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Honorable Salvador Mendoza, Jr.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

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

Plaintiff,

v.

CENTENE MANAGEMENT COMPANY, LLC and COORDINATED CARE CORPORATION,

Defendants.

No. 2:18-CV-00012-SMJ

DEFENDANTS' REPLY IN SUPPORT OF MOTION TO DISMISS SECOND AMENDED COMPLAINT

Oral argument: November 20, 2018, 9:30 AM

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Plaintiff's opposition to Defendants' renewed Motion to Dismiss is a futile attempt to circumvent the filed-rate doctrine, which bars both of Plaintiff's remaining claims for breach of contract and unfair business practices under the Washington Consumer Protection Act (WCPA). Plaintiff says that her claims should not be dismissed under the filed-rate doctrine because she is not challenging the reasonableness of rates approved by the Washington State Office of the Insurance Commissioner (OIC). But she asks for a refund of or a discount to the premiums that she paid. Even if her breach-of-contract claim is not barred by the filed-rate doctrine, it should be dismissed because Plaintiff has no response to the main thrust of Defendants' argument: the insurance contract at issue provides for a grievance and appeal procedure to resolve disputes concerning benefits; therefore a simple denial of benefits cannot constitute a breach of contract. And Centene Management Company (CMC) should be dismissed from the case because Plaintiff has failed to state a claim against it.

ARGUMENT

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

The filed-rate doctrine bars Plaintiff's claims because, contrary to her arguments, the doctrine applies to rates approved by state agencies and because her claims challenge the reasonableness of approved rates in exactly the way precluded

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by *McCarthy Finance, Inc. v. Premera*, 347 P.3d 872 (Wash. 2015). Plaintiff argues that the filed-rate doctrine should apply only to rates approved by federal agencies, but concedes (as she must) that the Washington Supreme Court in *Premera* unanimously applied the doctrine to rates approved by the OIC. Pl's Resp. to Defs' Renewed Mot. to Dismiss (Resp.) (ECF No. 56) at 7. The aim of her argument is apparently to persuade the Court that the rule of law applied in *Premera* was not the familiar filed-rate doctrine as recognized for decades in federal courts, but rather some different—and somehow narrower—"state doctrine." *Id*. at 6. But the *Premera* court gave no indication that it was adopting a different or narrower rule. *See* 347 P.3d at 875 (citing *Wegoland Ltd. v. NYNEX Corp.*, 806 F. Supp. 1112, 1113–16 (S.D.N.Y. 1992)).

Plaintiff tries to distinguish *Premera* from this case, but fails. *Premera* struck a careful balance in applying the filed-rate doctrine. It did not seek to preclude all state-law claims, and the present case does not call for so broad a rule. Instead, the *Premera* test is "whether the claims and damages are *merely incidental* to agency-approved rates and therefore may be considered by courts or would *necessarily require* courts to reevaluate agency-approved rates." 347 P.3d at 875 (emphases added). In this case, the alleged claims and damages would necessarily require this Court to reevaluate rates approved by the OIC.

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That is true for Plaintiff's "Benefit of the Bargain" damages theory, which seeks a "refund [of] the entire amount of all premiums paid," and Plaintiff's "Partial Refund" theory, which seeks a refund of any difference in value between the policy as represented and the policy as delivered. Resp. at 8. Under either of Plaintiff's theories, this Court "would need to determine what health insurance premiums would have been reasonable for the [insureds] to pay as a baseline." *Premera*, 347 P.3d at 876. For Plaintiff's Partial Refund theory, this Court would have to consider what premium would have been reasonable for the benefits that Plaintiff alleges she actually received. For Plaintiff's Benefit of the Bargain theory, this Court would have to conclude that Plaintiff received nothing of value under her policy such that she is entitled to a full refund of the premiums paid. Plaintiff's damages theories are thus analogous to the "refund" claim unanimously rejected in *Premera*.[1] *Id.*

Despite requesting damages that challenge agency-approved rates, Plaintiff tries to escape the filed-rate doctrine in two ways. Both fall short. *First*, Plaintiff

[1] Plaintiff cannot evade the filed-rate doctrine simply by seeking out-of-pocket expenses as an additional form of damages. If that were sufficient, then any plaintiff could render the filed-rate doctrine a nullity simply by adding a claim for out-of-pocket expenses.

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argues that she is challenging the benefits provided under her policy and not what she paid for the policy. But even though her *claim* is based on allegedly inadequate benefits, the *damages* she seeks would require this Court to reevaluate agency-approved rates. Moreover, Plaintiff's allegation that the benefits were inadequate in relation to the rates charged is logically equivalent to a claim that the rates were excessive in relation to the benefits provided. *See AT&T v. Cent. Office Tel., Inc.*, 524 U.S. 214, 223 (1998) (recognizing this equivalency); *Brown v. MCI, WorldCom Network Servs., Inc.*, 277 F.3d 1166, 1170–71 (9th Cir. 2002) (same). *Second*, Plaintiff argues that the OIC reviewed the benefits that Coordinated Care promised to provide, not the benefits that it actually delivered, which is what she purportedly challenges. But Plaintiff's challenge to the benefits as delivered is analogous to the barred claim in *Premera*. Plaintiffs in *Premera* alleged that the filed rates were based on the insurer's unfair and deceptive advertising and business practices, 347 P.3d at 874, whereas Plaintiff here asserts that the rates were based on overstated benefits. In both cases, the OIC approved the rates based on information that plaintiffs allege was misrepresented in some way. Plaintiff's claim thus falls squarely within *Premera*'s holding.

Finally, Plaintiff raises two other challenges to the filed-rate doctrine. The first is Plaintiff's implication that the doctrine would swallow any claim "*merely*

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related to agency-approved rates." *Premera*, 347 P.3d at 873. Even under Defendants' position, however, Plaintiff's claims could conceivably have survived had she not sought a refund of the agency-approved rate she paid. In fact, courts have allowed a variety of claims to overcome the filed-rate doctrine so long as they do not require a reevaluation of agency-approved rates. *See, e.g.*, *Siewert v. N. States Power Co.*, 793 N.W.2d 272, 277–83 (Minn. 2011) (tort claims against a power utility for losses caused by stray voltage where plaintiffs "[did] not seek a re-analysis of the rate paid for electricity, either retrospectively or prospectively, implicitly or explicitly"); *Williams v. Duke Energy Intern., Inc.*, 681 F.3d 788, 796–98 (6th Cir. 2012) (statutory claims against an electric utility for paying kickbacks to certain large customers pursuant to side agreements "made outside of the rate[-setting] scheme").

Plaintiff's second challenge, that the filed-rate doctrine leaves her with no recourse, fares no better. As part of its review of Coordinated Care's provider networks, the OIC has required Coordinated Care to adopt a corrective action plan that "detect[s] consumers who have suffered harm from insufficient access and [includes] a plan for making those consumers whole," which "must, at a minimum, include refund of any amount consumers paid over the in-network rate . . . and ensur[e] that consumers who obtained services paid no more than required by the

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policy terms." Resp. Ex. 1 (consent order), Compliance Plan, p. 4 (ECF No. 57 at 18). Thus, the OIC is working to ensure that the benefits delivered are adequate in relation to the agency-approved rates and providing for exactly the remedies that Plaintiff seeks here. There is no need for the Court to duplicate the regulator's efforts.

For these reasons, *Premera* mandates dismissal of Plaintiff's claims. If this Court has any doubt on that issue, it should certify the following question to the Washington Supreme Court: "Following *McCarthy Finance, Inc. v. Premera*, does the filed-rate doctrine bar claims under Washington law based on an allegation that an insurer provided inadequate benefits in relation to rates submitted and approved by the Washington State Office of the Insurance Commissioner?"

II. Plaintiff Fails To Adequately Plead Breach of Contract.

Plaintiff offers no response to Defendants' primary objection to the breach-of-contract claim, namely that the insurance contract itself establishes a grievance and appeal process for resolving benefit disputes and providing remedies where appropriate. Second Decl. of Tricia Dinkelman ("Reply Decl.") Ex. 1 (ECF No. 33-2) at 74–78 (excerpts from contract between Coordinated Care Corp. and Plaintiff). Because of the grievance and appeal process built into the contract, a particular initial benefit denial is a matter to be challenged and resolved through

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the contractual procedure rather than a federal breach of contract action. Plaintiff understands this fact and has successfully challenged her denied claims through the contractual procedure. SAC ¶ 56.

In addition, the contract warns members that certain providers within a hospital's emergency department may be out-of-network and that members may be "balance-billed" for those services. Reply Decl. Ex. 1 (ECF No. 33-2) at 32. Given this warning, the bill that Plaintiff received from an out-of-network provider in a hospital's emergency department cannot be a breach of contract. In short, because the contract provides a procedure for appealing benefit determinations and warns about the balance-billing underlying Plaintiff's claim, and because Plaintiff already has successfully appealed her claim denials, she should not be given an additional run in federal court.

Even setting those issues aside, Plaintiff's breach-of-contract claim is thinly pleaded. Resp. at 14. Plaintiff specifically alleges only two denials of benefits and cites a host of broadly worded contractual provisions. SAC ¶¶ 54–55. Defendants are thus left to guess whether and how the two particular incidents described by Plaintiff reflect breaches of the cited provisions. That tactic falls short of the notice pleading requirement. *Starr v. Baca*, 652 F.3d 1202, 1216 (9th Cir. 2011).

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III. Plaintiff Fails To State a Claim Against Centene Management Co.

Plaintiff has not pleaded a valid claim against CMC on either an alter-ego or direct-liability theory.

As to the alter-ego theory, Plaintiff does not dispute that fraud or injustice is a required element. She claims to meet this element because she wishes "to avoid a finger-pointing situation.'" Resp. at 19–20. There is no prospect of that happening here. No one disputes that Coordinated Care owes contractual and statutory duties to Plaintiff, or that Coordinated Care would potentially be liable if those duties were breached. Moreover, Plaintiff never suggests that Coordinated Care is unable to meet its obligations. *See Phillips v. USAA Cas. Ins. Co.*, No. 2:16-CV-0381-TOR, 2017 WL 26907, at *3 (E.D. Wash. Jan. 3, 2017) (declining to add a related company because veil-piercing was not "necessary to prevent an unjustified loss"). The cases cited by Plaintiff are not on point. *See Rapid Settlements Ltd.'s Application*, 271 P.3d 925, 931 (Wash. App. 2012) (addressing a situation where "assets were transferred between the entities to avoid the creditor claims"); *Landstar Inway, Inc. v. Samrow*, 325 P.3d 327, 338 (Wash. App. 2014) (noting that defendant allegedly used the corporate form to "accomplish [a] fraud"). Accordingly, because Plaintiff has not pled an injury caused by fraud or injustice, her alter ego theory fails as a matter of law.

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Moreover, it is well established that there is nothing improper about management services agreements like the one between Coordinated Care, the primary defendant, and CMC. *See* Defs' Mot. to Dismiss (ECF No. 50) at 19. Plaintiff suggests that this case is different because CMC allegedly "runs nearly every aspect of Coordinated's insurance business." Resp. at 18. But Plaintiff cannot suggest that CMC does more than is typical in management company relationships. In *In re Western States Wholesale Natural Gas Antitrust Litigation*, No. 03-cv-1431 *et al.*, 2009 WL 455658 (D. Nev. Feb. 23, 2009), for instance, the relevant management agreement covered a similarly full range of services, "including general administrative services, accounting, statistical and financial, risk management, tax, internal auditing, information management, legal communications, engineering, public affairs, and human resources services." *Id.* at *8. Yet that court rejected plaintiffs' alter-ego theory. *Id.* at *11.

Plaintiff also seeks to plead her WCPA claim against CMC *directly* and identifies two bases for direct liability: that CMC was responsible for alleged misrepresentations about Coordinated Care's provider networks, and that CMC allegedly misprocessed health insurance claims filed by Coordinated Care members. Resp. at 16–17. As to the first, Plaintiff unreasonably reads CMC's responsibility for "provider and enrollee services and records" to assign CMC

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blame for any allegedly misleading claims from Coordinated Care. *Id*. at 17. And as to the second, Plaintiff fails to allege that she was harmed by any misprocessing of claims. Instead, she alleges that she appealed "each" time one of her claims was denied, SAC ¶ 56, and that "[i]n many cases, her appeal was ultimately successful." *Id.* The inconvenience of pursuing a contractually provided appeal is not a harm compensable under the WCPA. *See Pitner v. Northland Grp., Inc.*, No. C11-5853BHS, 2012 WL 254035, at *3 (W.D. Wash. Jan. 26, 2012) (finding that "mere inconvenience unaccompanied by pecuniary harm" is not compensable injury under CPA). On both of Plaintiff's theories, if they survive the other grounds for dismissal, her claims against CMC should be dismissed.

CONCLUSION

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

Dated: October 31, 2018.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on October 31, 2018 I caused a true and correct copy of the foregoing to be electronically filed with the Clerk of the Court using the CM/ECF system which will send notification of such filing to the following participants:

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