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

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

Attorneys for Defendants

Honorable Salvador Mendoza, Jr.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

CYNTHIA HARVEY and STEVEN A. MILMAN, individually and on behalf of all others similarly situated,

Plaintiffs,

v.

CENTENE CORPORATION, COORDINATED CARE CORPORATION, and SUPERIOR HEALTHPLAN, INC.,

Defendants.

No. 2:18-CV-00012-SMJ

COORDINATED CARE'S REPLY IN SUPPORT OF MOTION TO DISMISS

(Oral Argument: July 19, 10:00 AM)

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

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

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

Counts I, II, and IV of the Complaint should be dismissed against Coordinated Care Corporation ("Coordinated Care") because there is no private right of action under the Affordable Care Act ("ACA") provisions at issue, the Complaint fails to adequately state a claim for breach of contract, and, as Plaintiffs effectively concede, claims arising under the Texas Deceptive Trade Practices Act ("TDTPA") cannot be maintained against Coordinated Care.

ARGUMENT

I. The Affordable Care Act Claims Must Be Dismissed for Lack of a Private Right of Action.

Plaintiffs have no private right of action to bring their ACA claims. They acknowledge that the statute affords no express right of action, Pls.' Resp. to Defs.' Mots. to Dismiss, ECF No. 30 at 17 ("Resp."), but continue to argue for an *implied* right of action. That argument is riddled with errors. For starters, Plaintiffs apply the wrong legal standard for inferring a private right of action where Congress has not created one. They then make the illogical argument that the ACA has incorporated the private right of action provision from the Employee Retirement Income Security Act ("ERISA") because the ACA references and modifies some parts of ERISA.

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

As for the legal standard, Plaintiffs get it wrong. They cite a three-factor test adopted by the Supreme Court in *Blessing v. Freestone* and applied by the Ninth Circuit in *Cal. State Foster Parent Ass'n v. Wagner*. Resp. 16–19. That test, however, is for determining whether a federal statute provides a right that can be enforced *under 42 U.S.C. § 1983*—which is not the issue presented in this case. In that circumstance, § 1983 affords a private right of action that allows individuals to sue state or local officials, and the only question is whether some other federal law establishes an enforceable right. The question in this case is different—whether the ACA itself provides a private right of action. The Supreme Court has made clear that these are two distinct inquiries with two distinct legal tests: "[i]n implied right of action cases, [the Court] employ[s] the four-factor *Cort* [*v. Ash*] test" cited in Coordinated Care's motion, not the three-factor *Blessing* test cited by Plaintiffs. *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 508 n.9 (1990).[1]

[1] While some courts have questioned whether the four *Cort v. Ash* factors have been subsumed into a single inquiry into congressional intent, the Ninth Circuit continues to use the *Cort* test while stressing that congressional intent is the touchstone. *See Opera Plaza Residential Parcel Homeowners Ass'n v. Hoang*, 376 F.3d 831, 834 (9th Cir. 2004).

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

Plaintiffs do not even attempt to argue that the ACA provisions at issue satisfy the *Cort* test, nor would any such argument be viable. Plaintiffs' Response focuses on sections 300gg-6 and -9 of the ACA, Resp. 19–20, but those provisions fail the very first *Cort* factor, which "look[s] to whether the plaintiffs that claim a cause of action exists are specifically mentioned as beneficiaries in the statute." *Opera Plaza*, 376 F.3d at 835. Sections 300gg-6 and -9 of the ACA, however, impose requirements on health insurers and say nothing about policyholders like Plaintiffs. In other words, these provisions "focus on the person regulated rather than the individuals protected" and therefore "create no implication of an intent to confer rights on a particular class of persons." *Alexander v. Sandoval*, 532 U.S. 275, 289 (2001) (internal quotation marks and citation omitted).

At bottom, Plaintiffs have offered no affirmative evidence of congressional intent to provide a private right of action for their ACA claims. Nor have they rebutted the clear evidence to the contrary—that Congress had administrative, rather than private enforcement in mind. Plaintiffs attempt to wave aside this fact by arguing that there is no administrative agency where "insureds can go as a class for recompense for failure to receive what they are entitled to under Section 300gg-6 and -9." Resp. 22. Their argument misses the central point from *Gonzaga v. Doe* and *Alexander v. Sandoval*: a statute's express reference to enforcement by

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

agencies is strong evidence that Congress did not intend to permit private lawsuits. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 289–90 (2002); *Alexander v. Sandoval*, 532 U.S. 275, 289–90 (2001). That is precisely the case here. For the ACA provisions at issue, Congress vested primary enforcement authority in state agencies, 42 U.S.C. § 18041(b); 42 U.S.C. § 300gg-22(a)(1), and authorized a federal agency, the Centers for Medicare & Medicaid Services, to step in should the state regulators fall short. 42 U.S.C § 18041(c)(1); 42 U.S.C. § 300gg-22(a)(2). Inferring a private right of action would allow federal courts to interfere with the administrative enforcement scheme that Congress specifically envisioned.

With not a single case supporting their argument for an implied private right of action under the ACA provisions they cite, Plaintiffs resort to an attempt to draw a connection between ERISA's private right of action and the ACA. They acknowledge that the only cases to infer a private right of action under the ACA involve § 1557—the statute's anti-discrimination provision—but attempt to analogize this case to those involving § 1557. According to Plaintiffs, "[t]he ACA's cross-reference to ERISA for the Section 300gg1-19 requirements is just like the ACA's cross-reference to anti-discrimination statutes that justifies a private right of action for Section 1557 claims." Resp. 20.

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

Plaintiffs' analogy falls apart upon inspection. Section 1557 references four federal civil rights laws and specifically borrows their rights-creating language as well as private enforcement mechanisms. 42 U.S.C. § 18116(a). Because that provision so closely mirrors other statutory language that creates a private right of action, some courts have inferred that Congress intended for § 1557 to provide the same right. Coordinated Care Mot. 10–11. Plaintiffs' logic, however, runs in the opposite direction. Unable to show that the relevant *ACA* provisions incorporate rights-creating language *from ERISA*, Plaintiffs instead stress that *ERISA* has been amended with certain new requirements *from the ACA*. They do not explain how that leads to the inference that ERISA's express private right of action has migrated *into the ACA*. At most, the ACA's amendment of ERISA might allow insureds covered by ERISA plans to bring ERISA claims that invoke the incorporated ACA requirements. But the plans in this case are not ERISA plans, and Plaintiffs purport to bring this action under the ACA, not ERISA. In short, nothing about the ACA's cross-reference to ERISA suggests any congressional intent to establish a private right of action under the ACA.

The cases cited by Plaintiffs only highlight how their argument misses the mark. Two of them feature ERISA insurance plans and claims brought under ERISA; they merely state that ERISA incorporated new requirements from the

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

ACA. *King v. Blue Cross and Blue Shield of Illinois*, 871 F.3d 730, 739 (9th Cir. 2017); *New York State Psychiatric Ass'n, Inc. v. UnitedHealth Group*, 980 F. Supp. 2d 527, 544 (S.D.N.Y. 2013). The two other cases cited involve ACA claims but do not come close to inferring a private right of action under the ACA provisions at issue here. In *Briscoe v. Health Care Serv. Corp.*, plaintiffs asserted ACA violations under § 1557. 281 F. Supp. 3d 725, 737-738 (N.D. Ill. 2017). And in *Condry v. UnitedHealth Group*, the court made clear that the plaintiff was "not trying to create a private right of action under the Affordable Care Act but rather to enforce her own rights in contract and quasi-contract." No. 17-cv-00183-VC, 2017 WL 7420997, at *3 (N.D. Cal. Aug. 15, 2017).

Finally, Plaintiffs offer no real response to Coordinated Care's argument that, without an implied right of action under the ACA, Plaintiffs cannot bring claims under related regulations. Plaintiffs simply note that courts defer to an agency's reasonable interpretation of a statute. Resp. 24. Yet they present no agency interpretations finding an implied right of action in the ACA provisions cited in the Complaint. The one case they cite refers to regulations that confirm the private right of action available under § 1557. *Griffin v. Verizon Communs., Inc.*, No. 1:16-CV-00080-AT, 2017 WL 6350596, at *3 n.3 (N.D. Ga. Sept. 26, 2017). Plaintiffs have given this court no reason to infer a private right of action

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

contrary to congressional intent, and there is good reason to avoid unleashing a wave of similar federal lawsuits under the ACA. Count I should be dismissed.

II. The Complaint Fails To Adequately Plead Breach of Contract.

Plaintiffs' breach of contract claim must be dismissed because it does not "give the defendant fair notice of what the plaintiff's claim is and the grounds upon which it rests," a pleading requirement that Plaintiffs do not contest. *Pickern v. Pier 1 Imps. (U.S.), Inc.*, 457 F.3d 963, 968 (9th Cir. 2006) (internal quotation marks omitted). Their response doubles down on the Complaint's flawed strategy for asserting breach of contract. Plaintiffs cite broadly worded provisions from the plan contracts and raise a few isolated grievances without stating how those grievances reflect the necessary elements of breach, causation, and damages.

Under the contract provisions cited, policyholders should have a current list of providers, adequate access to a network of providers, and access to medically necessary care. Compl. ¶ 88. The Complaint contains a series of "mere conclusory statements" about Coordinated Care's alleged shortcomings in this regard, which are insufficient to survive a motion to dismiss. *Villegas v. United States*, 926 F. Supp. 2d 1185, 1195 (E.D. Wash. 2013) (citation and internal quotation marks omitted). The only specific allegations concern one instance in which Plaintiff Harvey allegedly could not access an in-network emergency room

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

physician and one other instance in which part of her claim for a covered procedure was denied. Compl. ¶¶ 60–61. Plaintiffs neglect to articulate how these two examples, even if true, show that Coordinated Care's provider network as a whole was inadequate. In other words, the Complaint draws too tenuous a connection between the alleged conduct and the relevant contractual provisions.

In fact, the health insurance contract itself shows that individual grievances like Ms. Harvey's do not rise to the level of a breach of contract. Coordinated Care anticipated that insureds may experience issues with accessing providers and built into the contract a grievance and appeal process to address those issues. Second Decl. of Tricia Dinkelman ("Reply Decl.") Ex. 1, ECF No. 33-1 at 74–78 (excerpts from contract between Coordinated Care Corp. and Plaintiff Harvey). This shows that the parties to the contract did not intend for issues that could be handled through the grievance process to turn into contract disputes in federal court. Indeed, Ms. Harvey admits that she successfully availed herself of that process. Compl. ¶ 62. Where the contract expressly provides for potential disputes and appeals, it cannot be a breach that she was "forced to complete the process of appeal." *Id*.

Moreover, as to Ms. Harvey's complaint concerning emergency room services, her contract with Coordinated Care expressly provides that:

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

"When receiving care at an in-network Ambetter Hospital, *some Hospital-Based Providers may not be in-network. . . . While an in-network Hospital's emergency department is contracted with Ambetter, the Providers within the department may not be*. As a result, these out-of-network Hospital-Based Providers may bill you for the difference between what Ambetter pays them and their total bill – this is known as Balance Billing." Reply Decl. Ex. 1 at 32.

In light of this clear contractual text, the fact that Ms. Harvey's emergency room provider was out-of-network and Ms. Harvey was billed accordingly cannot be a breach.

Plaintiffs' damages claim is likewise deficient. The alleged damages include essentially all the costs that Ms. Harvey paid for covered care, namely premiums, amounts paid pursuant to improper billings, and expenses incurred in seeking or obtaining medical services. Compl. ¶ 92. While Plaintiffs are not obligated to set out a detailed accounting of damages in the Complaint, they still must give defendants "fair notice" of the damages claim. *Starr v. Baca*, 652 F.3d 1202, 1216 (9th Cir. 2011). As it stands, Plaintiffs are not alleging that they received no services at all under their insurance plan; Plaintiff Harvey in fact describes the care she received. Compl. ¶¶ 60–61. Moreover, Ms. Harvey admits in her Complaint that she successfully appealed the initial denial of certain of her claims. Compl.

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

¶ 62. That means the damages owed cannot be the total amount that Plaintiffs allegedly incurred. The damages claim should, at a minimum, exclude the amount associated with services that were properly provided and claims that Coordinated Care has already paid in accordance with the contract. Put simply, Plaintiffs have failed to articulate damages caused by the alleged breach. The Complaint fails to state a claim for breach of contract, and Count II should be dismissed.

III. The Texas Deceptive Trade Practices Act Claims Must Be Dismissed as to Coordinated Care.

Plaintiffs' claims under the TDTPA cannot be maintained against Coordinated Care because the Complaint alleges no actions by Coordinated Care that bear any connection to Texas. Coordinated Care Mot. 13–14. Plaintiffs make no effort to rebut this argument. In fact, they effectively concede a parallel point—that Plaintiffs cannot maintain claims under the Washington Consumer Protection Act against Superior HealthPlan, Inc., a Texas corporation with no connection to Washington. Resp. 1. By the same logic and based on the lack of response on Plaintiffs' part, Count IV should be dismissed as to Coordinated Care.

CONCLUSION

For the foregoing reasons, the Court should dismiss Counts I, II, and IV of the Complaint as to Coordinated Care.

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

Dated: May 29, 2018

Respectfully submitted,

STOEL RIVES LLP

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

Brendan V. Sullivan, Jr.
(Admitted *Pro Hac*)
William R. Murray, Jr.
(*Pro Hac* application forthcoming)
George A. Borden
(*Pro Hac* application forthcoming)
Steven M. Cady
(Admitted *Pro Hac*)
Andrew C. McBride
(*Pro Hac* application forthcoming)
Meng Jia Yang
(*Pro Hac* application forthcoming)
WILLIAMS & CONNOLLY LLP
725 Twelfth Street, N.W.
Washington, D.C. 20005
Tel.: 202-434-5321
Fax: 202-434-5029
scady@wc.com

Attorneys for Defendants

CERTIFICATE OF SERVICE

I hereby certify that on May 29, 2018, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF System, which in turn automatically generated a Notice of Electronic Filing (NEF) to all parties in the case who are registered users of the CM/ECF system. The NEF for the foregoing specifically identifies recipients of electronic notice.

/s/Sherry R. Toves

Sherry R. Toves, Practice Assistant
STOEL RIVES LLP
600 University Street, Suite 3600
Seattle, WA 98101
Phone: (206) 624-0900
Email: sherry.toves@stoel.com