDIX PART 2

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

FILED
APR 09 2001
CLERK, U.S. DISTRICT COURT
WESTERN DISTRICT OF TEXAS
BY ________ DEPUTY CLERK

CECIL NOAH and BETH NOAH, §
§
Plaintiffs, §
§
v. § SA 00-CA-018 WWJ
§
GOVERNMENT EMPLOYEES §
INSURANCE COMPANY, §
§
Defendant. §

ORDER

On December 19, 2000, Defendant's Motion to Dismiss for Plaintiff's Lack of Standing, Rule 9(b) for Failure to Plead with Particularity, and Rule 12(b)(6) for Failure to State a Claim and Brief in Support was filed in the above-entitled and numbered civil action (Doc. No. 81). Pursuant to order of the court, an oral hearing was scheduled, and both parties were ordered to brief the court on the motion to dismiss. Accordingly, on February 6, 2001, defendant filed its Supplemental Brief in Support of its Motion to Dismiss (Doc. No. 89), and on February 7, 2001, plaintiffs filed their Opposition to Defendant's Motion to Dismiss for Lack of Standing (Doc. No. 90). On February 22, 2001, the court heard oral argument from each side regarding the motion to dismiss. Upon careful consideration of the pleadings, oral argument, and applicable authorities, the defendant's Motion to Dismiss will be **GRANTED**, on the ground that the plaintiffs lack standing to assert their claims against the defendant.

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Factual Summary

During 1999, the plaintiffs, Cecil and Beth Noah, were provided Personal Injury Protection ("PIP") coverage under an automobile insurance policy issued by the defendant, Government Employees Insurance Company ("GEICO"). Benefits provided by the plaintiffs' PIP coverage included "[r]easonable expenses incurred for necessary medical ... services." Defendant's Appendix, Exh. H (Plaintiffs' insurance policy). During 1999, the plaintiffs were treated by medical providers for injuries sustained arising out an automobile accident that took place on May 15, 1999. At least some of this treatment was covered by the PIP portion of their automobile insurance policy. In particular, treatment of both plaintiffs, administered by Michelle Berry, D.O., was covered. In addition, treatment of Cecil Noah, administered by the Therapeutic Massage Clinic, was covered.

It is the treatment with respect to these two health care providers that gives rise to this civil action. The plaintiffs visited Dr. Berry on several occasions, accumulating a total of $1,001.00 in charges, of which GEICO paid $910.00. Beth Noah visited the Therapeutic Massage Clinic on six occasions, accumulating a total of $846.00 in charges, of which GEICO paid $821.00.

GEICO did not pay the full amount of the medical expenses charged by Dr. Berry and the Therapeutic Massage Clinic on the advice of Medata, an independent company that GEICO consults regarding the reasonableness of medical bills. Medata owns a current cost and medical utilization database that it uses to help insurance companies determine whether charges for medical services are objectively reasonable. GEICO submitted the plaintiffs' above-described medical bills to Medata for the purpose of having GEICO determine the reasonableness of the

care providers' charges. Medata concluded that the amounts charged by the plaintiffs' medical providers exceeded the amounts that were reasonable when compared to the charges of other providers within the same geographic area. Medata concluded that the plaintiffs' reasonable and necessary expenses were limited to the amounts that GEICO ultimately paid.

In addition to simply reviewing the plaintiffs' medical records, Medata also added the plaintiffs' medical bill information to its database. The information that Medata inputted was the claim number of the patient, the medical provider's tax identification number, the provider's name, the provider's address, the date of service, the procedure code, the provider's charge, and the provider's type.

When GEICO made its adjustments to the care providers' medical bills, it issued letters to the care providers indicating that adjustments had been made, and it indicated its reasons for so doing. GEICO indicated that the payments issued were to be considered full payment, and that the providers were to contact GEICO if they had a dispute over the adjustment made to the provider's charges.

It is undisputed that Dr. Berry accepted GEICO's payment as full payment for the medical services provided by the plaintiffs. It is disputed, however, whether the Therapeutic Massage Clinic accepted GEICO's reduced payment as full payment. The owner of the Therapeutic Massage Clinic has indicated that his clinic accepted GEICO's payment as full payment on Beth Noah's account. However, Beth Noah has given testimony that she received a bill from the Therapeutic Massage Clinic for twenty-five dollars, representing the balance unpaid by GEICO. Beth Noah paid twenty-five dollars to the Therapeutic Massage Clinic on March 6, 2000.

The plaintiffs filed this lawsuit in state court on December 7, 1999, and it was removed to federal court on January 6, 2000. The lawsuit challenges GEICO's practice of utilizing the services of Medata, and it also challenges GEICO's practice of adjusting the bills of medical providers.

LEGAL STANDARD

The defendant's motion is styled as a Motion to Dismiss. However, each party has presented matters outside the pleadings, which have been accepted by the court, and the hearing on the Motion to Dismiss was delayed for the specific purpose of allowing the parties to collect and present evidence of the type that is admissible on summary judgment. Accordingly, the defendant's Motion to Dismiss as it relates to the alleged lack of standing will be treated as if it were a Rule 56 motion for summary judgment. *See* FED. R. CIV. P. 12(b), (c).

Article III of the Constitution limits federal jurisdiction to "Cases" and "Controversies." U.S. CONST. art. III, § 2, cl.1. One core part of this limitation is that a party invoking the jurisdiction of a federal court must have standing to bring that suit. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-1 (1992). To satisfy this standing requirement, a plaintiff must show (1) that he or she has suffered an actual or imminent injury that is concrete and particularized; (2) that the injury is fairly traceable to the defendant's action; and (3) that the injury will likely be redressed if the plaintiffs prevail in the lawsuit. *See id.* The standing requirements must be satisfied at the time the lawsuit is commenced. *See Pederson v. Louisiana State Univ.*, 213 F.3d 858, 869 (5th Cir. 2000). If the standing requirements are not satisfied, then the exercise of power by a federal court would be "gratuitous and thus inconsistent with constitutional

limitations," and in such a circumstance, the suit should be dismissed for want of jurisdiction. *Gabrielsen v. BancTexas Group, Inc.*, 675 F. Supp. 367, 371 (N.D. Tex. 1987) (citing *Simon v. Eastern Kentucky Welfare Rights Org.*, 426 U.S. 26, 38-9 (1976)).

In response to a summary judgment motion, dismissal of a plaintiff's claim for lack of standing is proper unless the plaintiff can "set forth by affidavit or other evidence," specific facts that support each element required to establish standing. *Lujan*, 504 U.S. at 561. If it is shown that there is no genuine issue of material fact disputing the plaintiff's failure to fulfill one of the standing requirements, the defendant can succeed in summary judgment proceedings in having the plaintiff's complaint dismissed for lack of standing. *See Barrett Computer Serv., Inc. v. PDA, Inc.*, 884 F.2d 214, 219 (5th Cir. 1989). When assessing a motion for summary judgment, the court must make all factual inferences in favor of the party opposing the motion. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986).

DISCUSSION

The first question that needs to be addressed is whether the plaintiffs have suffered an injury-in-fact. If they have suffered no such injury, then they do not possess standing to file suit in this court. *See Lujan*, 504 U.S. at 560. The plaintiffs claim to have suffered three types of injuries. First, the plaintiffs claim to have suffered actual injury through GEICO's reduced payment of their medical bills. Second, the plaintiffs claim to have suffered threatened injury because of Dr. Berry's acceptance of partial payment of her original medical bill to the Noahs. Finally, the plaintiffs claim to have suffered actual injury because of the defendant's unauthorized distribution of the plaintiffs' private medical information.

A. Actual Injury Caused by Reduced Medical Bills

The plaintiffs first allege that the reduction of their medical bills caused actual injury to them in two ways. First, the plaintiffs claim that they "suffered a financial injury-in-fact when they paid a bill incurred as a result of GEICO's fraudulent reductions." Plaintiff's Opposition at 10. Second, the plaintiffs claim that they "suffered actual injury through the diminution of their policy value." *Id.*

1. Payment to Therapeutic Massage

The Noahs contend that they were deprived of rightful policy benefits when Beth Noah was forced to pay twenty-five dollars in medical charges due to GEICO's reduction in charges. In particular, plaintiffs claim that they received a bill from the Therapeutic Massage Clinic sometime before March 6, 2000, in the amount of twenty-five dollars. Plaintiffs further represent that they believed that they would have to pay this bill in order to avoid being held liable for further charges, and that, as a consequence, they paid the Therapeutic Massage Clinic twenty-five dollars on March 6, 2000. GEICO responds by arguing that the twenty-five dollar payment was not made in response to a demand from Therapeutic Massage, but that, instead, it was made voluntarily. GEICO also points out that the payment was made well after the time this civil action was filed.

Regarding the question of whether the payment to Therapeutic Massage was made voluntarily, it is found that there are material facts putting the issue in dispute. There is no documentary evidence of any correspondence between Therapeutic Massage and the Noahs, and further, the owner of Therapeutic Massage, Terry Vogt, has given a sworn affidavit indicating

that the Noahs were never billed for any twenty-five dollar balance. In fact, Vogt indicated that Therapeutic Massage considered the Noahs balance paid in full when it received GEICO's reduced payment in December 1999. However, Beth Noah testified under oath that she paid the twenty-five dollars to GEICO in response to a bill that she received from Therapeutic Massage. This testimony is sufficient to create a fact issue on whether the twenty-five dollars was paid in response to a bill from Therapeutic Massage.

With regard to GEICO's second argument, however, there is no fact in issue that would dispute the defendant's claim. The evidence is undisputed that Beth Noah had not paid any bill to Therapeutic Massage at the time the lawsuit was initially filed. Since the question of standing is determined at the time the suit is originally filed, *see Pederson*, 213 F.3d at 869 (standing is determined at the time suit is filed), subsequent events cannot be used to confer standing on a litigant that lacked standing originally. Accordingly, since the plaintiffs' asserted injury took place after the civil action commenced, the injury cannot confer standing on them.[1]

2. *Reduced Policy Value*

The plaintiffs second asserted actual injury is that by reducing the Noahs' medical bills, GEICO has reduced the value of the Noahs' policy. The defendant argues that the reduction of the Noahs' medical bills actually confers a benefit on the Noahs, because for every dollar that the insurance company saves on a particular medical treatment, the Noahs have another dollar

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[1] Moreover, as discussed in the section relating to the plaintiffs' "reduced policy value," Section A.2, there are no facts indicating that the plaintiffs were actually forced to pay their own medical bills.

available to them for the next time that they undergo medical treatment.

First, it should be pointed out what argument the plaintiffs are not making. The plaintiffs are not attempting to sell their insurance policy to any third party, and there is no allegation that they have suffered any investment loss. Instead, the "value" of the policy according to the plaintiffs is simply that the policy pays for the plaintiffs' medical expenses when the plaintiffs have an accident. *See* Plaintiff's Opposition at 10.

The plaintiffs point out that GEICO agreed to pay 100 percent of their reasonable medical expenses, and they argue that by reducing the plaintiffs medical bills, GEICO reduces the value of their policy. The plaintiffs' argument rests on the assumption that whatever charges are initially made by the medical providers are reasonable medical expenses. At least on an abstract level, it must be acknowledged that a doctor could conceivably charge, to an insured, medical expenses that exceed what is reasonable. In that event, if GEICO were to pay the entire medical bill, GEICO would be paying more than 100 percent of the insured's reasonable medical expenses. This would reduce the value of the insurance policy, because by paying excessive medical costs, GEICO would be causing the insured to reach his or her policy limits more rapidly.

GEICO could also theoretically reduce the insurance policy value by paying less than 100 percent of the insured's reasonable medical expenses. In such a scenario, GEICO might decide to pay 90 percent of an insured's reasonable medical expenses, and then refuse to pay any further amount in spite of a provider's insistence that such an amount was owing, and in spite of an insured's request that GEICO pay such an amount pursuant to the policy. This would reduce the value of the insurance policy, because the policy would no longer be covering expenses that it

was designed to cover when it was purchased.

What is notable about each of these scenarios is that neither of them describes the plaintiffs' actual experience. There are no facts in evidence suggesting that GEICO is paying more than the plaintiffs' reasonable medical expenses. Moreover, there are no facts in evidence that GEICO is demanding to pay less than the plaintiffs' reasonable medical expenses. Instead, GEICO has asserted that the charges imposed by two particular medical providers were unreasonably expensive, and GEICO has represented that fact to the providers on behalf of the plaintiffs. The plaintiffs take from this that GEICO is refusing to pay reasonable medical expenses. With full knowledge that the court must make all inferences from the facts in the record in favor of the plaintiffs, it must be found that the facts in the record do not support the inference that the plaintiffs are making. GEICO disputed the reasonableness of claims with the medical providers – not the plaintiffs. To the extent that a determination was made that the plaintiffs' entire bills were reasonable, every indication from the evidence is that GEICO would have paid them. In other words, GEICO represented to both the Noahs and the medical providers that GEICO remained responsible for paying the reasonable medical expenses of the plaintiffs.

To rebut this claim, the plaintiffs' attorney attempted to show injury to the plaintiffs by asserting during oral argument that the Personal Injury Protection statute stipulates that the insureds shall at all times remain responsible for their medical bills. TEX. INS. CODE ANN. art. 5.06-3 (Vernon 2000). Upon a review of the Personal Injury Protection statute, however, it is found that there is actually no language to this effect in the statute. *Id.* Moreover, as long as the insured is afforded its contractual rights under the insurance policy, the Texas Insurance Board has stated that it does not take issue with insurers using review organizations to help keep

medical providers from overcharging their patients. *See* Defendant's Appendix, Exh. I (Commissioner's Bulletin). Finally, the only evidence that would suggest that GEICO refused to pay reasonable medical expenses was the fact the Noahs received a medical bill from Therapeutic Massage. The undisputed facts, however, show that GEICO never received such a bill, and that the plaintiffs never attempted to have GEICO either pay or dispute that bill.

In reality, GEICO's actions enhanced the value of the plaintiffs' policy. Because the plaintiffs' PIP policy had an upper limit, for every dollar that GEICO induced the plaintiffs' medical providers to reduce the plaintiffs' medical charges, another dollar was made available to the plaintiffs for any future medical expenses under the policy.

Accordingly, viewing the evidence most favorably to the plaintiffs, and taking all inferences in the plaintiffs favor, there is no evidence in the record that would support the notion that the value of the plaintiffs' policy was reduced by GEICO's actions.

B. Threatened Injury Caused by Reduced Medical Bills

The Noahs assert that when they filed this lawsuit, they had an outstanding balance with Dr. Michelle Berry, one of their medical providers. They claim that GEICO attempted to destroy their standing by calling Dr. Berry to determine whether the Noahs actually had an outstanding balance.[2] Since, as the undisputed evidence shows, the Noahs did not have any unpaid balance, the Noahs now claim that GEICO made false representations to Dr. Berry to cause her to think

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[2] The plaintiffs characterize this behavior as unusual and unethical. The court finds it neither unusual nor unethical, and perhaps if the plaintiffs had done the same thing, the perceived necessity of filing this lawsuit could have been avoided.

the balance was paid in full. The Noahs claim that if Dr. Berry comes to learn of these falsehoods, they will be held liable at some point in the future for the reductions in the medical expenses paid by GEICO. The defendants respond that this injury is far too speculative to satisfy the standing requirements of the Constitution, and that any such lawsuit would be barred by accord and satisfaction.

As a matter of law, the plaintiffs' asserted injury is too speculative an injury to be the basis of an in-fact injury. *See Lujan*, 504 U.S. at 560 (injury cannot be conjectural or hypothetical). There is no allegation in the pleadings that Dr. Berry has in fact found herself to be defrauded by GEICO, or that she plans to sue the plaintiffs in the future. Moreover, there is no evidence in the record to support the notion that Dr. Berry is in any way dissatisfied with her dealings with GEICO. In fact, there is a serious question as to whether Dr. Berry would even have a viable lawsuit against the plaintiffs, even assuming that she became dissatisfied at some point in the future. Finally, if Dr. Berry later determined that the medical expenses that she originally billed were reasonable, there is no indication that she would not contact GEICO about the matter, or that GEICO would not agree to pay those expenses.

Accordingly, it is found that the plaintiffs' threatened injury is merely hypothetical and is thus insufficient to confer standing.

C. Unauthorized Distribution of Plaintiffs' Confidential Medical Information

Finally, the plaintiffs claim to have been injured by GEICO's violation of their privacy rights under the Fourteenth Amendment and the Texas Occupations Code. GEICO responds that the Fourteenth Amendment only applies to state action, and thus, as a private entity, it cannot

violate the Fourteenth Amendment. GEICO also responds that it did not violate the Texas Occupations Code because the plaintiffs authorized the release of their medical records, and, further, that insurers have a qualified privilege to collect and disseminate information about its insureds in order to make determinations concerning eligibility or the payment of claims.

The Fourteenth Amendment claim is easily disposed of. It is patently clear that there is no state action involved in this case. Therefore, since GEICO is a private entity, it cannot violate the plaintiffs' Fourteenth Amendment rights through disclosure of the plaintiffs' medical information. While the cases cited by the plaintiffs stand for the proposition that individuals have rights under the Fourteenth Amendment not to suffer the unauthorized release of their medical records, none of the cases cited indicate that such is the case when a private entity is responsible for that release.

Turning to the Texas Occupations Code, the plaintiffs' argument, while not as obviously lacking, is also untenable. The Texas Occupations Code states that a communication between a patient and a physician, relative to the professional services provided by the physician to the patient, are confidential and may not be disclosed with certain limited exceptions. TEX. OCC. CODE ANN. § 159.002(a) (Vernon 2000). The law further states that if an individual receives a confidential medical record, that individual may not further disclose that record except to the extent that further disclosure is consistent with the purpose for which the confidential record was first released. TEX. OCC. CODE ANN. § 159.002(c) (Vernon 2000).

The exceptions to the non-disclosure requirements of the Occupations Code that are relevant in this case are twofold. First, a physician may disclose "those parts of the medical records reflecting charges and specific services provided if necessary in the collection of fees for

medical services provided." TEX. OCC. CODE ANN. § 159.004(4) (Vernon 2000). Second, a physician may disclose confidential medical information to a "person who has the written consent of the patient." TEX. OCC. CODE ANN. § 159.004(5) (Vernon 2000). The person who then receives that information from the physician may disclose the information to others "only to the extent consistent with the authorized purposes for which consent to release the information is obtained." TEX. OCC. CODE ANN. § 159.005(e) (Vernon 2000).

There is no dispute that both of the plaintiffs signed medical authorizations on May 24, 1999. Further, there is no dispute that the authorizations stated, in relevant part, that "[p]resentation of this authorization or an exact photo or valid copy thereof will permit the personal review, copying or photostating of such records, information and evidence by a GEICO Insurance Company employee or designated independent representative or utilization review agency consulted by GEICO Insurance Companies." Plaintiffs' Appendix, Exh. L (Authorizations).

In spite of the undisputed authorizations, the plaintiffs contend that the release by GEICO to Medata of confidential medical records is not permitted by the Texas Occupations Code for three reasons. First, the plaintiffs claim that since the releases were obtained for the purposes of paying a claim, the release of that information to Medata was not necessary for the limited purpose for which the information was first obtained. Second, the plaintiffs claim that the written authorization only contemplates legitimate "peer review," and that Medata does not conduct legitimate peer review. Third, the plaintiffs claim that Medata has harmed the plaintiffs by keeping the confidential medical records, and not returning them after Medata had finished using them for the purpose for which Medata obtained the records.

As the plaintiffs point out, the purpose for which GEICO obtained the plaintiffs' medical information was "in order to process and pay their claims." *See* Plaintiffs' Opposition at 18. GEICO lawfully obtained that medical information pursuant to sections 159.004(4) and 159.004(5) of the Texas Occupations Code. When GEICO obtained the plaintiffs' confidential medical information, they were authorized to disclose that information to Medata "to the extent consistent with the authorized purposes for which" the information was obtained. TEX. OCC. CODE ANN. §§ 159.002(c), 159.004(4,5), 159.005(e) (Vernon 2000). Plaintiffs argue that GEICO's release of medical information to Medata was not consistent with that purpose.

The plaintiffs' argument is not supported by the record. The undisputed evidence is that GEICO submitted the plaintiffs' medical information so that Medata could review the plaintiffs' medical records and assist GEICO in the processing of its claims. Plaintiffs' Appendix, Exh. H, at 3 ¶10 (Second Callas Affidavit); Plaintiffs' Appendix, Exh. D (Sample Letters to Providers). The part of this lawsuit that relates to reduced medical payments is predicated on that very fact. Moreover, the Texas Department of Insurance recognizes the processing of claims as one of the purposes of releasing medical information to an agency like Medata. *See* Defendant's Appendix, Exh. I (Commissioner's Bulletin). Finally, the medical authorizations signed by the plaintiffs expressly puts the plaintiffs on notice of the fact that GEICO will be using an independent review agency to help it in the processing of its claim. *See* Plaintiffs' Appendix, Exh. L (Authorizations).

The most the plaintiffs could argue is that GEICO releases the plaintiffs' medical information for purposes additional to the purpose of processing of the plaintiffs' insurance claims. Even if this were accepted as true, however, the law does not forbid GEICO's actions

As long as GEICO releases the information for a purpose that is consistent with the purpose for which they received the information, there is nothing in the law which forbids GEICO from having multiple motivations for the release. TEX. OCC. CODE ANN. §§ 159.002(c), 159.005(e) (Vernon 2000). Moreover, while there is evidence in the record that Medata retains and uses plaintiffs' medical information for its own purposes, there is no evidence that GEICO submits those records for the purpose of benefitting Medata.

The plaintiffs' second argument is that the medical authorization signed by the plaintiff only contemplates the release of medical information to a legitimate peer review organization. It is difficult to understand plaintiffs' basis for this notion. The authorization states that information may be released to a "utilization review agency." *See* Plaintiffs' Appendix, Exh. L (Authorizations). It does not say anything about peer review. Moreover, section 159.002 and 159.004(4) of the Occupations Code allow GEICO to release the plaintiffs' medical information independent of the plaintiffs' written consent. TEX. OCC. CODE ANN. §§ 159.002, 159.004(4) (Vernon 2000).

The plaintiffs' third argument is that Medata should have returned the plaintiffs' records when they were done reviewing them, and that the plaintiffs' were harmed by Medata's retention of the records.

However, nothing in the Occupations Code contemplates any return of confidential documents once they have already been disclosed, and the plaintiffs have not directed the court to any other law that would require the return of the plaintiffs' medical records. Moreover, even if Medata's conduct were wrongful, the plaintiffs' complaint would properly lie against Medata – not GEICO, because the evidence in no way suggests that GEICO is in complicity with Medata's

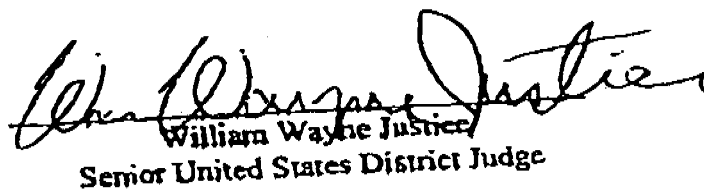
alleged wrongful retention of the plaintiffs' medical records.

CONCLUSION

For the foregoing reasons, the plaintiffs have not demonstrated an injury-in-fact that is fairly traceable to the defendant's actions. Consequently, this court lacks subject matter jurisdiction to adjudicate the plaintiffs' complaint. The defendant's Motion to Dismiss, therefore, shall be, and is hereby **GRANTED**. Further, it is

ORDERED that Plaintiff's Third Amended Class Action Complaint shall be, and is hereby, dismissed from the docket of this court,[3] and pursuant to 28 U.S.C. § 1447(c),[4] this case is **REMANDED** to the District Court of Kendall County, State of Texas, 216th Judicial District.

SIGNED this 5th day of April 2001.



William Wayne Justice
Senior United States District Judge

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[3] The plaintiffs have requested that they have the opportunity to amend their complaint to avoid the dismissal of their claims. However, since this case has been disposed of on summary judgment, it is found that the plaintiffs' request would be futile. It is not because of inartful pleading that their claims are being dismissed. Their claims are being dismissed because there is no evidence in the record that they have been injured by the defendant.

[4] In pertinent part, 28 U.S.C. § 1447(c) states: "If at any time before final judgment it appears that the district court lacks subject matter jurisdiction, the case shall be remanded."

Appendix Part 3

Choeun NY [FN1]

FN1. Consolidated with Sahoeut Noeun v. Metropolitan Property and Casualty Insurance Co., Lowell Division No. 9511-CV-1315.

v.
METROPOLITAN PROPERTY & CASUALTY INSURANCE CO.
Sahoeut Noeun
v.
Metropolitan Property and Casualty Insurance Co.

No. 9489.

Massachusetts Appellate Division, District Court Department, Northern District.

Heard June 3, 1998.

Opinion Certified Sept. 2, 1998.

[1] INSURANCE ⚿2524
217k2524
When an insurer has conducted a fee review of the amount of the charge for a service, as opposed to the medical necessity of the service itself, no "peer review" is necessary before the insurer pays only the amount of the charge which is deemed reasonable. M.G.L.A. c. 90, § 34M.

[2] INSURANCE ⚿3567
217k3567
Fact that personal injury protection (PIP) insurer had policy of defending and indemnifying its insureds in event that medical provider made claim against insured for balance of a fee reduced by insurer's fee review program did not preclude insureds from being "unpaid parties" with standing to sue insurer for balance of fee and attorney fees, where such policy was not communicated to insureds and was not binding upon insurer. M.G.L.A. c. 90, § 34M.

[3] INSURANCE ⚿3567
217k3567
Where the calculation of reasonable medical expenses has been made and paid by a personal injury protection (PIP) insurer who had made a binding undertaking to defend and indemnify the insured against any claim for the balance of the provider's bill, the individual insured is not an "unpaid party" entitled under statute to seek the balance of the bill as well as attorney fees. M.G.L.A. c. 90, § 34M.

[4] INSURANCE ⚿2526
217k2526
Where personal injury protection (PIP) insurer obtained releases from insureds' medical providers under which providers agreed to accept as full payment the payment already received from insurer, insureds could not prove that their reasonable medical costs exceeded the PIP benefits already paid and, thus, were not "unpaid parties" entitled to nominal damages and attorney fees. M.G.L.A. c. 90, § 34M.

[4] INSURANCE ⚿3585
217k3585
Where personal injury protection (PIP) insurer obtained releases from insureds' medical providers under which providers agreed to accept as full payment the payment already received from insurer, insureds could not prove that their reasonable medical costs exceeded the PIP benefits already paid and, thus, were not "unpaid parties" entitled to nominal damages and attorney fees. M.G.L.A. c. 90, § 34M.
In the Lowell Division, Harvey and Melahn, JJ.; Docket Nos. 9511 CV 1314, 9511-CV-1315.

Francis A. Gaimari, Lowell, MA, for Plaintiff.

Alexander J. Cochis, Smith & Brink, Quincy, MA, for Defendant.

Before SHERMAN, P.J., [FN2] MERRICK and COVEN, JJ.

FN2. The Honorable Arthur Sherman, Presiding Justice, participated in the hearing and post-hearing conference on this case, but retired from the bench prior to the issuance of this opinion.

MERRICK, Justice.

*1 Plaintiffs Choeun Ny and Sahoeut Noeun filed separate small claims actions to recover Personal Injury Protection ("PIP") benefits for injuries allegedly sustained while in a motor vehicle insured by the defendant. The actions were transferred to the

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regular civil docket and consolidated for trial upon motions by the defendant.

The record indicates that invoices received by the defendant for the plaintiffs' medical treatments were submitted to a fee review program. At the conclusion of the fee review, the defendant paid the majority of the invoices in full. Payment for two of Ny's invoices, however, was reduced by a total of $269.00, and payment of one of Noeun's bills was reduced by $454.00. The fee review determined that these amounts were in excess of reasonable charges for the services in question in the region where they were provided. The defendant has a policy of defending its insureds and contesting any cases wherein the medical provider disputes the determination of the fee review or attempts to collect the balance of the bill from the insured. The medical providers did not do so in this case.

Cross-motions for summary judgment were heard and denied in September, 1996. The defendant thereafter scheduled depositions of those medical providers who received partial payments. At that point, the providers all agreed to accept the payments made by the defendant as full payment of their claims, and executed releases to that effect in favor of both the plaintiffs and the defendant. No additional money was paid for the releases. The only consideration given was the defendant's agreement to refrain from involving the medical providers in any litigation concerning the bills. Based upon that development, the parties again filed cross-motions for summary judgment, which were heard by a second judge. That judge denied the defendant's motion, and allowed the plaintiffs' motion, awarding nominal damages of $1.00 and attorney's fees. The defendant has appealed that decision pursuant to Dist./ Mun. Cts. R.A.D.A., Rule 8C. [FN3] The plaintiffs filed a Rule 8C cross-appeal on a charge of error in the court's failure to award interest on the unpaid invoice amounts up to the date of the execution of the providers' releases. The parties have briefed and argued the issues raised in both sets of Mass. R. Civ. P., Rule 56 motions.

FN3. The defendant has also appealed the court's approval of attorney's fees in the amount of $17,592.00 on the grounds that the plaintiffs' contracts with their counsel were champertous. That doctrine has recently been abolished. Saladini v. Righellis, 426 Mass. 231, 687 N.E.2d 1224 (1997). Rule 1.5 of the Mass. R. Prof. C. effectively "contemplates, without so stating, that champerty is an issue of the past, so long as the Rule is complied with." James S. Bolan, "The New Rules of Professional Conduct," Editor's Commentary at 39. The judge retains the inherent power to disapprove an unreasonable fee. Saladini v. Righellis, supra at 236, 687 N.E.2d 1224. The judge in this case, tellingly and appropriately, drew an adverse inference from the refusal of defense counsel to demonstrate that their fees for the same case were less than those claimed by plaintiffs' counsel.

[1] 1. In their first motions for summary judgment, the plaintiffs argued that G.L. c. 90, § 34M prohibits the defendant from contesting the reasonableness of the amount charged by a medical provider without conducting a "medical review" by a practitioner licensed in the same field as the provider. If there were any question about the error of that proposition in September, 1996 when the motions were decided, there is none now. When an insurer has conducted a fee review of the amount of the charge for a service, as opposed to the medical necessity of the service itself, no "peer review" is necessary before the insurer pays only the amount of the charge which is deemed reasonable. Nhem v. Metropolitan Prop. & Cas. Ins. Co., 1997 Mass.App. Div. 84, 86-87, aff'd. 45 Mass.App.Ct. 1102 (1998). The plaintiffs' original motions for summary judgment were properly denied.

*2 2. The defendant's first motion for summary judgment asserted that it had paid the invoice amounts determined to be due by its fee review program. "[A]n insurer's proper use of such internal system for calculating reasonable expenses or charges has been recognized." Id., 1997 Mass.App. Div. at 87. The defendant is in fact required to operate the fee review and other similar programs under performance standards issued by Commonwealth Automobile Reinsurers, see G.L. c. 175, § 113H (C) and (E), and by the Commissioner of Insurance. Automobile Insurers Bureau of Mass. v. Commissioner of Insurance, 415 Mass. 455, 461-462, 614 N.E.2d 639 (1993) (Insurers required to use scientific and statistical techniques to investigate fraud in auto liability and PIP claims). See also, Cost and Expense Containment Standards for Motor Vehicle Insurers, 211 C.M.R. § 93.04(6)(c). It remained open to the plaintiffs, however, "either to demonstrate another plausible and coherent method of calculation that would result

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in higher figures for reasonable and customary charges than those paid by [the defendant]; or, alternatively, to show that [the defendant's] method of calculating reasonable and customary charges was conceptually flawed." Boston v. John Hancock Mut. Life Ins. Co., 35 Mass.App.Ct. 318, 320, 619 N.E.2d 622 (1993). The medical bills submitted by the plaintiff and certified under G.L. c. 233, § 79G were thus sufficient to raise a genuine issue of material fact on that subject.

[2] The defendant argued further, however, that it has a policy of voluntarily defending and indemnifying its insureds in the event that a medical provider makes a claim against an insured for the balance of a fee reduced by the defendant's fee review program. Relying on a line of Michigan cases, the defendant argued that the plaintiffs had no standing to bring this claim because they had no damages in view of both (1) the defendant's payment of what it calculated to be reasonable medical expenses and (2) its undertaking to defend and indemnify the plaintiffs against any provider's claim for a balance. See McGill v. Automobile Ass'n of Michigan, 207 Mich.App. 402, 526 N.W.2d 12 (1994) and LaMothe v. American Auto. Ass'n of Michigan, 214 Mich.App. 577, 543 N.W.2d 42 (1995). We think that the question under Massachusetts law is better stated as whether either of the plaintiffs was, in § 34M terms, an "unpaid party" entitled to seek damages and attorney's fees under that statute. To interpret the statute, we consider the underlying legislative intent.

> "The comprehensive statutory scheme for motor vehicle insurance in this Commonwealth which is set forth in G.L. c. 90, §§ 34A-34Q was enacted not only to create an inexpensive procedure for obtaining full compensation for injuries sustained in automobile accidents, but also to control the skyrocketing costs of automobile insurance in this State."

Im v. Metropolitan Prop. & Liab. Ins. Co., 1994 Mass.App. Div. 113, 114, citing Flanagan v. Liberty Mut. Ins. Co., 383 Mass. 195, 198, 417 N.E.2d 1216 (1981) and Chipman v. Massachusetts Bay Transp. Auth., 366 Mass. 253, 255 n. 3, 316 N.E.2d 725 (1974). "The limitation of reasonableness [of medical expenses] is consistent with the Legislature's purpose in enacting the Massachusetts No-Fault Insurance scheme 'to address the high costs of motor vehicle insurance in this Commonwealth.' " Nhem, supra, 1997 Mass.App. Div. at 87, citing Creswell v. Medical West Commun. Health Plan, Inc., 419 Mass. 327, 328, 644 N.E.2d 970 (1995). Containment of medical costs is as much in the plaintiff's own interest as the defendant's, as long as the plaintiffs are protected from claims by the medical providers. Insurers and health care providers are much better able to contest the value of medical services than are individual patients. "The patient wants to be removed from the collection process as soon and as fully as possible ." Boston v. Aetna Life Ins. Co., 399 Mass. 569, 572, 506 N.E.2d 106 (1987). Undoubtedly, it is for this reason that a provider who has not received full payment of his bill is included within the § 34M definition of an "unpaid party," entitled to bring suit directly against the insurer and, if successful, recover attorney's fees.

*3 [3] In light of the public policy underlying § 34M, we find persuasive the reasoning of the Michigan cases cited above, and conclude that where the calculation of reasonable medical expenses has been made and paid by a PIP insurer who has made a binding undertaking to defend and indemnify the insured against any claim for the balance of the provider's bill, the individual insured is not an "unpaid party" entitled under § 34M to seek the balance of the bill as well as a bonanza of counsel fees. If the defendant in this case had in fact issued a binding statement of indemnification, no issue as to the status of either of the plaintiffs as an "unpaid party" entitled to bring a § 34M suit would have arisen, and thus, consistent with the purposes of the no-fault statutory scheme, wholly unnecessary litigation would have been prevented. That was not, however, the situation in this case at the time of the defendant's first motion for summary judgment.

The defendant's policy of defending and indemnifying against "balance billing" claims was not communicated to the plaintiffs or binding upon the defendant. In the Michigan cases, by comparison, the insurers' policy was buttressed by a directive of the Commissioner of Insurance requiring auto insurers to "act at all times to assure that the insured or claimant is not exposed to harassment, dunning, disparagement of credit, or lawsuit as a result of a dispute between the health care provider and the insurer." McGill v. Automobile Ass'n of Michigan, supra, 207 Mich.App. at 406-407, 526 N.W.2d at 14.

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The defendant's first motion for summary judgment was properly denied.

[4] 3. By the time the second set of cross-motions for summary judgment were filed, however, the defendant had obtained releases from the providers who had agreed to accept as full payment only what they had already received from the defendant. As noted, the only consideration given by the defendant was forbearance from involving the medical providers in litigation over the reasonable value of their services. In view of those releases and agreements, it cannot be said that there remains any genuine issue of material fact as to whether the PIP benefits paid prior to suit constituted full compensation for the plaintiffs' "reasonable" medical expenses, or whether either plaintiff is, or ever was, as an "unpaid party."

In Fascione v. CNA Ins. Companies., 1997 Mass.App. Div. 132, on which the plaintiffs rely, uncontested PIP benefits were paid late, after suit was brought. In that specific circumstance, we held that while the plaintiff could not at the time of judgment recover PIP benefits which by then had been paid, she was entitled to both interest for the period of time in which the benefits had been withheld and attorney's fees. The plaintiffs now wish us to view the releases in this case as a late "payment," and to interpret § 34M and Fascione as making each plaintiff an "unpaid party" entitled to nominal damages and counsel fees. The payment of benefits in Fascione after suit was brought established that the plaintiff had been an "unpaid party" at the time suit was brought. In this case, however, the releases and agreements, which were executed after suit but involved no additional payment, establish that the plaintiff was not an "unpaid party" at the time suit was commenced. Certainly, given the agreement between the providers and the insurer that the plaintiffs' "reasonable" expenses were the amounts paid before suit, the plaintiffs had "no reasonable expectation of proving an essential element" of their cases, Kourouvacilis v. General Motors Corp., 410 Mass. 706, 716, 575 N.E.2d 734 (1991); i.e., that their "reasonable" medical costs exceeded the PIP benefits paid before suit.

*4 Given what we have said about the purposes of the no-fault statutory scheme, it would be a perverse interpretation of § 34M indeed which required the payment of attorney's fees when no medical expenses have been determined to be unpaid or untimely paid. On the second set of cross-motions for summary judgment, both the allowance of the plaintiffs' motions and the denial of the defendant's motion were error.

The judgments are reversed. [FN4] Judgment is to enter in both cases for the defendant.

FN4. In view of our decision, it is unnecessary to address the plaintiffs' contention on their cross-appeal that they were entitled to interest.

So ordered.

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Appendix Part 4

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STATE OF MISSOURI)
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MISSOURI CIRCUIT COURT
TWENTY-SECOND JUDICIAL CIRCUIT
(St. Louis City)

DENISE KINNARD, et al.,)
)
Plaintiffs,)
) Cause No. 992-00812
vs.)
) Division No. 1
ALLSTATE INSURANCE COMPANY,)
)
Defendant.)

ORDER

Defendant's Amended Motion to Stay and Amended Motion to Dismiss were called, heard, and submitted on October 26, 1999. The Court has considered the pleadings, motions, and arguments of the parties and now rules as follows.

Plaintiffs brought the present action as individuals and on behalf of a class of persons insured by Defendant, Allstate Insurance Company. Plaintiffs claim that Allstate denied full payment of medical bills under the medical payment coverage of its policies. The named plaintiffs allege that they were injured in automobile accidents, that medical bills were submitted to Allstate, and that Allstate refused to pay the bills in full, on the ground that the charges were unreasonably excessive.

Allstate seeks an order staying the present action in favor of two actions against Allstate pending in federal court in Illinois.[1] The two Illinois actions seek declaratory relief,

[1] Puritt v. Allstate Ins. Co., No. 99C 4238 (N.D.Ill.) and Loizon v. Allstate Ins. Co., No. 99C 4237 (N.D.Ill.).

equitable relief, and damages for Allstate's alleged failure to pay fully under its medical payment coverage for expenses incurred as a result of automobile accidents. The Illinois cases have been pending since 1995, and it is the Court's understanding that neither case has yet been certified as a class action.

Allstate contends that the present case is wholly subsumed by the class actions alleged in the Illinois cases, that the issues in the Illinois actions are parallel to the issues in the present action, and that the actions involve the same putative class. Therefore, Allstate concludes, the present action is duplicative of the Illinois actions. Plaintiffs counter that the present case does not involve the same activity, because the present action seeks statutory relief pursuant to Missouri's vexatious refusal statute, § 375.420 RSMo, and involves Missouri plaintiffs, unlike the Illinois actions.

The decision whether the grant or refuse a stay of proceedings, on the ground that another action is pending, is discretionary with the trial court. Green v. Miller, 851 S.W.2d 553 (Mo.App. W.D. 1993). The pending Illinois cases, although brought as putative class actions, are not deemed class actions until certified as such pursuant to Rule 52.08. Until certified by the court as a class action, an action brought as a putative class action is brought only on behalf of the named plaintiffs. Beatty v. St. Louis Sewer Dist., 914 S.W.2d 791, 795 (Mo.banc 1995); see also, Parker v. Pulitzer Pub. Co., 882 S.W.2d 245 (Mo.App. E.D. 1994).

An action may be stayed where it involves the same parties, issues and relief as another pending action. Searles v. Searles, 495 S.W.2d 759, 761 (Mo.App. 1973). Allstate points out that, in determining whether a stay of proceedings is warranted, a court considers the desirability of avoiding a multiplicity of forums, the stage of the litigation, and the likelihood of obtaining complete relief in the foreign jurisdiction. However, the priority of filing, by itself, does not control whether a stay is appropriate. 1A C.J.S. Actions p. 736 (1985).

The uncertified Illinois cases remain merely putative class actions. Despite the age of the Illinois cases, the Court cannot ascertain whether these cases would afford relief to the plaintiffs in the present action. Accordingly, a stay, at this point in both the present case and the Illinois actions, is not appropriate. Allstate's Amended Motion for Stay is therefore denied.

Allstate also seeks an order dismissing Plaintiffs' class action allegations and the breach of contract claim brought by plaintiff Sam Bush. Allstate contends that Plaintiffs' class action allegations necessarily involve individual determinations of coverage; the nature, necessity, and extent of medical treatment; and the circumstances giving rise to Plaintiffs' injuries, and therefore are ill suited for a class action. In response, Plaintiffs contend that their alleged damages, albeit different, arise from common conduct on the part of Allstate, and that Plaintiffs represent a class of persons insured under the policies.

As noted above, an action allegedly brought on behalf of a class is brought only on behalf of the named plaintiffs until certified by the court. The file and court minutes indicate that the Court has not certified this action as a class action. Until and unless the action is so certified, the action is brought only on behalf of the named plaintiffs. Accordingly, it is premature to consider dismissal of an uncertified class action, on the grounds that the requirements for class certification have not been met.[3]

Allstate challenges the claim brought on behalf of plaintiff Bush, for failure to plead a compensable injury. Specifically, Allstate contends that Bush fails to state a cause of action for breach of contract, because the petition lacks facts indicating that Bush sustained damages.

A motion to dismiss for failure to state a claim is solely a test of the adequacy of the plaintiff's petition. The Court assumes that all of plaintiff's averments are true, and liberally grants to plaintiff all reasonable inferences therefrom. Murphy v. A. A. Mathews, a Division of CRS Group Engineers, Inc., 841 S.W.2d 671, 672 (Mo.banc 1992). No attempt is made to weigh any facts as to whether they are credible or persuasive. Instead, the petition is reviewed to see whether the facts alleged meet the elements of a recognized cause of action, or of a cause that might be adopted in that case. Nazeri v. Missouri Valley College, 860 S.W.2d 303, 306 (Mo.banc 1993). An action for

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[3] However, class action certification does not preclude subsequent dismissal for failure to state a claim. Reinhold v. Fee Fee Trunk Sewer, Inc., 664 S.W.2d 599 (Mo.App. 1984).

breach of contract must allege (1) the making and existence of a contract between plaintiff and defendant: (2) defendant's violation of the contract; and (3) damages resulting from the breach. Lick Creek Sewer Systems, Inc. v. Bank of Bourbon, 747 S.W.2d 317, 324 (Mo.App. 1988).

Plaintiff alleges that Bush was involved in an automobile accident while operating a vehicle owned by a person insured by Allstate and that Bush was injured in the accident and incurred medical expenses. Plaintiffs' claim for breach of contract, as it pertains to Bush, alleges in part as follows:

> Allstate refused to pay Plaintiff Bush in full for a bill he submitted from Dr. Brenda Mills on the grounds that the charges for the medical treatment, services and/or products set forth in the bill exceeded the reasonable amount for the procedures in the region where the services were provided.

(First Amended Petition, ¶ 23). There is no allegation that Bush incurred any out-of-pocket expenses or paid the bill in full; rather, the First Amended Petition states only that "Plaintiff Bush has suffered damages in the amount of $13.00."

Although technical forms of pleading are not required in Missouri, a pleader must set forth sufficient facts to show that the pleader is entitled to relief. Rule 55.05; Love v. St. Louis City Bd. of Educ., 963 S.W.2d 364 (Mo.App. E.D. 1998). Mere conclusions, not supported by factual allegations, cannot be taken as true and cannot be considered in determining whether the petition states a cause of action. Id.

The pleading fails to state facts indicating how Bush's submission of damages to Allstate, and Allstate's refusal to pay "in full" gave rise to damages of $13.00. Although Bush

allegedly incurred expenses, there is no allegation that he was required to pay amounts, contrary to the terms of the Allstate policy. The mere conclusion that Bush had damages of $13.00 does not show how that sum relates in any way to Allstate's alleged actions. The breach of contract claim of plaintiff Bush is therefore dismissed for failure to state a claim.

ORDER

WHEREFORE, IT IS ORDERED that Defendant's Amended Motion to Stay is hereby denied; and

IT IS FURTHER ORDERED that Defendant's Amended Motion to Dismiss is granted as to the claims brought on behalf of plaintiff Bush and denied as to Plaintiffs' class action allegations.

SO ORDERED:

Michael B. Calvin, Presiding Judge

Dated: Nov. 15, 1999

cc: David T. Butsch, Attorney for Plaintiffs
Roger K. Heidenreich, Attorney for Defendant