

1 Brendan V. Sullivan, Jr.
Steven M. Cady
2 WILLIAMS & CONNOLLY LLP
725 Twelfth Street, N.W.
3 Washington, D.C. 20005
Tel.: 202-434-5321
4 scady@wc.com

Honorable Salvador Mendoza, Jr.

5 Maren R. Norton
STOEL RIVES LLP
6 600 University Street, Suite 3600
Seattle, WA 98101
7 Tel.: 206-624-0900
maren.norton@stoel.com

8
Attorneys for Defendants

10 UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
11 AT YAKIMA

12 CYNTHIA HARVEY, individually
and on behalf of all others similarly
13 situated,

14 Plaintiff,

15 v.

16 CENTENE MANAGEMENT
COMPANY, LLC and
17 COORDINATED CARE
CORPORATION,

18 Defendants.

No. 2:18-CV-00012-SMJ

**MOTION TO DISMISS SECOND
AMENDED COMPLAINT**

(Oral Argument Requested)

NOTE ON MOTION CALENDAR:
**November 20, 2018 at 10:00 a.m.
in Spokane**

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1 Defendants Coordinated Care Corporation (Coordinated Care) and Centene
2 Management Company (CMC), by undersigned counsel, hereby move to dismiss
3 the Second Amended Complaint in this action pursuant to Rules 8(a) and 12(b)(6)
4 of the Federal Rules of Civil Procedure.

5 **PRELIMINARY STATEMENT**

6 In her third attempt to plead a valid claim, Plaintiff continues to assert that
7 she paid too much for health insurance because she allegedly did not get all the
8 benefits she was promised. As such, her Second Amended Complaint seeks to
9 second-guess the work of the Washington State Office of the Insurance
10 Commissioner (Insurance Commissioner), which reviewed the insurance policies
11 and approved the insurance rates that Plaintiff paid. Plaintiff is asking this Court to
12 step into the shoes of the Insurance Commissioner and pass on the adequacy of
13 health-insurance provider networks and the propriety of approved health-insurance
14 premiums. Those are matters that the Insurance Commissioner is specifically
15 charged with overseeing—and is in fact overseeing. Under recent unanimous
16 controlling authority from the Washington Supreme Court, Plaintiff’s attempt at an
17 end-run around the Insurance Commissioner’s authority is barred by the filed-rate
18 doctrine. While Plaintiff’s latest complaint primarily aims to plead around that
19 doctrine by reframing her damages claim, the revisions in fact only manage to

1 affirm the doctrine’s applicability. This case should therefore be dismissed under
2 Washington’s filed-rate doctrine.

3 In addition, the Second Amended Complaint fails to plead a breach of
4 contract. Despite multiple attempts to replead, the Complaint’s factual allegations
5 –focused on an alleged inadequate provider network and alleged failure to properly
6 reimburse claims—are still too thin to state a valid claim.

7 Finally, even if the Second Amended Complaint survives (and it should
8 not), the claims against Centene Management Company should be dismissed.
9 Plaintiff does not allege that she had any contractual relationship with CMC. CMC
10 merely provides management and administrative services to Coordinated Care and
11 other Centene subsidiaries. Plaintiff pleads no facts suggesting that CMC is
12 Coordinated Care’s alter ego, and thus there is no basis for including CMC as a
13 defendant.

14 Because Plaintiff has been given three chances to plead a valid claim and has
15 failed to do so, dismissal should be with prejudice.

16 **BACKGROUND**

17 Plaintiff filed her initial complaint on January 11, 2018. After Defendants
18 moved to dismiss and the motion was fully briefed, on the eve of oral argument,
19 Plaintiff filed a First Amended Complaint, which was a whittled-down version of

1 her initial complaint. Plaintiff abandoned her Affordable Care Act and Texas state
2 law claims, dropped some defendants, and abandoned her attempt to certify a
3 “nationwide” class. Once the case was limited to Washington claims, Defendants
4 again moved to dismiss, this time focusing on the Washington filed-rate doctrine.
5 Once again, Plaintiff chose to amend rather than defend the pleading she had filed.

6 In her Second Amended Complaint, Plaintiff again asserts claims for breach
7 of contract and unfair business practices under the Washington Consumer
8 Protection Act against Coordinated Care and CMC. Plaintiff’s claims still revolve
9 around her alleged inability to access certain providers and the denial of certain
10 claims. She now purports to bring the action on behalf of “[a]ll persons in the state
11 of Washington who were insured by Defendants’ Ambetter insurance product
12 which was purchased through an ACA [Health Insurance Exchange] from January
13 11, 2012 to the present.” SAC ¶ 59. But, as set forth in detail below, the claims
14 remain deficient and should be dismissed.

15 **ARGUMENT**

16 Plaintiff asserts that, by maintaining an allegedly inadequate provider
17 network and denying claims, Coordinated Care and CMC breached Plaintiff’s
18 contract with Coordinated Care and violated the Washington Consumer Protection
19 Act. The filed-rate doctrine precludes both of Plaintiff’s claims because the claims

1 challenge insurance rates that were filed with and approved by the Insurance
2 Commissioner. Even if Plaintiff's claims were not precluded by the filed-rate
3 doctrine, her breach-of-contract claim must be dismissed because it is inadequately
4 pled. Finally, Plaintiff cannot maintain either claim against CMC on an alter-ego
5 theory, and CMC should be dismissed from the case.

6 **I. The Filed-Rate Doctrine Precludes Both of Plaintiff's Claims.**

7 To adjudicate Plaintiff's claims would require this Court to second-guess
8 Coordinated Care's insurance rates, which have been approved by the Insurance
9 Commissioner. In *McCarthy Finance, Inc. v. Premera*, 347 P.3d 872, 875 (Wash.
10 2015), the Washington Supreme Court unanimously held that the filed-rate
11 doctrine bars precisely this kind of judicial second-guessing of agency-regulated
12 ratemaking. *Premera* is on all fours with this case, and mandates that Plaintiff's
13 claims be dismissed.

14 As the *Premera* court explained, the Insurance Commissioner is charged
15 with reviewing and approving health insurance premiums in Washington pursuant
16 to a detailed framework of state laws and regulations. *Premera*, 347 P.3d at 875
17 (collecting relevant statutory and regulatory provisions). The Insurance
18 Commissioner protects consumers from "benefits [that] . . . are 'unreasonable in
19 relation to the amount charged for the contract.'" *Id.* (citations omitted). To that

1 end, the Insurance Commissioner is vested with the authority to approve or
2 disapprove health insurance contracts and rates on a variety of grounds. Wash.
3 Rev. Code § 48.44.020. One basis for disapproval is the failure to satisfy the
4 minimum health insurance standards set forth in state regulations, *id.* §
5 48.44.020(2)(f), including the requirements for maintaining adequate provider
6 networks. Wash. Admin. Code § 284-170-200. As part of the review process, the
7 Insurance Commissioner requires insurers to submit detailed information
8 concerning insurance rates and their ratemaking methodology. Wash. Rev. Code
9 §§ 48.44.017(2) & 48.44.020(3). Rates and modifications of rates must go through
10 the Insurance Commissioner’s review and approval process before taking effect.
11 *Id.* § 48.44.020(3).

12 The filed-rate doctrine is a doctrine of deference. It recognizes that courts
13 should not intrude into ratemaking processes that are overseen and carefully
14 regulated by agencies. The doctrine is a “court-created rule to bar suits against
15 regulated utilities involving allegations concerning the reasonableness of the filed
16 rates. This doctrine provides, in essence, that any ‘filed rate’—a rate filed with and
17 approved by the governing regulatory agency—is per se reasonable.” *Premera*,
18 347 P.3d at 875 (citation omitted). Courts fashioned this limitation on their own
19 power with two purposes in mind: “(1) to preserve the agency’s primary

1 jurisdiction to determine the reasonableness of rates, and (2) to insure that
2 regulated entities charge only those rates approved by the agency.” *Id.* (citation
3 omitted). To achieve those goals, courts will not reevaluate any filed and approved
4 rates “because doing so would inappropriately usurp the agency’s role.” *Id.* at 873.

5 In *Premera*, the Washington Supreme Court unanimously applied the filed-
6 rate doctrine to health insurance rates in a case analogous to this one. *See* 347 P.3d
7 872; *see also Heaphy v. State Farm Mut. Auto. Ins. Co.*, No. C05 5404RBL, 2006
8 WL 278556, at *2 (W.D. Wash. Feb. 2, 2006) (affirming that filed-rate doctrine
9 applies to claims related to insurance premiums). In that case, plaintiffs alleged
10 that a group of insurers colluded and induced plaintiffs to purchase policies under
11 false pretenses and then charged them excessive and deceptive rates. *Premera*,
12 347 P.3d at 873–74. They sought compensation for the excessive premium
13 payments under the CPA. *Id.* at 874. The Washington Supreme Court affirmed
14 dismissal of the plaintiffs’ claims based on the filed-rate doctrine. The key
15 question was “whether the claims and damages related to agency-approved rates
16 . . . would necessarily require courts to reevaluate agency-approved rates.” *Id.* at
17 875. The court concluded that, to evaluate whether the premiums charged were
18 excessive, it would need to “determine what health insurance premiums would
19 have been reasonable for the Policyholders to pay as a baseline.” *Id.* at 876. Thus,

1 the “requested damages cause[d] [plaintiffs’] CPA claims to run squarely against
2 the filed rate doctrine.” *Id.*

3 That reasoning controls the outcome here: Plaintiff’s Consumer Protection
4 Act and breach-of-contract claims run squarely into the filed-rate doctrine.
5 Plaintiff tries to avoid that problem by dividing her damages claims into three
6 alternative theories: (1) a full refund of premiums paid; (2) a “Partial Refund” or
7 the “difference in value” between the policy as represented and the policy as
8 delivered; and/or (3) “Out-of-Pocket Expenses” that Plaintiff allegedly paid for
9 covered services. SAC ¶ 76 & ¶ 85. With the first two damages theories, Plaintiff
10 is asserting that the policy she purchased was worth nothing or worth less than the
11 premiums paid, or in other words, that the premiums were excessive in relation to
12 the benefits received—and thus she is owed a “refund.”¹

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14 ¹ Plaintiff tacks on out-of-pocket expenses as an alternative to a full or
15 partial refund of premium payments without explaining what those expenses are or
16 how she incurred them. It is not clear how the three forms of damages relate to
17 each other. The additional claim for out-of-pocket expenses certainly does not
18 change the fact that Plaintiff’s damages claim seeks to challenge rates filed with
19 and approved by the Insurance Commissioner.

1 To assess the refund that Plaintiff requests, this Court would have to set a
2 “reasonable . . . baseline” for what Plaintiff should have paid for the policy and
3 then subtract that amount from the premiums charged by Coordinated Care.
4 *Premera*, 347 P.3d at 876. Clearly, calculating a refund would force the Court to
5 reevaluate the insurance rates that the Insurance Commissioner has already
6 reviewed and approved. *Premera* unanimously rejected a request for a refund of
7 excessive premium payments, and this Court should too. *Premera*, 347 P.3d at
8 876; *see also Alpert v. Nationstar Mortgage LLC*, 243 F.Supp.3d 1176, 1183
9 (W.D. Wash. 2017) (applying the filed-rate doctrine to dismiss CPA and breach-
10 of-contract claims where plaintiff sought “difference between what he was charged
11 and the reasonable cost of insurance”); *Hardy v. Claircom Comm’cns Grp. Inc.*,
12 937 P.2d 1128, 495–96 (Wash. App. 1997) (dismissing CPA and breach-of-
13 contract claims because “court would necessarily have to consider the
14 reasonableness of the rates charged”).

15 Plaintiff tries to address her clear filed-rate doctrine problem with a
16 disclaimer that she is “not challenging the reasonableness of the rates filed with the
17 Office of the Insurance Commissioner.” SAC ¶ 14. According to Plaintiff, instead
18 of challenging rates, her complaint is that Defendants failed to “actually deliver[]
19 the insurance services for which its filed rates were approved by the [Insurance

1 Commissioner],” and that Defendants “misrepresented and made material
2 omissions regarding the coverage actually provided.” *Id.* This attempt to dodge
3 the filed-rate doctrine only serves to reinforce its applicability. Excessive
4 insurance rates and inadequate services are simply two sides of the same coin. As
5 the U.S. Supreme Court explained 20 years ago: “Rates . . . do not exist in
6 isolation. They have meaning only when one knows the services to which they are
7 attached. Any claim for excessive rates can be couched as a claim for inadequate
8 services and vice versa.” *AT&T v. Cent. Office Tel., Inc.*, 524 U.S. 214, 223
9 (1998). Accordingly, “the filed-rate doctrine . . . bars suits challenging services,
10 billing, or other practices when such challenges, if successful, would have the
11 effect of changing the filed tariff.” *Brown v. MCI, WorldCom Network Servs.,*
12 *Inc.*, 277 F.3d 1166, 1170 (9th Cir. 2002) (citing *AT&T*).

13 Those principles apply here: despite characterizing her claims as focused on
14 the insurance benefits at issue, Plaintiff is still in effect alleging that the premiums
15 she paid were too high in light of the benefits provided. By the same token, it does
16 not matter that Plaintiff cloaks her claims in the language of misrepresentation,
17 because the relief she seeks still requires the Court to reevaluate the reasonableness
18 of filed rates. *See Hardy*, 937 P.2d at 1132 (applying filed-rate doctrine despite
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1 plaintiffs’ argument that they are “specifically challenging the allegedly deceptive
2 advertising practices of [defendants], not the underlying rate”).

3 Not only is the filed-rate doctrine an exact fit with Plaintiff’s claims, but the
4 policy rationale behind the doctrine—judicial deference to the regulatory agency in
5 overseeing insurance rates—also applies with particular force here. *See Premera*,
6 347 P.3d at 875. As the Complaint describes, the Insurance Commissioner
7 currently is reviewing Coordinated Care’s provider networks and related issues.
8 SAC ¶¶ 15–20. It does not make sense to allow a private litigant to police network
9 adequacy when the Insurance Commissioner already is working with Coordinated
10 Care on that very issue. The Insurance Commissioner is doing his job—ensuring
11 that the benefits provided under the policies correspond to the rates charged.
12 Dismissing Plaintiff’s claims under the filed-rate doctrine would not leave her
13 without recourse—she can bring complaints directly to Coordinated Care or the
14 Insurance Commissioner and receive appropriate remedies. Indeed, Ms. Harvey
15 admits that she has successfully availed herself of remedies available under her
16 insurance contract, including making complaints to Coordinated Care and the
17 Insurance Commissioner. SAC ¶ 56. This Court need not step into this ongoing
18 administrative process. Instead, it should reject Plaintiff’s challenge to rates

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1 approved by the Insurance Commissioner and dismiss Plaintiff’s Second Amended
2 Complaint as barred by the filed-rate doctrine.

3 **II. The Second Amended Complaint Fails To Adequately Plead Breach of**
4 **Contract.**

5 Even if Plaintiff’s breach-of-contract claim were to survive the filed-rate
6 doctrine, it still would fail on its own terms. Despite filing two amended
7 complaints, Plaintiff has made next to no attempt to improve her deficient breach-
8 of-contract claim. To survive a motion to dismiss, Plaintiff’s claims “must contain
9 sufficient allegations of underlying facts to give fair notice and to enable the
10 opposing party to defend itself effectively.” *Starr v. Baca*, 652 F.3d 1202, 1216
11 (9th Cir. 2011). Put slightly differently, the complaint’s allegations must “give the
12 defendant fair notice of what the plaintiff’s claim is and the grounds upon which it
13 rests.” *Pickern v. Pier 1 Imps. (U.S.), Inc.*, 457 F.3d 963, 968 (9th Cir. 2006)
14 (internal quotation marks omitted). Here, the allegations fail under these
15 standards.

16 The Second Amended Complaint plucks from the insurance contract some
17 broad language delineating members’ rights, SAC ¶¶ 69–70, and makes a series of
18 “mere conclusory statements” that Coordinated Care failed to meet those
19 obligations. *Villegas v. United States*, 926 F. Supp. 2d 1185, 1195 (E.D. Wash.

1 2013) (citation and internal quotation marks omitted). The only specific
2 allegations concern one instance in which Ms. Harvey allegedly could not access
3 an in-network emergency room physician and one other instance in which part of
4 her claim for a covered procedure was denied. SAC ¶¶ 54–55. Plaintiff neglects to
5 articulate how these two examples, even if true, show that Coordinated Care’s
6 provider network as a whole was inadequate. Taking Plaintiff’s tack, any
7 policyholder could transform small-scale grievances into a federal case of breach
8 of contract. That approach gives Coordinated Care no notice of *how* the alleged
9 conduct breached the cited contractual provisions or *how* Coordinated Care fell
10 short of any obligations.

11 In fact, the health insurance contract itself shows that individual grievances
12 like Ms. Harvey’s do not rise to the level of a breach of contract. Coordinated Care
13 anticipated that insureds may experience issues with accessing providers and built
14 into the contract a grievance and appeal process to address those issues. Second
15 Decl. of Tricia Dinkelman (“Reply Decl.”) Ex. 1, ECF No. 33-2 at 74–78 (excerpts
16 from contract between Coordinated Care Corp. and Plaintiff Harvey). That process
17 provides for an internal appeal of denied claims and, if a policyholder is not
18 satisfied with the outcome, further external review by an independent claims
19 review organization. *Id.* The inclusion of this detailed procedure shows that the

1 parties to the contract did not intend for issues that could be handled through the
2 grievance process to turn into lawsuits in federal court. As noted above, Ms.
3 Harvey admits that she successfully availed herself of the appeal process on
4 multiple occasions. SAC ¶ 56. Where the contract expressly provides for appeals
5 to resolve disputes over benefit determinations, it cannot be a breach that Plaintiff
6 was “forced to complete the process of appeal.” *Id.* Accordingly, Plaintiff should
7 not be allowed to bring a separate contract claim based on issues she already
8 addressed through that process.

9 Moreover, as to Ms. Harvey’s allegation that she was billed for out-of-
10 network emergency room services, her contract with Coordinated Care expressly
11 put her on notice of this possibility: “When receiving care at an in-network
12 Ambetter Hospital, *some Hospital-Based Providers may not be in-network. . . .*
13 *While an in-network Hospital’s emergency department is contracted with*
14 *Ambetter, the Providers within the department may not be.* As a result, these out-
15 of-network Hospital-Based Providers *may bill you for the difference* between what
16 Ambetter pays them and their total bill – this is known as Balance Billing.” Reply
17 Decl. Ex. 2 at 32 (emphasis added). In light of this language in Plaintiff’s contract,
18 the fact that Plaintiff’s emergency room provider billed Ms. Harvey cannot be a
19 breach of her contract with Coordinated Care.

1 Plaintiff's allegation of damages is likewise deficient. By requesting three
2 forms of compensatory damages, Plaintiff is demanding a full or partial refund of
3 her premium payments and/or reimbursement for out-of-pocket expenses she
4 allegedly incurred for care that her plan should have covered. None of those is a
5 valid theory of damages. First, Plaintiff is not eligible for a full refund or the
6 "Benefit of the Bargain." SAC ¶ 76. That would only be appropriate if Plaintiff
7 had obtained no benefits at all under her policy, which is not the case here. The
8 Complaint in fact describes services that Plaintiff received under her plan and
9 payments she received after appealing denied claims. *Id.* ¶¶ 54–56.

10 Second, Plaintiff's damages theories are impermissibly vague. Her claim
11 amounts to saying that some undefined portion of what Plaintiff paid Coordinated
12 Care and/or some undefined out-of-pocket expenses represents Plaintiff's damages.
13 In other words, Defendants allegedly owe Plaintiff some or all of whatever cost she
14 incurred for covered care. This claim provides no notice of what compensation
15 Plaintiff is seeking or how that compensation is tied to the alleged contractual
16 breach, making it too vague to support a claim for relief. *See Adolf Jewelers, Inc.*
17 *v. Jewelers Mut. Ins. Co.*, No. 3:08-CV-233, 2008 WL 2857191, at *4 (E.D. Va.
18 July 21, 2008) ("[A]llegations that [plaintiff] (1) incurred unnecessary and
19 considerable costs and other damages, (2) was inconvenienced, and (3) lost time do

1 not give [defendant insurance company] fair notice of the grounds for [plaintiff's]
2 claim.” (internal quotation marks omitted)). Plaintiff’s breach-of-contract claim—
3 despite being presented a third time—remains facially inadequate and should be
4 dismissed.

5 **III. Plaintiff Fails To State a Claim Against CMC Under an Alter Ego**
6 **Theory.**

7 As an apparent admission that her alter ego theory against Centene
8 Corporation in the original complaint was unworkable, Plaintiff dropped that entity
9 as a defendant. But Plaintiff has added Centene Management Company as a
10 defendant and now advances an even more tenuous alter ego theory—that this
11 Court should pierce the veils of both Coordinated Care *and* CMC through their
12 connection with Centene Corporation, and hold CMC liable for Coordinated Care’s
13 alleged wrongdoing.

14 This new alter ego theory fails like the first one. Plaintiff again ignores a
15 foundational requirement of the alter ego doctrine—that the corporate form must
16 be respected unless it has been misused to commit a fraud or injustice. Plaintiff
17 makes no allegations at all explaining how the relationship between Coordinated
18 Care and CMC effects any fraud or injustice on Plaintiff. But even as to the other
19

1 main requirement of the alter ego doctrine—the total domination and control of
2 one corporation by another—Plaintiff’s allegations fall short.

3 **A. Plaintiff Fails To Allege Fraud or Injustice.**

4 Whatever the relationship between two related corporate entities, veil-
5 piercing is not appropriate unless it is required to avoid a fraud or injustice on the
6 plaintiff. *See, e.g., Meisel v. M & N Modern Hydraulic Press Co.*, 645 P.2d 689,
7 692 (Wash. 1982) (en banc) (recognizing that veil-piercing is appropriate only
8 where it is “necessary and required to prevent unjustified loss to the injured party”
9 (internal quotation marks and citation omitted)); *Massey v. Conseco Servs., L.L.C.*,
10 879 N.E.2d 605, 609 (Ind. App. 2008) (requiring that plaintiff show that “the
11 misuse of the corporate form would constitute a fraud or promote injustice”
12 (internal quotation marks and citation omitted)); *Consumer’s Co-op v. Olsen*, 419
13 N.W.2d 211, 214 (Wis. 1988) (requiring plaintiff to show that “applying the
14 corporate fiction would accomplish some fraudulent purpose, operate as a
15 constructive fraud, or defeat some strong equitable claim” (internal quotation
16 marks and citation omitted)).²

17 ² Because Plaintiff seeks to disregard the corporate separateness of both
18 Coordinated Care (an Indiana corporation) and CMC (a Wisconsin corporation),
19 Indiana and Wisconsin law likely apply. *See* Restatement (Second) of Conflict of

1 The Second Amended Complaint lacks any allegations that suggest this
2 prong of the alter ego inquiry is met. The sole factual basis of Plaintiff’s alter ego
3 case is a one-paragraph cut-and-paste from a financial statement, which says that
4 Coordinated Care contracts with CMC for the provision of various “management
5 services.” SAC ¶ 2. From that point forward, Plaintiff proceeds to ignore any
6 distinction between Coordinated Care and CMC. *See id.* (stating that the term
7 “Centene” is used to “refer to the joint activities of Centene Management
8 Company, LLC and Coordinated Care”).

9 Even if such a management services agreement were improper (as is shown
10 below, *see infra* p. 19, it is not), Plaintiff fails to suggest any reason why that
11 arrangement is fraudulent or unjust as to her. Notably absent from the Second
12 Amended Complaint is any allegation that Coordinated Care is undercapitalized or
13 unable financially to provide Plaintiff appropriate relief. In fact, Plaintiff’s
14 allegations suggest the opposite; she states that she has successfully used the
15 appeal process provided for in her insurance contract to secure reimbursement
16 from Coordinated Care. SAC ¶ 56. This is reason enough to dismiss Plaintiff’s
17 Laws § 307 (law of “state of incorporation” applies to questions of shareholder
18 liability). The alter ego tests of Indiana, Wisconsin, and Washington are broadly
19 similar, and Plaintiff’s alter ego allegations would fail under each one.

1 alter ego claim. If Coordinated Care can provide Plaintiff sufficient relief, then
2 veil-piercing clearly is not necessary. *See, e.g., Poulos v. Naas Foods, Inc.*, 959
3 F.2d 69, 74 (7th Cir. 1992) (Wisconsin law) (recognizing that veil-piercing was not
4 “required to avoid . . . possible fraud” because plaintiff could not allege “that the
5 assets of [the subsidiary] would be insufficient to satisfy a judgment”); *Phillips v.*
6 *USAA Cas. Ins. Co.*, No. 2:16-CV-0381-TOR, 2017 WL 26907, at *3 (E.D. Wash.
7 Jan. 3, 2017) (Washington law) (declining to add parent entity under veil-piercing
8 theory because piercing was not “necessary to prevent an unjustified loss,” as its
9 subsidiary “is willing to pay the amount . . . owed”).

10 Moreover, Plaintiff has not pled any causal connection between Defendants’
11 corporate form and Plaintiff’s alleged injury, nor has Plaintiff pled any misuse of
12 the corporate form. *See, e.g., Meisel*, 645 P.2d at 693 (“Intentional misconduct
13 must be the cause of the harm that is avoided by disregard.”); *CBR Event*
14 *Decorators, Inc. v. Gates*, 962 N.E.2d 1276, 1282–83 (Ind. App. 2012) (“[T]he
15 fraud or injustice alleged by a party seeking to pierce the corporate veil must be
16 caused by, or result from, misuse of the corporate form.”); *Consumer’s Co-op*, 419
17 N.W.2d at 218 (misuse of corporate form “must proximately cause the injury or
18 unjust loss complained of”). Plaintiff alleges that she was harmed because
19 Coordinated Care did not appropriately reimburse her for various treatments. SAC

1 ¶¶ 54–55. These allegations have nothing at all to do with the relationship between
2 Coordinated Care and CMC.

3 **B. Plaintiff Fails To Allege Complete Domination.**

4 Plaintiff does no better on the other prong of the alter ego test, which
5 requires a showing that one company “complete[ly] dominat[ed]” the other.
6 *Consumer’s Co-op*, 419 N.W.2d at 217–18. The only basis for Plaintiff’s
7 suggestion that CMC dominates Coordinated Care is that, under a “management
8 services agreement,” CMC provides Coordinated Care a number of management
9 and administrative services. SAC ¶ 2. These arrangements are common and not
10 indicative of a failure to respect corporate separateness. *See In re Western States*
11 *Wholesale Natural Gas Antitrust Litig.*, No. 03-cv-1431 *et al.*, 2009 WL 455658, at
12 *11–*12 (D. Nev. Feb. 23, 2009); *Everitt v. Dover Downs Ent’mt Inc.*, No. 98-cv-
13 6116, 1999 WL 374163, at *6 (E.D. Pa. June 9, 1999). As the Court in *Everitt*
14 noted, in a traditional holding company structure (like Centene’s), it “makes
15 economic sense” for “[c]ertain activities [to be] centralized.” *Everitt*, 1999 WL
16 374163, at *6. That is all that Plaintiff has alleged that Defendants have done.
17 Accordingly, her control allegations fall far short, and CMC should be dismissed.

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19

1 **CONCLUSION**

2 For the foregoing reasons, the Court should dismiss the Second Amended
3 Complaint as to all Defendants with prejudice.

4 Dated: September 12, 2018

Respectfully submitted,

5 STOEL RIVES LLP

6 By: /s/ Maren R. Norton

Maren R. Norton

7 600 University Street, Suite 3600

Seattle, WA 98101

8 Tel.: 206-624-0900

maren.norton@stoel.com

9
10 Brendan V. Sullivan, Jr. (admitted *Pro Hac*
Vice)

Steven M. Cady (admitted *Pro Hac Vice*)

11 WILLIAMS & CONNOLLY LLP

725 Twelfth Street, N.W.

12 Washington, D.C. 20005

Tel.: 202-434-5321

13 Fax: 202-434-5029

scady@wc.com

14 *Attorneys for Defendants*

1 **CERTIFICATE OF SERVICE**

2 I hereby certify that on September 12, 2018, I electronically filed the
3 foregoing with the Clerk of the Court using the CM/ECF System, which in turn
4 automatically sent a Notice of Electronic Filing to all parties in the case who are
5 registered users of the CM/ECF system. The Notice of Electronic Filing for the
6 foregoing specifically identifies recipients of electronic notice.

7
8 /s/ Maren R. Norton
Maren R. Norton
600 University Street, Suite 3600
Seattle, WA 98101
Tel.: 206-624-0900
maren.norton@stoel.com

1 Brendan V. Sullivan, Jr.
Steven M. Cady
2 WILLIAMS & CONNOLLY LLP
725 Twelfth Street, N.W.
3 Washington, D.C. 20005
Tel.: 202-434-5321
4 scady@wc.com

Honorable Salvador Mendoza, Jr.

5 Maren R. Norton
STOEL RIVES LLP
6 600 University Street, Suite 3600
Seattle, WA 98101
7 Tel.: 206-624-0900
maren.norton@stoel.com

8
Attorneys for Defendants

10 UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
11 AT YAKIMA

12 CYNTHIA HARVEY, individually
and on behalf of all others similarly
13 situated,

14 Plaintiff,

15 v.

16 CENTENE MANAGEMENT
COMPANY, LLC and
17 COORDINATED CARE
CORPORATION,

18 Defendants.
19

No. 2:18-CV-00012-SMJ

**[PROPOSED] ORDER
GRANTING MOTION TO
DISMISS SECOND AMENDED
COMPLAINT**

[PROPOSED] ORDER GRANTING MOTION TO
DISMISS SECOND AMENDED COMPLAINT- 1
No. 2:18-CV-00012-SMJ

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

1 Before this Court is Defendants Coordinated Care Corporation and Centene
2 Management Company’s Motion to Dismiss Second Amended Complaint. The
3 Court has reviewed the motion and being fully advised in the premises; it is
4 ORDERED that the motion be, and hereby is, GRANTED. The Second
5 Amended Complaint is dismissed with prejudice.

6 DATED this _____ day of _____, 2018.

7

8

Hon. Salvador Mendoza, Jr.
United States District Court Judge

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Presented by:

12

Stoel Rives LLP

13

/s/ Maren R. Norton

14

Maren R. Norton, WSBA No. 35435

15

600 University Street, Suite 3600

16

Seattle, WA 98101

17

Tel.: 206-624-0900

18

maren.norton@stoel.com

19

Counsel for Defendants

[PROPOSED] ORDER GRANTING MOTION TO
DISMISS SECOND AMENDED COMPLAINT- 1
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STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900