approved by the legislature through the Legislative Commission. NRS 233B.067.

While the ultimate interpretation of the amendment is the prerogative of this Court, the interpretation held by the executive branch through the Labor Commissioner and the legislative branch reflected in the legislative approval of the regulations nonetheless warrants due consideration by this Court. *e.g. State v. Glenn*, 18 Nev. 34, 44, 1 P. 186, 190-191 (1883); *Nevada Power Co. v. Pub. Serv. Comm'n of Nevada,* 102 Nev. 1, 4, 711 P.2d 867, 869 (1986) ("while not controlling, the interpretation of the statute by the agency charged with administration of the statute is persuasive."). Further, the administrative expertise wielded by the Labor Commissioner in interpreting the amendment calls for a degree of deference. *See Steamboat Canal Co. v. Garson*, 43 Nev. 298, 316-317, 185 P. 801, 807 (1919) (recognizing the role of agency expertise in interpreting the law).

The definition of "offering health benefits" applies to the directive that an employer must provide health benefits in order to qualify to pay the lower-tier wage rate. Nev. Const. art. 15 § 16(A). As NAC 608.100(1) is consistent with this understanding of the constitutional text, it does not conflict with the minimum wage amendment, let alone generate the clear conflict necessary to invalidate a regulation. The district court's decision finding otherwise should be reversed.

F. NAC 608.104 Does Not Conflict With the Amendment

The second part of the district court's order found that the amendment's 10 percent cost cap on insurance premiums based upon "gross taxable income from the employer" means that the cost cap must be calculated based only upon the taxable income such as base wages paid by the employer to the employee, and must exclude tips. JA 0410-0413.

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

If the Court accepts the first premise of the district court's order and finds that the term "offering health benefits" does not apply to an employer's provision of insurance then the issue of the 10 percent cost cap is rendered moot, as the cost cap is also an element of "offering health benefits." Nev. Const. art. 15. § 16(A). If, however, the Court finds that "offering health benefits" and its attendant elements do apply to an employer's provision of insurance, then it should still overturn the district court's order on this point.

1. The Necessity of Looking to Federal Law

The amendment's cost cap is limited to "not more than 10 percent of the employee's gross taxable income from the employer." Nev. Const. art. 15 sec. 16.

Under the Nevada Constitution, there is no taxable income on employee earnings. Nev. Const. art. 10, § 1(9). Hence the only viable source of standards to measure an employee's gross taxable income is federal tax law. NAC 608.104(2) reflects this reality by referring to federal individual income tax standards to determine the amount of "gross taxable income of the employee attributable to the employer." NAC 608.104(2). The reason that NAC 608.104(2) includes tips as part of an employee's gross taxable income is because federal income tax laws deem it to be so. *See Declaratory Order of Nevada Labor Commissioner Affirming Validity of NAC 608.102(3) and NAC 608.104(2)*, JA 0218-0222.

2. Under Federal Income Tax Law, Tips Are Wages Earned in Connection with Employment

Under federal tax law tips are considered part of an employee's income. *Olk v. United States*, 536 F.2d 876, 879 (9th Cir. 1976). For purposes of income tax law, tips are not considered to be gifts to the employee from a customer. *Commissioner of Internal Revenue v. Duberstein*, 363 U.S. 278

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

(1960). Rather, tips are defined as "wages." 26 U.S.C. § 3401(f). "Wages" in turn are defined as "...remuneration (other than fees paid to a public official) for services performed by an employee for his employer." 26 U.S.C. § 3401(a) (ellipsis in original). Therefore under federal income tax laws, tips are deemed remuneration for services performed by an employee for his employer. Thus, an employee's "gross taxable income" includes tips. *Roberts v. Commissioner of Internal Revenue*, 176 F.2d 221 (9th Cir. 1949).

The district court however, held that under the minimum wage amendment tips are not to be included as part of the "gross taxable income from the employer" when calculating the 10 percent cost cap. The district court reached this conclusion by stressing the phrase "from the employer" and reasoning that this phrase can mean only "...such income that comes 'from the employer,' as opposed to gross taxable income that emanates from any other source, including from tips and gratuities provided by an employer's customers." JA 0411:5-7.

This aspect of the district court's order also renders a portion of the constitutional text meaningless. In particular the word "gross" is deprived of any meaning. "Gross income " means "...all income from whatever source derived..." 26 U.S.C. § 61(a). The word "gross" thus envisions more than a single source of income. If the district court were correct to hold that the minimum wage amendment only applies to income from a single source (the employer) and does not allow for any other source of income then there is no discernable meaning to the word "gross." In contrast, under NAC 608.104's deference to federal income tax law the word "gross" retains meaning.

Under the administrative regulations, this meaning of the phrase "gross taxable income" does not come at the expense of any other constitutional language. Contrary to the district court's analysis, NAC 608.104 does not

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

negate the phrase "from the employer" or deprive it of meaning. The phrase "from the employer" has meaning in that it clarifies that the extent of "gross taxable income" means only that income that is earned in connection with employment for a particular employer. *See* NAC 608.104(1) (establishing the income reported on an employer's Form W-2 as the base measure of gross taxable income relative to the 10 percent cost cap). Under the Labor Commissioner's view the phrase "from the employer" performs the function of specifying that an individual's "gross taxable income" must be employment-related and excludes include income from non-employment related sources, such as rents, dividends, annuities or alimony that are otherwise included as part of an individual's gross income. 26 U.S.C. § 61.

3. Excluding Tips from Gross Taxable Income Unnecessarily Creates Disparity

Excluding tips from the measure of an employee's gross taxable income, as the district court found, creates disparity between tipped employees and non-tipped employees. Under the district court's interpretation an employee that does not earn tips will actually pay a higher percentage of his or her taxable income in health insurance premiums than will an employee who earns tips. For example, if an employee is a non-tipped employee and earns $6,746.66 annually, the premium rate for health insurance benefits should be no more than $674.66 per year, which is 10 percent of the employee's taxable earnings. However, if that same employee is a tipped employee and earns $15,979.16 annually (including tips),[4] but is under the same cost-cap of $674.66 for health insurance premiums, this premium cost would be only

[4] These figures are taken from the Form W-2 submitted by Hancock to the district court. JA 0354.

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

roughly 4 percent of the employee's taxable earnings. Such a rule would disparately favor tipped employees over non-tipped employees.

Whether or not to create such a rule that favors tipped employees is a policy question. Within the amendment itself the drafters included a provision that favors tipped employees in the context of using tips to satisfy the applicable wage rate. *See* Nev. Const. art. 15 § 16(A) ("Tips or gratuities received by employees shall not be credited as being any part of or offset against the wage rates required by this section"). However, the drafters of the amendment did not include a similar specific provision that allows for such a disparate rule under the 10 percent cost cap provision. *Id.*

The district court's order further creates a new and inconsistent requirement on employers when treating employee tips. Under the Internal Revenue Code, an employer is responsible for treating tips as taxable income and making the appropriate withholding. 26 U.S.C. § 3402(a)(1). But under the minimum wage amendment employers must treat tips effectively as gifts rather than "gross taxable income." Aside from creating needless complications for employers resulting from an inconsistent treatment of tips, this reasoning has no support in the text of the amendment itself.

Under both the minimum wage amendment and NAC 608.104, the federal standards for measuring gross taxable income apply. This is consistent with the language of the minimum wage amendment and achieves an interpretation that gives effect to every word of the minimum wage amendment.

VI.

CONCLUSION

The canons of constitutional interpretation hold that this Court should not read the constitution in such a way as to exclude meaning from any portion

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

of the constitutional text. When this canon is applied, the district court's order cannot be affirmed.

The lower-tier wage rate is predicated upon an employer providing health benefits as described within the amendment. That means an employer "making health insurance available" to an employee as described in the constitutional text. The district court's contrary finding that an employee must actually receive health benefits cannot be achieved without writing off the phrase "as described herein" and the constitutional definition of "offering health benefits."

The challenged administrative regulations comport with the constitutional text, and allow for meaning for each word and phrase in the amendment because they reflect the same language and standard contained within the constitutional definition of "offering health benefits."

NAC 608.104 does not conflict with the minimum wage amendment because the amendment's cost cap is based upon "gross taxable income" and the regulations simply refer to federal tax laws to provide the measure of an employee's gross taxable income. Consistent with the amendment's phrase "from the employer," the regulations exclude non-employment related sources of income from the calculation.

//

//

//

//

//

//

//

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

Ultimately there is no conflict between either NAC 608.100 or NAC 608.104 and the text of the minimum wage amendment. The regulations are constitutionally valid and the district court's decision finding otherwise should be reversed.

DATED this 30th day of November, 2015.

ADAM PAUL LAXALT
ATTORNEY GENERAL

BY:/s/ Scott Davis
SCOTT DAVIS, #10019
Sr. Deputy Attorney General
555 E. Washington Avenue, Suite 3900
Las Vegas, NV 89101
Attorneys for STATE OF NEVADA,
OFFICE OF THE LABOR
COMMISSIONER

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

CERTIFICATE OF COMPLIANCE

1. I hereby certify that this Opening Brief of the State of Nevada, Office of the Labor Commissioner complies with the formatting requirements of NRAP 32(a)(4), the typeface requirements of NRAP 32(a)(5) and has been prepared in a proportionally spaced typeface using Times New Roman in font 14.

2. I further certify that this brief complies with the type-volume limitations of NRAP 32(a)(7) because, excluding the parts of the brief exempted by NRAP 32(a)(7)(C), it is proportionally spaced, has a typeface of 14 points or more and contains 7,625 words.

2. I hereby certify that I have read this Answering Brief of the State of Nevada, Local Government Employee-Management Relations Board and to the best of my knowledge, information and belief it is not frivolous or interposed for any improper purpose. I understand that I may be subject to sanctions in the event that the accompanying brief is not in conformity with the requirements of the Nevada Rules of Appellate Procedure.

DATED this 30th day of November, 2015.

ADAM PAUL LAXALT
ATTORNEY GENERAL

BY: /s/ Scott Davis
SCOTT DAVIS, #10019
Deputy Attorney General
555 E. Washington Avenue, Suite 3900
Las Vegas, NV 89101
Attorneys for STATE OF NEVADA,
OFFICE OF THE LABOR
COMMISSIONER

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

CERTIFICATE OF SERVICE

I hereby certify that I am an employee of the Office of the Attorney General and that on the 30th day of November, 2015, pursuant to NRAP 25(c)(1)(B), I caused the foregoing OPENING BRIEF OF STATE OF NEVADA, OFFICE OF THE LABOR COMMISSIONER to be served by mail on the parties listed below:

DON SPRINGMEYER, ESQ.
BRADLEY SCHRAGER, ESQ.
DANIEL BRAVO, ESQ.
WOLF, RIFKIN, SHAPIRO, SCHULMAN
& RABKIN, LLP
3556 E. Russell Road, 2nd Floor
Las Vegas, Nevada 89120

/s/ Marilyn Millam
An Employee of the ATTORNEY
GENERAL'S OFFICE

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

ADDENDUM A: Text of Nev. Const. art. 15 § 16

Sec. 16. **Payment of minimum compensation to employees.**

A. Each employer shall pay a wage to each employee of not less than the hourly rates set forth in this section. The rate shall be five dollars and fifteen cents ($5.15) per hour worked, if the employer provides health benefits as described herein, or six dollars and fifteen cents ($6.15) per hour if the employer does not provide such benefits. Offering health benefits within the meaning of this section shall consist of making health insurance available to the employee for the employee and the employee's dependents at a total cost to the employee for premiums of not more than 10 percent of the employee's gross taxable income from the employer. These rates of wages shall be adjusted by the amount of increases in the federal minimum wage over $5.15 per hour, or, if greater, by the cumulative increase in the cost of living. The cost of living increase shall be measured by the percentage increase as of December 31 in any year over the level as of December 31, 2004 of the Consumer Price Index (All Urban Consumers, U.S. City Average) as published by the Bureau of Labor Statistics, U.S. Department of Labor or the successor index or federal agency. No CPI adjustment for any one-year period may be greater than 3%. The Governor or the State agency designated by the Governor shall publish a bulletin by April 1 of each year announcing the adjusted rates, which shall take effect the following July 1. Such bulletin will be made available to all employers and to any other person who has filed with the Governor or the designated agency a request to receive such notice but lack of notice shall not excuse noncompliance with this section. An employer shall provide written notification of the rate adjustments to each of its employees and make the necessary payroll adjustments by July 1 following the publication of the bulletin. Tips or gratuities received by employees shall not be credited as being any part of or offset against the wage rates required by this section.

B. The provisions of this section may not be waived by agreement between an individual employee and an employer. All of the provisions of this section, or any part hereof, may be waived in a bona fide collective bargaining agreement, but only if the waiver is explicitly set forth in such agreement in clear and unambiguous terms. Unilateral implementation of terms and conditions of employment by either party to a collective bargaining relationship shall not constitute, or be permitted, as a waiver of all or any part of the provisions of this section. An employer shall not discharge, reduce the compensation of or otherwise discriminate against any employee for using any civil remedies to enforce this

section or otherwise asserting his or her rights under this section. An employee claiming violation of this section may bring an action against his or her employer in the courts of this State to enforce the provisions of this section and shall be entitled to all remedies available under the law or in equity appropriate to remedy any violation of this section, including but not limited to back pay, damages, reinstatement or injunctive relief. An employee who prevails in any action to enforce this section shall be awarded his or her reasonable attorney's fees and costs.

C. As used in this section, "employee" means any person who is employed by an employer as defined herein but does not include an employee who is under eighteen (18) years of age, employed by a nonprofit organization for after school or summer employment or as a trainee for a period not longer than ninety (90) days. "Employer" means any individual, proprietorship, partnership, joint venture, corporation, limited liability company, trust, association, or other entity that may employ individuals or enter into contracts of employment.

D. If any provision of this section is declared illegal, invalid or inoperative, in whole or in part, by the final decision of any court of competent jurisdiction, the remaining provisions and all portions not declared illegal, invalid or inoperative shall remain in full force or effect, and no such determination shall invalidate the remaining sections or portions of the sections of this section.

ADDENDUM B: Text of NAC 608.100

NAC 608.100 **Minimum** wage: Applicability; rates; annual adjustments. (Nev. Const. Art. 15, § 16; NRS 607.160, 608.250)

1. Except as otherwise provided in subsections 2 and 3, the minimum wage for an employee in the State of Nevada is the same whether the employee is a full-time, permanent, part-time, probationary or temporary employee, and:

(a) If an employee is offered qualified health insurance, is $5.15 per hour; or

(b) If an employee is not offered qualified health insurance, is $6.15 per hour.

2. The rates set forth in subsection 1 may change based on the annual adjustments set forth in Section 16 of Article 15 of the Nevada Constitution.

3. The minimum wage provided in subsection 1 does not apply to:

(a) A person under 18 years of age;

(b) A person employed by a nonprofit organization for after-school or summer employment;

(c) A person employed as a trainee for a period not longer than 90 days, as described by the United States Department of Labor pursuant to section 6(g) of the Fair Labor Standards Act; or

(d) A person employed under a valid collective bargaining agreement in which wage, tip credit or other provisions set forth in Section 16 of Article 15 of the Nevada Constitution have been waived in clear and unambiguous terms.

4. As used in this section, "qualified health insurance" means health insurance coverage offered by an employer which meets the requirements of NAC 608.102.

ADDENDUM C: Text of NAC 608.102

NAC 608.102 Minimum wage: Qualification to pay lower rate to employee **offered health insurance.** (Nev. Const. Art. 15, § 16; NRS 607.160, 608.250)

To qualify to pay an employee the minimum wage set forth in paragraph (a) of subsection 1 of NAC 608.100, an employer must meet each of the following requirements:

1. The employer must offer a health insurance plan which:

(a) Covers those categories of health care expenses that are generally deductible by an employee on his individual federal income tax return pursuant to 26 U.S.C. § 213 and any federal regulations relating thereto, if such expenses had been borne directly by the employee; or

(b) Provides health benefits pursuant to a Taft-Hartley trust which:

(1) Is formed pursuant to 29 U.S.C. § 186(c)(5); and

(2) Qualifies as an employee welfare benefit plan:

(I) Under the guidelines of the Internal Revenue Service; or

(II) Pursuant to the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq.

2. The health insurance plan must be made available to the employee and any dependents of the employee. The Labor Commissioner will consider such a health insurance plan to be available to the employee and any dependents of the employee when:

(a) An employer contracts for or otherwise maintains the health insurance plan for the class of employees of which the employee is a member, subject only to fulfillment of conditions required to complete the coverage which are applicable to all similarly situated employees within the same class; and

(b) The waiting period for the health insurance plan is not more than 6 months.

3. The share of the cost of the premium for the health insurance plan paid by the employee must not exceed 10 percent of the gross taxable income of the employee attributable to the employer under the Internal Revenue Code, as determined pursuant to the provisions of NAC 608.104.

ADDENDUM D: Text of NAC 608.104

NAC 608.104 Minimum wage: Determination of whether employee share of premium of qualified health insurance exceeds 10 percent of gross taxable income. (Nev. Const. Art. 15, § 16; NRS 607.160, 608.250)

1. To determine whether the share of the cost of the premium of the qualified health insurance paid by the employee does not exceed 10 percent of the gross taxable income of the employee attributable to the employer, an employer may:

(a) For an employee for whom the employer has issued a Form W-2 for the immediately preceding year, divide the gross taxable income of the employee paid by the employer into the projected share of the premiums to be paid by the employee for the health insurance plan for the current year;

(b) For an employee for whom the employer has not issued a Form W-2, but for whom the employer has payroll information for the four previous quarters, divide the combined total of gross taxable income normally calculated from the payroll information from the four previous quarters into the projected share of the premiums to be paid by the employee for qualified health insurance for the current year;

(c) For an employee for whom there is less than 1 aggregate year of payroll information:

(1) Determine the combined total gross taxable income normally calculated from the total payroll information available for the employee and divide that number by the number of weeks the total payroll information represents;

(2) Multiply the amount determined pursuant to subparagraph (1) by 52; and

(3) Divide the amount calculated pursuant to subparagraph (2) into the projected share of the premiums to be paid by the employee for qualified health insurance for the current year; and

(d) For a new employee, promoted employee or an employee who turns 18 years of age during employment, use the payroll information for the first two normal payroll periods completed by the employee and calculate the gross taxable income using the formula set forth in paragraph (c).

2. As used in this section, "gross taxable income of the employee attributable to the employer" means the amount specified on the Form W-2 issued by the employer to the employee and includes, without limitation, tips, bonuses or other compensation as required for purposes of federal individual income tax.

EXHIBIT "1"

Nev. Const. Art 15, Sec. 16. Payment of minimum compensation to employees.

A. Each employer shall pay a wage to each employee of not less than the hourly rates set forth in this section. The rate shall be five dollars and fifteen cents ($5.15) per hour worked, if the employer provides health benefits as described herein, or six dollars and fifteen cents ($6.15) per hour if the employer does not provide such benefits. Offering health benefits within the meaning of this section shall consist of making health insurance available to the employee for the employee and the employee's dependents at a total cost to the employee for premiums of not more than 10 percent of the employee's gross taxable income from the employer. These rates of wages shall be adjusted by the amount of increases in the federal minimum wage over $5.15 per hour, or, if greater, by the cumulative increase in the cost of living. The cost of living increase shall be measured by the percentage increase as of December 31 in any year over the level as of December 31, 2004 of the Consumer Price Index (All Urban Consumers, U.S. City Average) as published by the Bureau of Labor Statistics, U.S. Department of Labor or the successor index or federal agency. No CPI adjustment for any one-year period may be greater than 3%. The Governor or the State agency designated by the Governor shall publish a bulletin by April 1 of each year announcing the adjusted rates, which shall take effect the following July 1. Such bulletin will be made available to all employers and to any other person who has filed with the Governor or the designated agency a request to receive such notice but lack of notice shall not excuse noncompliance with this section. An employer shall provide written notification of the rate adjustments to each of its employees and make the necessary payroll adjustments by July 1 following the publication of the bulletin. Tips or gratuities received by employees shall not be credited as being any part of or offset against the wage rates required by this section.

B. The provisions of this section may not be waived by agreement between an individual employee and an employer. All of the provisions of this section, or any part hereof, may be waived in a bona fide collective bargaining agreement, but only if the waiver is explicitly set forth in such agreement in clear and unambiguous terms. Unilateral implementation of terms and conditions of employment by either party to a collective bargaining relationship shall not constitute, or be permitted, as a waiver of all or any part of the provisions of this section. An employer shall not discharge, reduce the compensation of or otherwise discriminate against any employee for using any civil remedies to enforce this section or otherwise asserting his or her rights under this section. An employee claiming violation of this section may bring an action against his or her employer in the courts of this State to enforce the provisions of this section and shall be entitled to all remedies available under the law or in equity appropriate to remedy any violation of this section, including but not limited to back pay, damages, reinstatement or injunctive relief. An employee who prevails in any action to enforce this section shall be awarded his or her reasonable attorney's fees and costs.

C. As used in this section, "employee" means any person who is employed by an employer as defined herein but does not include an employee who is under eighteen (18) years of age, employed by a nonprofit organization for after school or summer employment or as a trainee for a period not longer than ninety (90) days. "Employer" means any individual, proprietorship, partnership, joint venture, corporation, limited liability company, trust, association, or other entity that may employ individuals or enter into contracts of employment.

D. If any provision of this section is declared illegal, invalid or inoperative, in whole or in part, by the final decision of any court of competent jurisdiction, the

remaining provisions and all portions not declared illegal, invalid or inoperative shall remain in full force or effect, and no such determination shall invalidate the remaining sections or portions of the sections of this section.

EXHIBIT "2"

PROPOSED EMERGENCY REGULATIONS OF THE
LABOR COMMISSIONER
NOVEMBER 29, 2006

EXPLANATION- Matter that is underlined is new; matter in brackets [omitted material] is material to be omitted.

AUTHORITY: §§1-13, NRS 607.160(1)(b), NRS 608.270, NRS 608.018, NRS 2338.0613.

Section 1. Chapter 608 of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 12, inclusive, of this regulation. This regulation shall expire at the end of 120 days from filing with the Secretary of State or upon the filing of a temporary or permanent regulation whichever should occur first.

Sec. 2. Nevada has established a two-tiered minimum wage.

A. The first tier, lower tier, is from $5.15 to $6.14 per hour for employers who provide qualified health insurance benefits.

B. The second tier, upper tier, is $6.15 per hour for employers who do not provide qualified health benefits.

Sec. 3. The minimum wage may be adjusted annually.

A. These rates will be adjusted annually to include increases in the federal minimum wage and a yearly cost of living adjustment as set forth in Article 15, Section 16 of the Constitution of Nevada.

B. The annual adjustments will be announced in April and become effective on July 1 of each year.

C. Each minimum wage tier will increase by the same dollar amount as the federal rate increase.

Sec. 4. A. The minimum wage applies to all employees in Nevada.

B. The minimum wage exemptions codified at NRS 608.250(2) conflict with Article 15, Section 16 of the Constitution of Nevada and are no longer applicable.

C. People under the age of 18, employed by a nonprofit organization for after school or summer employment or as a trainee for a period not longer than ninety (90) days are not considered employees for the purpose of compliance with the minimum wage.

D. There is no distinction between whether an employee is full-time, permanent, part-time, or temporary.

Sec. 5 In order to qualify for the lower minimum wage tier an employer must comply with all of the following:

A. Health insurance coverage must be made available to the employee and the employees dependents; and

B. The employee's share of the cost of the premium cannot exceed 10% of the employee's gross income as defined under the Internal Revenue Code for the time interval between the premium payments; and

C. The health insurance must be a policy, contract, certificate or agreement offered or issued by a carrier authorized by the Nevada Insurance Commissioner to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services or, in the alternative, any federally approved self-funded plans established under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, except that medical discount plans as defined by NRS 695H.050 and workers compensation insurance do not qualify as health insurance.

Sec. 6. If an employee declines coverage under a qualified health insurance plan offered by the employer, the employee may be paid in the lower minimum wage tier, however, the employer must document that the employee has declined coverage and declining coverage may not be a term or condition of employment.

Sec. 7. If an employer offers qualified health insurance, but for some reason the employee is not eligible to receive the coverage provided by the employer or there is a delay before the coverage can become effective, the employee must be paid the upper tier wage until such time as the employee becomes eligible and is offered coverage or when the insurance becomes effective.

Sec. 8. For the purposes of complying with the overtime provisions of NRS 608.018(1),

A. An employer who qualifies for the lower tier minimum wage shall pay all employees with a base hourly rate of $7.725 per hour or less overtime whenever the employee works more than eight hours in a workday.

B. An employer who is required to pay the upper tier minimum wage shall pay all employees with a base hourly rate of $9.225 per hour or less overtime whenever the employee works more than eight hours in a workday.

EXHIBIT "3"

Chapter 608 of NAC

LCB File No. T004-07

ADOPTED TEMPORARY REGULATION OF THE OFFICE OF THE LABOR COMMISSIONER

Filed with the Secretary of State on April 10, 2007

EXPLANATION- Matter that is *italicized* is new; matter in brackets [omitted material] is material to be omitted.

AUTHORITY: § § 1-10; Article 15, Section 16, the constitution of the State of Nevada, NRS 607.110, NRS 607.160

Section 1 Chapter 608 of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 9, inclusive, of this regulation.

Sec. 2 *Definition of minimum wage tiers.*

1. *The lower tier is from $5.15 to $6.14 per hour for employees who offered qualified health insurance benefits.*
2. *The upper tier is $6.15 per hour for employees who are not offered qualified health benefits.*
3. *An employer must pay the upper tier rate unless the employee qualifies for the lower tier rate.*
4. *These rates may change based on the annual adjustments as set forth in Article 15, Section 16 of the Constitution of Nevada.*

Sec. 3 *Applicability of Minimum Wage.*

1. *The minimum wage applies to all employees in Nevada.*
2. *The only exceptions to the minimum wage are*

   (a) Persons under the age of 18; or

   (b)Persons employed by a nonprofit organization for after school or summer employment; or

   (c)Persons employed as trainees for a period not longer than ninety (90) days as interpreted by the U. S. Department of Labor pursuant to Section 6(g) of the Fair Labor Standards Act; or

   (d)Persons employed under a valid collective bargaining agreement where Article 15, Section 16 of the Nevada Constitution relating to minimum wage, tip credit or other provisions included therein have been waived in clear and unambiguous terms.
3. *There is no distinction between full-time, permanent, part-time, probationary, or temporary employees.*

Sec. 4 *In order to qualify for the lower minimum wage tier an employer must comply with all of the following:*

1. *Qualified health insurance coverage must be made available to the employee and the employee's dependents, if any. For the purposes of this section, qualified health insurance coverage is "available to the employee and employee's dependents" when an employer contracts for or otherwise maintains qualified health insurance for the class of employees of which the employee is a member, subject only to fulfillment of the conditions required to complete the coverage which are applicable to all similarly-situated employees within this class, unless the waiting period exceeds six months; and*
2. *The employee's share of the cost of the premium cannot exceed 10% of the employee's gross taxable income attributable to the employer as defined under the Internal Revenue Code;*
   (a) *"Gross Taxable Income" attributable to the employer means the amount specified on the employee's W-2 issued by the employer and includes tips, bonuses or other compensation as required for purposes of federal individual income tax.*
   (b) *To determine whether the employee's share of the premium does not exceed 10% of the employee's gross taxable income, the employer may:*
      I. *For an employee for whom the employer has issued a W-2 for the immediately preceding year, divide the gross taxable income from the employer into the projected employee's share of the premiums for qualified health insurance for the current year;*
      II. *For an employee for which the employer has not issued a W-2 and has payroll information for the four prior quarters, divide the combined total of gross taxable income normally calculated from this payroll information from these four quarters into the projected employee's share of the premiums for qualified health insurance for these four quarters;*
      III. *For an employee for which there is less than an aggregate year of payroll information, the employer shall*
         1) *take the total payroll information available for the employee determine the combined total of gross taxable income normally calculated from this payroll information; and*
         2) *After dividing it by the number of weeks it represents and multiplying it by 52, divide this annualized number into the projected employee's share of the premiums for qualified health insurance for the current year;*
      IV. *For a new employee, promoted employee, or an employee who turns eighteen years of age during employment, the employer shall wait until the employee has completed two normal payroll periods and then utilize this payroll information as set forth in subsection 3 above relating to an employee for which there is less than a complete year of employment; and*
3. *Offers a health benefit plan that meets one of the following requirements:*
   (a) *The plan covers only those categories of health care expenses that are generally deductible by employees on their individual federal income tax returns pursuant to the provisions of 26 U.S.C. Sec. 213 and any federal*

regulations relating thereto, if those expenses had been borne directly by those employees; or

(b) Provides health benefits pursuant to a Taft-Hartley trust which:

I. Is formed pursuant to 29 U.S.C. Sec. 186(c)(5); and

II. Qualifies as an employee welfare benefit plan under the Internal Revenue Service guidelines; or

(c) Is a qualified employee welfare benefit plan pursuant to the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001 et seq.

Sec. 5. An employer may decide to pay the maximum wage rate for minimum wage currently applicable in lieu of making any determination under this regulation that the employee may be paid the lower minimum wage rate.

Sec. 6. If a determination is made that the employee's share of the premium does not exceed 10% of the employee's gross taxable income from the employer, the employer may pay the employee through the end of the calendar year for which the determination has been made either:

1. The lowest minimum wage rate currently applicable; or

2. Any amount within the lower minimum wage tier currently applicable.

Sec. 7. If an employee declines coverage under a qualified health insurance plan offered by the employer, the employer must document that the employee has declined coverage. Declining coverage may not be a term or condition of employment.

Sec. 8. If an employer offers qualified health insurance with a waiting period of no more than 6 months, the employee may be paid at the lower tier wage rate. If an employer does not offer a qualified health insurance plan or the health benefit plan is not available or the health benefit plan is not provided within 6 months of employment, the employee must be paid the upper tier wage rate until such time as the employee becomes eligible and is offered coverage or when the insurance becomes effective. The term of the waiting period may be modified in a bona fide collective bargaining agreement, but only if the modification is explicitly set forth in such agreement in clear and unambiguous terms.

Sec. 9. For the purposes of complying with the daily overtime provisions of NRS 608.018(1), an employer shall pay overtime based on the minimum wage tier for which that employee is qualified.

Sec. 10. NAC 608.110 is hereby repealed.

~~[Sec. 608.110 Minimum wage. (NRS 608.250) The minimum wage for an employee in covered employment who:~~

~~1. Is 18 years of age or older is $5.15 per hour.~~

~~2. Is under 18 years of age is $4.38 per hour.]~~

NOTICE OF ADOPTION OF TEMPORARY REGULATION
LCB File No. T004-07

The Office of the Labor Commissioner adopted temporary regulations assigned LCB File No. T004-07 which pertain to chapter 608 of the Nevada Administrative Code on March 6, 2007.

INFORMATIONAL STATEMENT

Pursuant to NRS 233B.066, the Office of the Labor Commissioner provides the following information concerning newly adopted temporary regulations for NAC 608.

(a) *A description of how public comment was solicited, a summary of the public response, and an explanation how other interested persons may obtain a copy of the summary.*
Public comment on the proposed rule was solicited on the agency website, posted notices, e-mail, direct mail to persons on the agency 233B mailing list, public workshops, and press releases. Copies of the summary are available through the agency website or upon request from the agency.

(b) *The number of persons who:*
(1) *Attended each hearing:*
Forty-four people attended the hearing, twenty-five in Las Vegas and nineteen in Carson City.

(2) *Testified at each hearing:*
Seven individuals testified at the hearing.

(3) *Submitted to the agency written statements:*
Written comments were received from six individuals and organizations.

Andrea McHenry of Administaff and Cecilia Renn Kurzweg of ADP Total Source submitted comments concerning health insurance provided by professional employer organizations (PEO) who sponsor and maintain benefit plans for clients pursuant to "co-employment relationships."

Gary Reed a Nevada casino dealer submitted comments concerning the 10% gross taxable income requirement.

Tom Haynie representing Manpower Inc. of Southern Nevada and the Nevada Staffing Association submitted questions concerning the insurance requirements.
Jen Sarafina of the Kainer, Zucker & Abbott law firm submitted comments concerning the insurance requirements.

This Opposition is brought in accordance with Nevada case law, the attached Memorandum of Points and Authorities, the affidavit of Jeremy J. Thompson attached hereto as **Exhibit A**, the papers and records on file with the court herein, and on such oral and documentary evidence as may be presented at the time of hearing on this Motion.

DATED this 13 day of May, 2016.

MORRIS POLICH & PURDY LLP

By: _____
NICHOLAS M. WIECZOREK
Nevada Bar No. 6170
DEANNA L. FORBUSH
Nevada Bar No. 6646
JEREMY J. THOMPSON
Nevada Bar No. 12503
3800 Howard Hughes Parkway, Suite 500
Las Vegas, Nevada 89169
Attorneys for Defendants

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION.

It would be difficult to envision a motion for summary judgment less worthy of being granted than the one proffered by Plaintiffs here. Plaintiffs' motion takes the Court on a trip to their disorganized factual recitals, weak and unpersuasive arguments, and inapplicable law. The motion takes the Court to Connecticut, of all places, for legal authority in an attempt to answer the questions "what is meant by the term 'health benefits' as used in the Nevada Minimum Wage Amendment and what are its elements" and "do the health benefits Defendants provide meet those requirements." Further, Plaintiffs use the Affordable Care Act, which was enacted in 2014, to analyze what sort of coverage the Defendants should have provided its employees in 2010 through 2013. That position is nonsensical.

Plaintiffs contend, as does their proffered expert Matthew Milone (who is a former co-employee of Plaintiff's counsel) that the health benefits Nevada employers provide their employees pursuant to the Minimum Wage Amendment must be so expansive so as to cover every conceivable medical scenario in order to comply with the minimal requirements set forth in the Minimum Wage Amendment and its companion regulations, irrespective of the substantial costs associated with such comprehensive coverage. If Plaintiffs' theory was plausible, then the obligations the Minimum Wage Amendment imposed on Nevada employers were/are so burdensome that they far outweigh the benefit of providing any health insurance to any employees whatsoever. Specifically, no Nevada employer could offer its employees health insurance under the 10 percent cost cap due to the substantial costs they would incur in providing the "major medical coverage" Plaintiffs believe they are entitled to under the Minimum Wage Amendment.

Plaintiffs' position is simply untenable. Their result-oriented argument obscures what is an uncomplicated path to compliance with Nevada's minimum wage requirements. There is no doubt that Defendants have complied with the minimum wage requirements established by the state constitution and associated regulations.

In addition, Plaintiffs are improperly seeking a decision from this Court which only the Labor Commissioner has the authority to issue. Only the Labor Commissioner has the authority to

determine what plans comply with NAC 608.102 and this Court cannot circumvent the Labor Commissioner's authority. NRS 607.160. In fact, the Eighth Judicial District Court resolved this specific issue in *Christopher McLaughlin v. Deli Planet, Inc.* and concluded that whether or not a plan complied with NAC 608.102 is a determination to be made by the Labor Commissioner, not the court. That fact alone supports denying Plaintiffs' request for summary judgment.

II. BACKGROUND.

In Nevada, the minimum wage is established by the state constitution. Nev. Const. art. 15 § 16(A). Section (16)(A) of Article XV, commonly referred to as the Minimum Wage Amendment ("MWA"), states:

> Each employer shall pay a wage to each employee of not less than the hourly rates set forth in this section. The rate shall be five dollars and fifteen cents ($5.15) per hour worked, if the employer provides health benefits as described herein, or six dollars and fifteen cents ($6.15) per hour if the employer does not provide such benefits. Offering health benefits within the meaning of this section shall consist of making health insurance available to the employee for the employee and the employee's dependents at a total cost to the employee for premiums of not more than 10 percent of the employee's gross taxable income from the employer.

At the time the amendment was adopted in 2006, the federal minimum wage rate was $5.15 per hour. *See* 29 U.S.C. § 206(a) (2006). The amendment raised the state minimum wage rate to $6.15 per hour and also provided for a lower-tier wage rate that remained consistent with the prior wage rate of $5.15 per hour. The lower-tier wage rate created a residual exception to the amendment's general increase in wages by giving the employers the ability to continue to pay the same wage rate that was in effect prior to the amendment's approval, provided that the employer makes health benefits available to the employee.

Prior to the amendment's final voter approval, then-Labor Commissioner Michael Tanchek sought and obtained an Attorney General opinion indicating that he would likely retain administrative enforcement over the new minimum wage amendment.[1] In light of the amendment's approval, and in order to provide necessary guidance concerning compliance with

[1] **Exhibit B** – Opening Brief of the State of Nevada, Office of the Labor Commissioner, Nev. Sup. Ct. Case No. 38770, at 7 (*citing* Op. Nev. Att'y Gen. 2005-04 (March 2, 2005)).

the residual exception, Commissioner Tanchek invoked the rulemaking authority granted by NRS 607.160(1)(b) to promulgate emergency regulations that interpreted the new MWA and provided guidance to employers on the issues of MWA compliance.[2] The emergency regulations were transformed into temporary regulations, which in turn were converted into permanent regulations. *See* Nevada Administrative Code ("NAC") 608.100-608.108.

In the legislative session immediately following the 2006 general election, and in the process of converting emergency regulations into more permanent regulations, Commissioner Tanchek appeared before the Senate Committee on Commerce and Labor to explain the administrative regulations associated with the MWA and the Labor Commission's view of the MWA.[3] Commissioner Tanchek provided an oral and written explanation of the amendment and the objectives of the associated regulations. He acknowledged that the relation of health benefits to the two-tier wage structure was the "the major area of confusion over the amendment.[4] Commissioner Tanchek explained that in order to qualify for the lower-tier wage rate an employer must satisfy each of the following conditions: (1) insurance was to be made available to an employee; (2) that it must be for an employee and employee's dependents; and (3) that it must fall within the 10 percent cost cap.[5] Notably, Commissioner Tanchek addressed the question "what if the employee does not want health insurance" and explained to the Committee that if an employee were to decline health insurance the employer would still meet its obligations under the amendment if it makes the insurance available.[6]

As part of the Committee's question and answer process, Commissioner Tanchek was also posed with answering the question "what is health insurance" as contemplated by the MWA and associated regulations.[7] He responded:

> That is a good question. The amendment does not say what it is, just that the employer has to offer it in order to take advantage of

---

[2] *Id.* at 7-8; JA0289-0297.

[3] *Id.* at JA0299-0319, Minutes of Hearing on Minimum Wage before Senate Committee of Commerce and Labor, 2007 Leg. 74th Sess. (Feb. 8, 2007)

[4] *Id.* at JA0328

[5] *Id.* at JA0321-337, Discussion of the Impacts of the New Minimum Wage Law, Senate Commerce and Labor Committee, 2007 Leg. 74th Sess. (Feb 8, 2007); *see* NAC 608.102.

[6] Id. at JA0329.

[7] *Id.* at JA0328-0329.

> the lower rate. As I pointed out earlier, there are all sorts of different kinds of health benefits that are available. Think of group health, HMOs, PPOs, self-funded plans, cost reimbursement plans, and the list goes on.
>
> . . .
>
> You have to be careful with this question because it is really easy to get bogged down in the complexity [of] insurance... The preferred approach is to set understandable standards so the employers and the employees can draw their own conclusions.
>
> . . .
>
> The current approach is to adopt the standard used in the business tax provisions of NRS 363A and 363B. This has several advantages. We didn't need to reinvent the wheel. It is a standard that is already in existence and with which employers are familiar. Employers know whether their insurance meets the standard. Since it is statutory, there is legislative history behind it. Finally, we were able to get a good consensus for that approach from business and the drafters of the amendment. In addition, we included ERISA plans and Taft-Hartley plans. Those types of plans are rooted in preemptive federal law, are regulated, and cover some types of plans not covered under our statutes.[8]

Thus, at the time of enacting the regulations associated with the MWA, Nevada legislators were cognizant of the how the Nevada Labor Commission interpreted the MWA and related regulations and of the specific requirements an employer was to meet if the employer paid any of its employees under the MWA's excepted wage rate.

Acting through the Administrative Procedures Act's full notice-and-comment rulemaking procedures, Commissioner Tanchek codified administrative regulations that were based upon, and consistent with, the representations he made before the Senate Commerce and Labor Committee. *See* NAC 608.100-608.108.[9] NAC 608.102 set the parameters that an employer must meet to qualify to pay an employee the MWA's excepted rate. NAC 608.102, ***which is titled "Minimum wage: Qualification to pay lower rate to employee offered health insurance***," states that in order to qualify to pay an employee the excepted wage rate specified in the MWA, the health insurance must: (1) cover those categories of health care expenses that are generally deductible by an employee on his individual federal income tax return pursuant to 26 U.S.C. § 213 and any federal

---

[8] *Id.*

[9] Id. at JA0335-0337.

regulations relating thereto, if such expenses had been borne directly by the employee; (2) be made available to the employee and any dependents of the employee; (3) not have a waiting period that exceeds more than six months; and (4) not cost the employee more than 10 percent of the gross taxable income of the employee attributable to the employer. NAC 608.102.

Defendants' plans satisfy every requisite of the term "health insurance" as defined by the MWA and supporting regulations. Specifically, the plans: (1) cover those categories of health care expenses that are generally deductible by an employee on his individual federal income tax return pursuant to 26 U.S.C. § 213 if such expenses had been borne directly by the employee; (2) are available to employees and their dependents; (3) have a waiting period that does not exceed more than six months; and, (4) cost the employee no more than 10 percent of the employee's gross taxable income attributable to the employer. Nev. Const. art. 15 § 16(A); NAC 608.102. Plaintiffs do not dispute points (2) through (4) and thus Plaintiffs concede that the Defendants' health plans comply with the MWA's requirements that health insurance is made available to employees and their dependents, with NAC 608's requirement that the health insurance waiting period is less than six months, and that the MWA's requirement that the health insurance offered cost no more than 10 percent of the employee's gross taxable income. In fact all Plaintiffs dispute is whether or not the health benefits Defendants' provided constituted "health insurance" under the MWA, which goes to point (1).

Plaintiffs ask the Court to expand the term "health insurance" as it relates to the MWA and NAC 608.102.[10] They argue that the Court should create its own definition of health insurance based upon Plaintiffs' counsel's wish list of what qualifies as health insurance (which is coverage that would be impossible for Nevada employers to offer considering the 10 percent cost cap), the Affordable Care Act, "social expectation," irrelevant statutes, and counsel's former colleague's expert report. Such information provides this Court no assistance in determining whether the Defendants' health plans are commensurate with what is required by the MWA and the NAC.

[10] This contradicts what Plaintiffs' alleged in their First Amended Complaint, which is that Defendants did not provide health insurance benefits "that are generally deductible by an employee on his/her individual federal income tax return" and/or that the health insurance premiums that exceeded 10 percent of the employee's gross taxable income pursuant to the MWA and NAC 608.102. *See* First Amended Complaint, ¶¶ 8-9, 31, 34, 59.

Defendants' plans are health insurance for the purposes of the MWA and the NAC and therefore the Court should deny Plaintiffs' Motion.

III. LEGAL STANDARD.

Any legal issue of substantive law may be decided by summary judgment. NRCP 56. Summary judgment is "appropriate where there is no legally sufficient evidentiary basis for a reasonable jury to find for the nonmoving party." *Moss v. Washoe Med. Ctr., Inc.*, 2006 WL 508088, *1 (D. Nev. March 1, 2006).[11] Judgment as a matter of law is appropriate where there is no legally sufficient evidentiary basis for a reasonable jury to find for the nonmoving party. *Id.* Conversely, "[i]f a reasonable jury could find for the non-moving party, summary judgment is inappropriate" *Borgerson v. Scanlon*, 117 Nev. 216, 220 (2001). Summary judgment is appropriate only if "the facts and law will reasonably support only one conclusion." *McDermott Intern., Inc. v. Wilander*, 498 U.S. 337, 356 (1991) (citing *Anderson v. Liberty Lobby, Inc.*, 488 U.S. 242, 248, 250-51 (1986)); *Delange v. Dutra Constr. Co.*, 183 F.3d 916 (9th Cir. 2002). If the party opposing summary judgment would be entitled to prevail under any reasonable construction of the evidence, and any acceptable theory of law, summary judgment against that nonmoving party cannot be sustained. *Harris v. Itzhaki*, 183 F.3d 1043 (9th Cir. 1999).

IV. THE HEALTH PLANS.

Defendants dispute several of Plaintiffs' purported undisputed facts, although those facts are irrelevant to the legal argument at issue in Plaintiffs' motion. Specifically, Defendants dispute that Plaintiffs Diaz, Wilbanks, Olszynski, and Fitzlaff were paid a rate of $7.25 for the employment dates cited. As pointed out in Defendants' Opposition to Motion for Certification, the four named Plaintiffs had varying rates of pay throughout their employment with Diaz making $8.25 per hour to $10.25 per hour to $11.00 per hour, and later $7.25 per hour; Wilbanks recalling she made either $7.25 or $7.45 per hour; Olszynski making $7.25 per hour and then $5.13 per hour

[11] Nevada Supreme Court has noted "[f]ederal cases interpreting the Federal Rules of Civil Procedure 'are strong persuasive authority, because the Nevada Rules of Civil Procedure are based in large part upon their federal counterparts.'" *Exec. Mgmt., Ltd. V. Ticor Title Insur. Co.*, 118 Nev. 46, 53, 38 P.3d 872, 876 (2002) (quoting *Las Vegas Novelty, Inc. v. Fernandez*, 106 Nev. 113, 119, 787 P.2d 772, 776 (1990))

in a Colorado location; and Fitzlaff making $7.25 per hour.[12]

In addition, Plaintiffs fail to cite any undisputed facts associated with the coverage they believe they were entitled to. There is no explanation, let alone undisputed facts, as to the specific benefits the Defendants should have provided to comply with the MWA. Instead, Plaintiffs use hearsay and argument lacking in foundation to define what actual benefits the Defendants should have provided. Plaintiffs "undisputed facts" are also supported by conclusory and inaccurate allegations unsupported by specific reference to admissible evidence. For example, Plaintiffs claim that Mancha Development Company selects and contracts for health benefit plans for the employees of the Defendant. That "undisputed fact" is objectionable and lacking in foundation as the business no longer exists after its bankruptcy. Such inappropriate and inadmissible information defeats summary judgment.

The 2010-2013 Starbridge Plans

Defendants do agree that between July 1, 2010 and December 31, 2013 they offered Plaintiffs the CIGNA Starbridge limited benefit health plan (the "Starbridge Plan).[13] The Starbridge Plans covered expenses for outpatient care such as, but not limited to, diagnostic tests, urgent care facility services, doctor's office visits, emergency room service, charges for casts, splints, trusses, crutches and braces (except dental braces), charges for a postpartum visit, radiation and chemotherapy treatment, and anesthetics.[14]

In addition, the Starbridge Plans covered in-hospital surgeries, $1,500 per occurrence with unlimited occurrences and no maximum amount to be paid by the Plan.[15] The Starbridge Plans covered $2,000-$3,000 per year for inpatient care with the patient responsible for no deductible.[16] An accidental death benefit is included in the Plans for $10,000 or $15,000 and office visits are

---

[12] *See* Opposition to Motion for Class Certification Pursuant to Nevada Rule of Procedure 23 on file herein and incorporated by reference, p. 14:17-22. Diaz Depo., Exhibit C at 144:12-148:13; Wilbanks Depo., Exhibit D at 69:8-70:16; Olszynski Depo., Exhibit E at 110:13-15; and Fitzlaff Depo., Exhibit F at 64:12-16.

[13] **Exhibit C** - 2010-2012 Starbridge Plan (MDC000087-000096); 2013 Starbridge Plan (MDC000097-000120).

[14] *Id.* at MDC000091, MDC000103.

[15] *Id.* at MDC000090.

[16] *Id.*

covered at 100 percent.[17] Maternity benefits are unlimited and the Plans cover $1,500 per year per occurrence.

The 2014 TransChoice Plan

Between January 1, 2014 and December 31, 2014 Defendants offered Plaintiff Olszynski the Transamerica TransChoice Advance Plan (the "TransChoice Plan).[18] The TransChoice Plan covered medical expenses such as, but not limited to, hospital confinement, doctor's visits, prescription drugs, physical exams and stress tests, outpatient CT scan, MRI myelogram, PET, and angiograms, anesthesia, inpatient mental and nervous disorder confinement, and critical illnesses such as cancer, heart attacks, stroke, end-stage renal failure or major organ failure.[19]

Depending on which version of the TransChoice Plan an employee selected, the TransChoice Plan covered between $500 to $1,000 per day for inpatient surgeries and $250-$500 per day for outpatient surgeries with no maximum.[20] The TransChoice Plan also covered $100 per day up to 31 days for each day an individual was confined to an inpatient hospital or mental health facility. Similarly, the TransChoice Plan covered $100 per day up to 31 days for each day an individual was confined to a residential treatment facility as the result of drug and/or alcohol addiction.[21] Those two features alone provided potentially $6,000 in coverage for what cost an employee approximately $600.

The 2015 MPV Plan

For 2015, Defendants offered to employees a benefits plan known as the Minimum Value Plan (the "MVP Plan").[22] The MVP Plan covered medical expenses such as, but not limited to, office visits, preventative care, x-rays, imaging, and lab work, all emergency room services, prescriptions, urgent care, pregnancy and pre-natal care, approve contraceptives, medical care for domestic partners, and preventative/wellness care such as immunizations and colonoscopies, and

---

17 Id. at MDC000090,MDC000095.

18 **Exhibit D** 2014 TransChoice Plan (MDC000129-00130; MDC000686-000757).

19 *Id.* at MDC000129-000130, MDC000751-00753).

20 *Id* at MDC000752.

21 *Id.*

22 **Exhibit E** 2014 MVP Plan (MDC000770-000777).

such care was covered at 100 percent.[23] The MVP Plan's wellness/preventative benefits were "limited to only CMS mandated preventative services," which include a list of services, including: alcohol counseling, annual wellness visits, bone mass measurements, colorectal screening, cardiovascular disease screening, diabetes screening, depression screening, glaucoma screening, influenza virus vaccine and administration, initial preventative physical examinations (IPPE), behavior therapy for obesity, lung cancer screening, medical nutrition therapy, prostate cancer screening, STD screening, mammography screening, ultrasound screening for abdominal aneurysm, and pelvic examination screenings.[24]

The MVP Plan included "Chronic Disease Management Benefits" which were payable at 100 percent and not subject to the copay. Those benefits included treatment related to asthma, atherosclerosis, atrial fibrillation, chronic obstructive pulmonary disease, chronic renal insufficiency, congestive heart failure, coronary heart disease, diabetes, epilepsy, HIV, hyperlipidemia, hypertension, hyperthyroidism, hypothyroidism, metabolic syndrome, multiple sclerosis, Parkinson's disease, pre-diabetes, polymyalgia rheumatic, pulmonary hypertension, COPD, rheumatoid arthritis, sleep apnea, chronic venous thrombotic disease, and inflammatory bowel syndrome.[25]

V. ARGUMENT.

1. Defendants' Plans Comply with the MWA and NAC 608.102.

As discussed *supra*, the MWA created two wage rates – a rate that that was commensurate with the federal minimum wage rate and a lower, excepted wage rate. Employers were entitled to pay the excepted wage rate "if the cost of health insurance benefit premiums for the employee, and his or her dependents, [did] not exceed 10 percent of the employee's gross taxable income from the employer." Nev. Const. Art. XV, § 16. Other than the 10 percent threshold, the amendment contained no other requirements for a health plan that employers must satisfy in order to pay the lower excepted wage rate. After the MWA was enacted the Labor Commissioner issued

---

[23] *Id.*
[24] *Id.* at MDC000775.
[25] *Id.* at MDC000776

regulations adding requirements beyond what is in the Constitution to define a qualifying health plan, which is what was needed for an employer to not pay the higher wage rate.

NAC 608.100 provides in pertinent part:

> 1. Except as otherwise provided in subsections 2 and 3, the minimum wage for an employee in the State of Nevada is the same whether the employee is a full-time, permanent, part-time, probationary or temporary employee, and:
>
> (a) If an employee is offered qualified health insurance, is $5.15 per hour; or
>
> (b) If an employee is not offered qualified health insurance, is $6.15 per hour.

NAC 608.102 in turn states that to qualify to pay an employee the minimum wage set forth in NAC 608.100(1)(a), "an employer must meet each of the following requirements": (1) the employer must offer a health insurance plan that covers those categories of health care expenses that are ***generally deductible*** by an employee on his individual federal income tax return pursuant to 26 U.S.C. § 213 and any federal regulations relating thereto, if such expenses had been borne directly by the employee; (2) be made available to the employee and any dependents of the employee; (3) not have a waiting period that exceeds more than six months; and (4) not cost the employee more than 10 percent of the gross taxable income of the employee attributable to the employer. NAC 608.102. (emphasis added). The Labor Commissioner did not impose any other requirements on an employer in order for the employer to pay the lower wage rate.

26 U.S.C. § 213[26] (itemized tax deductions for medical expenses) sets forth the type of medical care expenses that are deductible on a federal tax return. The term "medical care" is defined as: (1) amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; (2) amounts paid for transportation primarily for and essential to medical care; (3) for qualified long term-term care services; or (4) for insurance covering medical care. The definition of "medical care" is further defined in its Treasury Regulation § 1.213(e), which sets forth specific examples of medical care.

[26] "There shall be allowed as a deduction the expenses paid during the taxable year... for medical care of the taxpayer, his spouse, or a dependent..." 29 U.S.C. § 213(a).

26 CFR 1.213-1. For example, the regulation states:

> Amounts paid for operations or treatments affecting any portion of the body, including obstetrical expenses and expenses of therapy or X-ray treatments, are deemed to be for the purpose of affecting any structure or function of the body and are therefore paid for medical care. Amounts expended for illegal operations or treatments are not deductible. Deductions for expenditures for medical care allowable undersection 213 will be confined strictly to expenses incurred primarily for the prevention or alleviation of a physical or mental defect or illness. ***Thus, payments for the following are payments for medical care: hospital services, nursing services (including nurses' board where paid by the taxpayer), medical, laboratory, surgical, dental and other diagnostic and healing services, X-rays, medicine and drugs*** (as defined in subparagraph (2) of this paragraph, subject to the 1-percent limitation in paragraph (b) of this section), ***artificial teeth or limbs, and ambulance hire***. However, an expenditure which is merely beneficial to the general health of an individual, such as an expenditure for a vacation, is not an expenditure for medical care.

Thus, because hospital services, nursing services, medical, laboratory, surgical, dental and other diagnostic and healing services, X-rays, medicine and drugs, artificial teeth or limbs, and ambulance hire are all examples of "medical care," they qualify as health care expenses that are generally deductible by an individual on his or her federal tax return pursuant to 26 U.S.C. § 213. If a health insurance plan covers those same services, then it covers categories of health care expenses that are generally deductible by an individual on his or her federal tax return pursuant to 26 U.S.C. § 213.

It is without question that the medical care services specified in each of the Defendants' plans include health care expenses that are "generally deductible" by an employee under 26 U.S.C. § 213. The 2010-2013 Starbridge Plans covered doctor office visits, outpatient care, non-emergency care in emergency room, inpatient care, accidental injuries, diagnostic tests, radiation and chemotherapy treatment, anesthesia, prosthetic devices, casts, splints, crutches, oxygen, ambulance services and postpartum care among other health care expenses.[27]

The 2014 TransChoice Plan covered hospital confinement, doctor office visits, outpatient care, x-rays, diagnostic tests, surgery, anesthesia, accidental injuries prescription drugs, exams,

[27] **Exhibit C** 2010-2012 Starbridge Plan (MDC000087-000096); 2013 Starbridge Plan (MDC000097-000120).

inpatient mental and nervous disorder treatment, inpatient drug and alcohol addiction treatment, and ambulance services among other health care expenses.[28]

The 2015 MPV Plan covered doctor office visits, preventative care, x-rays and lab work, emergency room, prescription drugs, specialist visits, CT/PET scans and MRIs, preventative services and chronic disease management including services for asthma, congestive heart failure, diabetes, epilepsy, hypertension, multiple sclerosis, Parkinson's disease, pre-diabetes, and sleep apnea among other health care expenses.[29]

i. Plaintiffs' reliance on IRS Publication No. 502 for the Tax Year 2013 is **unavailing.**

To avoid this inescapable outcome, Plaintiffs argue that Defendants' plans were required to cover "the range," if not all, of the health care expenses that individuals can possibly deduct on their federal tax returns, including those listed in IRS Publication No. 502 for Tax Year 2013. Plaintiffs contend that NAC 608.102 does not state that "some" or "few" of those health care expenses that would be deductible need only be covered and that because the regulation reads "those categories of health care expenses" it must that mean "every" or "all" health care expenses that are tax deductible must be covered. Plaintiffs claim that NAC 608.102 includes nonexistent language requiring employers to provide insurance that covers every possible medical scenario that would be tax deductible under 26 U.S.C. § 213 while contemporaneously ignoring the plain language of the regulation, which states that an employer must offer a plan that covers categories of health care that are ***"generally deductible."*** Surely, had the Labor Commissioner wanted what the Plaintiffs imagine, he could have easily promulgated the regulation as follows: "The employer must offer a health insurance plan that covers ***all*** categories of health care expenses that are or ***can be deducted*** by an employee on his individual federal income tax return pursuant to 26 U.S.C. § 213." The problem for Plaintiffs is that the Commissioner and Nevada legislature did not issue such an expansive regulation.

[28] **Exhibit D** 2014 TransChoice Plan (MDC000129-00130; MDC000686-000757).
[29] **Exhibit E** 2014 MVP Plan (MDC000770-000777)

As noted by defense expert Timothy Mulliner, Milone's opinion, in particular, that Nevada employers who opt to pay their employees the lower excepted wage rate must cover "each of the" categories described in 26 U.S.C. § 213, would compel the absurd result that employers are required to provide the most expansive coverage imaginable, and coverage not required under prior statutes and regulations, at a cost to the employee of less than 10 percent of the employee's adjusted gross income.[30] Mulliner is a longtime practitioner of federal insurance law and he conducted substantial legal and legislative research in forming his opinions related to this litigation. His expert report, curriculum vitae, and deposition transcript are attached hereto as **Exhibit F.**

Regardless, Plaintiffs use of IRS Publication No. 502 for Tax Year 2013 in support of their claim is not persuasive. For example, under the caption "What are Medical Expenses" the IRS Publication sets forth the exact same description of health care expenses as 26 U.S.C. § 213 and Treasure Regulation 1.213.[31] Under the caption "What Medical Expenses are Includible?" the documents lists a series of examples, not "categories," of medical expenses that are deductible. The IRS Publication even states that the "list does not include all possible medical expenses" and therefore by its own terms the IRS Publication does not list the alleged "range of categories" Plaintiffs contend must be covered. The IRS Publication lists as examples of deductible medical expenses lead-based paint removal for the home, legal fees, televisions, trips, tuition and medical conferences, and Christian Science practitioner. It is different to imagine any insurance plan covering every example in the IRS Publication and it requires a substantial amount of wishful thinking to assume that the MWA and NAC 608.102 intended to have such services covered by qualified health insurance.

ii. Plaintiffs' concerns regarding any violation of NAC 608.102 must be brought before the Labor Commissioner.

Plaintiffs are attempting to circumvent the Labor Commissioner's authority by requesting summary judgment and asking this Court to deem Defendants' plans legally inadequate under

---

30 **Exhibit F** Expert Report of Timothy R. Mulliner, p. 6.

31 *See* IRS Publication No. 502 for Tax Year 2013, attached as **Exhibit 23** to Plaintiffs' Motion.

NAC 608.102., Because no private right of action exists under NAC 608.102, Plaintiffs' request for summary judgment as it relates to any violation of NAC 608.102 must be denied. One issue raised in Plaintiffs' motion is whether the Defendants offered health insurance as required by NAC 608.102. Plaintiffs do not claim that the premiums they paid exceeded 10 percent of their gross taxable income, which is the sole requirement identified in the MWA. Instead, Plaintiffs claim that the Defendants offered benefits that did not comply with NAC 608.102. Plaintiffs' claim, therefore, is not that Defendants violated the MWA but rather violated NAC 608.102. This poses a problem for Plaintiffs.

NRS 607.160 specifically states that only the Labor Commissioner is charged with enforcing all Nevada labor laws. NRS 607.160(1). In complying with that mandate, the Labor Commissioner is empowered to adopt regulations to carry out his duties and may take "any appropriate action against [a] person to enforce labor law or regulation whether or not a claim or complaint has been made to the Labor Commissioner concerning the violation." NRS 607.160(1)(b); NRS 607.160(2). In fact, NRS 607.160(6) provides that only the Labor Commissioner "may seek a civil remedy, impose an administrative penalty or take other administrative action" against a person who violates his regulations." NRS 607.160(6). There is no private right of action.

Because NAC 608.102 is a regulation promulgated by the Labor Commissioner solely for the purpose of defining qualifying health benefits beyond the terms of the MWA, Plaintiffs have no private right of action insofar as their claim regarding the quality of Defendants' health insurance plans. As an administrative regulation, NAC 608.102 lacks the force and effect of a statute. The Labor Commissioner also does not have the authority to "create" a private right of action to file in court. *See* NRS 607.160 (addressing the enforcement capabilities of the Labor Commissioner). This is why NAC 608.102 contains no provision allowing an employee to seek damages or other relief through a private right of action. The Labor Commissioner can adopt and enforce regulations but the Commissioner, alone, is empowered to enforce such regulations. Plaintiffs request for summary judgment as to the quality of Defendants' plans, therefore, should

be denied because there is no private right of action in NAC 608.102 and any argument regarding the quality of Defendants' plan should be first taken to the Labor Commissioner.

The Nevada Supreme Court's holding in *Baldonado v. Wynn Las Vegas, LLC*, 124 Nev. 951 (2008) supports this position. In *Baldonado*, the Supreme Court held that courts should not imply a private cause of action for wage claims, where no private cause of action is expressly created by statute. *Id.* at 964. The Nevada Supreme Court specifically held that "the absence of an express provision providing for a private cause of action to enforce a statutory right strongly suggests that the Legislature did not intend to create a privately enforceable judicial remedy." *Id.* at 959. The Nevada Supreme Court also concluded that "in light of the statutory scheme requiring the Labor Commissioner to enforce the labor statutes and the availability of an adequate administrative remedy for those statutes' violations, the Legislature did not intend to create a parallel private remedy for NRS 608.160 violations." *Id.* at 960. The Court further noted that "when an administrative official is expressly charged with enforcing a section of laws, a private cause of action generally cannot be implied," and that "the fact that the Legislature has ordered the Labor Commissioner to enforce NRS 608.160 weighs heavily against finding any intent to create a private remedy." *Id.* at 961.

Plaintiffs' counsel has been shopping their NAC 608.102 "junk insurance" claim around to various judicial departments and districts until they can identify the "right" judge to believe the farfetched interpretations and in an effort to ultimately expand the requirements of the MWA. Notably, Plaintiffs' counsel pursued an identical claim in a case entitled *Christopher McLaughlin v. Deli Planet, Inc.*, Case No. A-41-703656-C (J. Kishner). There, Plaintiffs' counsel similarly contended that the defendant's health insurance plan was "junk insurance" and "not comprehensive in coverage" and therefore violated NAC 608.102.[32] In granting the defendant's motion to dismiss, the court concluded that the MWA does not require its health plan to cover certain categories of health care expenses for the defendant to pay the lower excepted wage rate; instead, NAC 608.102 details the type of coverage required. The court noted that the plaintiff was

[32] **Exhibit G** Order Granting Defendant's Motion to Dismiss (December 16, 2014); Order Granting Defendant's Motion to Dismiss Plaintiff's First Amended Class Action Complaint (March 23, 2015)

claiming that the defendant's health insurance plan did not provide sufficient coverage to pay the lower wage rate and found that the plaintiff was in reality asserting a violation of a regulation, which is the Labor Commissioner's responsibility to address.

Here, this Court cannot grant Plaintiffs' Motion as it is not within this Court's discretion to make any determination as to whether the Defendants' plans comport with the requirements set forth in NAC 608.102. That responsibility belongs to the Labor Commissioner alone.

2. NRS 608.1555 is Inapplicable.

Plaintiffs contend that "under Nevada law, any health insurance plans provided by Defendants to Plaintiffs and other of its employees, for any purpose, have to comply with the substantive requirements of NRS Chapters 689A and 689B regarding individual or group health insurance." (emphasis in original). Plaintiffs only refer to NRS 608.1555 for that proposition, which provides: "Any employer who provides benefits for health care to his or her employees shall provide the same benefits and pay providers of health care in the same manner as a policy of insurance pursuant to chapters 689A and 689B of NRS." NRS 608.1555. Of note, Matthew Milone, Plaintiffs' proffered expert and colleague and former employee of Plaintiffs' counsel, analyzes Defendants' plans under 608.1555-608.1576[33] and NRS 689A and 689B. Milone's analysis is flawed and it is apparent that he is not qualified to opine on NRS 608.1555 *et seq.* The Court should disregard the Milone report.

According to Mulliner, NRS 608.1555 does not apply to all health benefits and "it is clear that it was never intended to apply to benefit plans which are already administered through an insurance plan."[34] A review of the legislative history of NRS 608.1555 proves that Mulliner is correct and that Milone's analysis is unreliable.

NRS 608.1555 became a part of Assembly Bill 647 in the Nevada Legislature's 63rd Session. According to the Assembly Commerce Committee May 20, 1985 meeting minutes, Assemblyman Bob Kerns submitted a proposed amendment to AB 647 which related "to self-

[33] *See* **Exhibit 2** to Plaintiffs' MPSJ, pp. 5, 11, 14, 18.

[34] **Exhibit G**, p. 2.

insuring employers."[35] (emphasis added). The amendment proposed to amend Chapter 608 by adding the following provision:

> Any employer providing a health benefit to his employees must provide the same benefits and pay health care providers in the same fashion as an insurance company pursuant to chapters 689A and 689B of NRS.

After some reworking of the language in the committee, the First Reprint of AB 647 included the following suggested revision to Chapter 608:[36]

> Any employer who provides benefits for health care to his employees shall provide the same benefits and pay providers of health care in the same manner as a policy of insurance pursuant to chapters 689A and 689B.

The Second Reprint had the same language and the amendment was subsequently codified in NRS 608.1555.[37]

Thus, despite Milone's and Plaintiffs' contention NRS 608.1555, and as a result NRS 689A and NRS 689B, does not apply to Defendants' plans because Defendants are not self-insured. Similarly, NRS 608.156-608.1576 would not apply as those statutes include the phrase "if an employer provides health benefits for his or her employees," which according to NRS 608.1555 is language that would apply only to self-insured employers.[38]

---

[35] **Exhibit H** - Assembly Commerce Committee meeting minutes (May 20, 1985)

[36] *Id.*

[37] *Id.*

[38] *See, e.g.*, **Exhibit I** - Legislative History of NRS 608.156. SB 166 was introduced during the 62nd Nevada legislative session and sought to make the inclusion of medical treatment of alcoholism and drug abuse mandatory for insurance coverage. As introduced, SB 166 included revisions to NRS 458, 689A, 689B, 695B, 695C. SB 166 passed the Senate side with several amendments to the original language. *See,* SB 166, Reprinted with Adopted Amendments, First Reprint.

When SB 166 reached the Assembly, the committee initially moved to "Do Pass" the bill. *See,* Minutes of the Assembly Nevada State Legislature, 1983 Leg. 62nd Sess. (April 6, 1983). However, subsequent conversation among the committee members occurred regarding self-insured employers and attaching the obligations to those entities. *Id.* at p. 9. As a result of the discussion, the Assembly moved to "Amend and Do Pass" the bill with an amendment to include self-insured employers by amending Chapter 608. *Id.* The Second Reprint of SB 166 added language to the bill, which resulted in the creation of NRS 608.156. *See,* SB 166, Reprinted with Adopted Amendments, Second Reprint.

i. **The Labor Commissioner chose not to include references to NRS 608.1555 through 608.1576 in the permanent regulations.**

A comparison of the Labor Commissioner's emergency regulations with the permanent regulations is quite telling. Section 5 of Emergency Regulations of the Labor Commissioner, Chapter 608 of the Nevada Administrative Code (December 12, 2006), indicates that a few of the requirements for an employer to qualify for the lower wage tier was that the employer was to provide qualified health insurance and comply with "the requirements of NRS 608.1555 through 608.1576, inclusive."[39] The final and permanent regulation removed the language requiring compliance with NRS 608.1555 through 608.1576 (which pertain to self-funded employers) and instead the Labor Commissioner "adopt[ed] the standards used in the business tax provisions of NRS 363A and 363B,"[40] which directs employers to offer a plan that covers categories of health care expenses that are generally deductible on an employee's federal income tax returns. NAC 608.102.

Plaintiffs will likely argue that the Labor Commissioner exceeded his authority in promulgating these regulations. However, the Labor Commissioner did not act in a vacuum. The Nevada Legislature was aware and approved of the Labor Commissioner's thought processes and analysis, the Labor Commissioner consulted with the Attorney General's Office, and he held public information workshops which involved hundreds of individuals.[41] There were numerous minds, ideas, and opinions associated with the rulemaking and one would be hard-pressed to believe that the issue of "what is health insurance" was never debated prior to the implementation of the regulations.

3. "Traditional Major Medical Insurance," "Comprehensive Coverage," and "Traditional Comprehensive."

Plaintiffs spend a large portion of their motion discussing limited benefit plans and fixed-indemnity plans. Plaintiffs repeat *ad-absurdum* that Defendants' plans are not "traditional major medical insurance," "comprehensive coverage," or "traditional comprehensive" plans. However,

---

[39] **Exhibit B – JA0295.**
[40] *Id.* at JA0329.
[41] *Id.* at JA0291-0292, 0299-0319, 0321-0337.

Plaintiffs do not explain how limited benefit plans and fixed-indemnity plans do not satisfy the MWA nor do they specify the language in the MWA that mandates "traditional major medical insurance," "comprehensive coverage," or "traditional comprehensive" plans. Indeed, nowhere in the MWA or the associated regulations is such verbiage used and the only requirements for a health insurance plan offered in relation to the MWA are detailed in NAC 608.102.

For self-interested purposes, Plaintiffs assert that the MWA created a heightened level of coverage, which it did not. Nevada employers who pay the lower wage tier are not obligated to provide the most expansive health care coverage possible, coverage which the majority of citizens do not receive or are otherwise not entitled to. Indeed, Plaintiffs farcically argue that the Defendants' plans do not cover such items as infertility treatments and skilled nursing facility charges, which are charges that many current insurance plans do not cover.

4. Federal Law Does Not Change an Employer's Obligations under the MWA.

Plaintiffs aver that the Defendants' plans do not meet the minimum requirements set forth in the Affordable Care Act ("ACA"). However, the ACA was enacted six years after the MWA and in no way changed an employer's obligations under the MWA. Plaintiffs have no compelling argument or admissible evidence to the contrary.

Indeed, Plaintiffs sole argument on this point is that the ACA imposes tax penalties on individuals who do not purchase qualifying health insurance and Defendants' plans do not free Plaintiffs from either purchasing qualifying health insurance or paying the penalties for not having done so. Again, Plaintiffs fail to identify the language in the MWA that requires an employer to ensure employees are free from tax penalties or are complying with the ACA. Neither the MWA nor its companion regulations, enacted six years before the ACA, impose such radical obligations on Nevada employers.

5. "Social Expectations" Cannot Support a Request for Summary Judgment.

Plaintiffs include a discussion about their beliefs related to the "public understanding and expectation leading up to an in the period after the [MWA] enactment." Neither Plaintiffs' nor their counsel's belief system is an appropriate ground for granting summary judgment relief. It is actually immaterial and of no assistance in resolving the legal questions before this court.

VI. EXPERT OPINIONS.

Plaintiffs contend that Milone's report supports their legal argument and they urge the Court to consider his application of Nevada law to the Defendants' plans. If the Court was to do so it would be misapplying Nevada law for the reasons discussed above. For example, Milone determined that because NRS 608.155 references NRS 689B that "it seemed to be the most relevant [statute] to this case."[42] However, as Mulliner pointed out, NRS 608.155 is applicable only to self-insured employers. Milone also remarkably testified that had the Nevada Division of Insurance approved Defendants' plans, his opinions regarding the quality of Defendants' plans would not change.[43] Milone's report is a work of advocacy as he not only misapplies Nevada law, but he fails to conduct any research regarding the legislative history of the pertinent statutes and has never litigated a case regarding the interpretation of the MWA.[44]

Plaintiffs scold Mulliner and fellow defense expert Michael Arrigo for boiling down their opinions as to what constitutes "health insurance" to "very simple definitions." That signifies the entire problem with this issue. Plaintiffs are convoluting what is a straightforward issue with a stew of irrelevant laws and subjective beliefs to ascertain the obligations of a Nevada employer under Nevada's MWA. Plaintiffs cite the ACA, NRS 608.1555, 608.156, 608.157, 608.1575, a statement from a Connecticut Attorney General, the Center on Health Insurance Reforms note on federal law, and an IRS Publication to ascertain the meaning behind the term "health insurance" as mentioned in Nevada's MWA. This hodgepodge of information is neither helpful nor relevant to resolving the issue.

As noted by both Mulliner and Arrigo, health insurance is generally understood in the industry to be a contract for insurance between an employer and a third-party insurer under which an employee health benefits plan is administered by a third party.[45] Generally, there are two components: (1) an employer plan to offer health benefits and (2) an administrator to process and pay claims. That is the nuts and bolts of what constitutes health insurance in the industry. To

---

42 **Exhibit J** – Depo. Trans. Matthew Milone, pp. 44:15-45:1.
43 *Id.* at 54:21-57:16.
44 *Id.* at pp. 24:8-17; 25:21-24;
45 **Exhibit F** –p. 5; **Exhibit 25** to Plaintiffs' MPSJ, p. MDC001261.

evaluate the specifics of the plan an employer needs to offer to qualify to pay an employee the excepted wage rate under the MWA, an employer turns to NAC 600.102 which provides the requirements any health insurance plan must have: (1) it must cover those categories of health care expenses that are generally deductible by an employee on the employee's federal tax return; (2) it must be available to the employee and the employee's dependents; (3) the waiting period for the health insurance plan cannot exceed more than six months; and (4) the cost of the premium to the employee cannot exceed 10 percent of the employee's gross taxable income. Quite frankly, the path for an employer to determine its statutory obligations is not as complex as Plaintiffs wish it to be.

VII. CONCLUSION.

Given the foregoing, Defendants request the Court to deny Plaintiffs Renewed Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans.

DATED this 13 day of May, 2016.

MORRIS POLICH & PURDY LLP

By: _____
NICHOLAS M. WIECZOREK
Nevada Bar No. 6170
DEANNA L. FORBUSH
Nevada Bar No. 6646
JEREMY J. THOMPSON
Nevada Bar No. 12503
3800 Howard Hughes Parkway, Suite 500
Las Vegas, Nevada 89169
Attorneys for Defendants

CERTIFICATE OF SERVICE

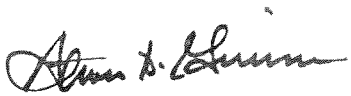
Pursuant to NEFCR 9, NRCP 5(b), EDCR 7.26, and Administrative Order 14-2, I certify that I am an employee of Morris Polich & Purdy LLP, and that on this 12 day of May, 2016, I served a true and correct copy of the above and foregoing **DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT ON LIABILITY REGARDING DEFENDANTS' HEALTH BENEFITS PLANS** via the Court's CM/ECF to all registered parties and /or their respective counsel of record.

Morris Polich & Purdy LLP	
Contact	Email
Beth A. Kahn, Esq.	bkahn@mpplaw.com
Deanna L. Forbush, Esq.	DForbush@mpplaw.com
Debbie Surowiec	dsurowiec@mpplaw.com
Jeremy J. Thompson, Esq.	jthompson@mpplaw.com
Lisa Woodruff	lwoodruff@mpplaw.com
Maria T. Escobedo	MEscobedo@mpplaw.com
Natasha Martinez	nmartinez@mpplaw.com
Nicholas M. Wieczorek, Esq.	nwieczorek@mpplaw.com

Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP	
Contact	Email
Bradley S. Schrager, Esq.	bschrager@wrslawyers.com
Christie Rehfeld	crehfeld@wrslawyers.com
Dan Hill, Esq.	dhill@wrslawyers.com
Daniel Bravo	dbravo@wrslawyers.com
Dannielle Fresquez	dfresquez@wrslawyers.com
Don Springmeyer	dspringmeyer@wrslawyers.com
E. Noemy Valdez	nvaldez@wrslawyers.com
Justin Jones, Esq.	jjones@wrslawyers.com
Lorrine Rillera	Lrillera@wrslawyers.com

Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP.	
Contact	Email
Jennifer Finley	jfinley@wrslawyers.com

An Employee of Morris Polich & Purdy LLP



EXHS

NICHOLAS M. WIECZOREK
Nevada Bar No. 6170
DEANNA L. FORBUSH
Nevada Bar No. 6646
JEREMY J. THOMPSON
Nevada Bar No. 12503
MORRIS POLICH & PURDY LLP
3800 Howard Hughes Parkway, Suite 500
Las Vegas, Nevada 89169
Telephone: (702) 862-8300
Facsimile: (702) 862-8400
NWieczorek@mpplaw.com
DForbush@mpplaw.com
JThompson@mpplaw.com

Attorneys for Defendants, MDC RESTAURANTS, LLC; LAGUNA RESTAURANTS, LLC; INKA, LLC

DISTRICT COURT

CLARK COUNTY, NEVADA

PAULETTE DIAZ, an individual; LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, an individual; and CHARITY FITZLEFF, an individual, on behalf of themselves and all similarly-situated individuals,

Plaintiffs,

v.

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company, and DOES 1 through 100, Inclusive,

Defendants.

Case No.: A-14-701633-C
Dept. No.: XVI

NOTICE OF LODGMENT OF EXHIBITS TO DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT ON LIABILITY REGARDING DEFENDANTS' HEALTH BENEFITS PLANS

Hearing Date: May 31, 2016
Hearing Time: 9:00 a.m.

Defendants MDC Restaurants, LLC, Laguna Restaurants, LLC and Inka, LLC (hereinafter collectively referred to as "Defendants"), by and through their counsel of record Morris Polich & Purdy LLP, hereby submit their Notice of Lodgment of Exhibits to Defendants' Opposition to Plaintiffs' Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans, which is filed concurrently herewith.

Exhibit	Description
A	Affidavit of Jeremy J. Thompson
B	Opening Brief of the State of Nevada, Office of the Labor Commissioner, Nev. Sup. Ct. Case No. 38770
C	2010-2012 Starbridge Plan and 2013 Starbridge Plan
D	2014 TransChoice Plan
E	2014 MVP Plan
F	Expert Report of Timothy R. Mulliner, dated March 14, 2016, Cirriculum Vitae and Deposition Transcript of Timothy R. Mulliner taken March 31, 2016
G	Order Granting Defendant's Motion to Dismiss filed December 16, 2014, and Order Granting Defendant's Motion to Dismiss Plaintiff's First Amended Class Action Complaint filed March 23, 2015
H	Assembly Commerce Committee meeting minutes (May 20, 1985)
I	Legislative History of NRS 608.156
J	Deposition Transcript of Matthew T. Milone, taken March 16, 2016

DATED this 16 day of May, 2016.

MORRIS POLICH & PURDY LLP

By: _____
NICHOLAS M. WIECZOREK
Nevada Bar No. 6170
DEANNA L. FORBUSH
Nevada Bar No. 6646
JEREMY J. THOMPSON
Nevada Bar No. 12503
3800 Howard Hughes Parkway, Suite 500
Las Vegas, Nevada 89169
Attorneys for Defendants

CERTIFICATE OF SERVICE

Pursuant to NEFCR 9, NRCP 5(b), EDCR 7.26, and Administrative Order 14-2, I certify that I am an employee of Morris Polich & Purdy LLP, and that on this 13. day of May, 2016, I served a true and correct copy of the above and foregoing **NOTICE OF LODGMENT OF EXHIBITS TO DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT ON LIABILITY REGARDING DEFENDANTS' HEALTH BENEFITS PLANS** via the Court's CM/ECF to all registered parties and /or their respective counsel of record.

Morris Polich & Purdy LLP	
Contact	**Email**
Beth A. Kahn, Esq.	bkahn@mpplaw.com
Deanna L. Forbush, Esq.	DForbush@mpplaw.com
Debbie Surowiec	dsurowiec@mpplaw.com
Jeremy J. Thompson, Esq.	jthompson@mpplaw.com
Lisa Woodruff	lwoodruff@mpplaw.com
Maria T. Escobedo	MEscobedo@mpplaw.com
Natasha Martinez	nmartinez@mpplaw.com
Nicholas M. Wieczorek, Esq.	nwieczorek@mpplaw.com

Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP	
Contact	**Email**
Bradley S. Schrager, Esq.	bschrager@wrslawyers.com
Christie Rehfeld	crehfeld@wrslawyers.com
Dan Hill, Esq.	dhill@wrslawyers.com
Daniel Bravo	dbravo@wrslawyers.com
Dannielle Fresquez	dfresquez@wrslawyers.com
Don Springmeyer	dspringmeyer@wrslawyers.com
E. Noemy Valdez	nvaldez@wrslawyers.com
Justin Jones, Esq.	jjones@wrslawyers.com
Lorrine Rillera	Lrillera@wrslawyers.com

Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP.	
Contact	**Email**
Jennifer Finley	jfinley@wrslawyers.com

Lisa Woodruff

An Employee of Morris Polich & Purdy LLP

0572

EXHIBIT A

EXHIBIT A

EXHIBIT A

AFFIDAVIT OF JEREMY J. THOMPSON IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT ON LIABILITY REGARDING DEFENDANTS' HEALTH BENEFITS PLANS

STATE OF NEVADA)
COUNTY OF CLARK)

I, JEREMY J. THOMPSON, being first duly sworn, deposes and states as follows:

1. I am an attorney duly licensed to practice law in the State of Nevada. I am an attorney affiliated with the firm of Morris Polich & Purdy LLP, located at 3800 Howard Hughes Parkway, Suite 500, Las Vegas, Nevada 89169, and counsel for record for defendants MDC Restaurants, LLC, Laguna Restaurants, LLC, and Inka, LLC. I have personal knowledge of the facts contained herein and if called as a witness I could and would competently testify to their accuracy.

2. Attached hereto as **Exhibit "B"** is a true and correct copy of Opening Brief of the State of Nevada, Office of the Labor Commissioner, Nev. Sup. Ct. Case No. 38770.

3. Attached hereto as **Exhibit "C"** are true and correct copies of the 2010-2012 Starbridge Plan and 2013 Starbridge Plan.

4. Attached hereto as **Exhibit "D"** is a true and correct copy of the 2014 TransChoice Plan.

5. Attached hereto as **Exhibit "E"** is a true and correct copy of the 2014 MVP Plan.

6. Attached hereto as **Exhibit "F"** is a true and correct copy of the Expert Report of Timothy R. Mulliner dated March 14, 2016, Cirriculum Vitae, Fee Schedule and Deposition Transcript of Timothy Mulliner taken March 31, 2016.

7. Attached hereto as **Exhibit "G"** are true and correct copies of the Order Granting Defendant's Motion to Dismiss (December 16, 2014); and Order Granting Defendant's Motion to Dismiss Plaintiff's First Amended Class Action Complaint (March 23, 2015).

8. Attached hereto as **Exhibit "H"** is a true and correct copy of the Assembly Commerce Committee meeting minutes (May 20, 1985).

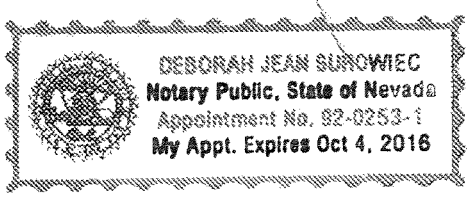
9. Attached hereto as **Exhibit "I"** is a true and correct copy of the Legislative History of NRS 608.156.

10. Attached hereto as **Exhibit "J"** is a true and correct copy of the Deposition Transcript of Matthew T. Milone, taken March 16, 2016.

FURTHER AFFIANT SAYETH NAUGHT.

JEREMY J. THOMPSON

SUBSCRIBED and SWORN to before me on this 13 day of May, 2016.



NOTARY PUBLIC in and for the
County of Clark, State of Nevada

0575

EXHIBIT B

EXHIBIT B

EXHIBIT B

IN THE SUPREME COURT

OF THE STATE OF NEVADA

Electronically Filed
Nov 30 2015 04:07 p.m.
Tracie K. Lindeman
Clerk of Supreme Court

STATE OF NEVADA, ex. rel. OFFICE OF THE LABOR COMMISSIONER; and SHANNON CHAMBERS in her official capacity as Labor Commissioner of Nevada, Appellants, v. CODY C. HANCOCK, Respondent.	Supreme Court No.: 68770 District Ct. No.: 14OC00080 On Appeal from the First Judicial District Court

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

OPENING BRIEF OF THE STATE OF NEVADA,

OFFICE OF THE LABOR COMMISSIONER

ADAM PAUL LAXALT
Nevada Attorney General
Scott Davis
Senior Deputy Attorney General
Nevada State Bar No. 10019
555 E. Washington Ave. #3900
Las Vegas, NV 89101
Telephone: (702) 486-3894
Attorneys for *State of Nevada, Office of the Labor Commissioner and Shannon Chambers*

TABLE OF CONTENTS

Attorney General's Office
555 E. Washington, Suite 1900
Las Vegas, NV 89101

TABLE OF CONTENTS

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

TABLE OF AUTHORITIES

Nevada Cases

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

TABLE OF AUTHORITIES

Cases From Other Jurisdictions

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

TABLE OF AUTHORITIES

Constitutional Provisions and Statutes

Regulations

Other Authorities

I.

JURISDICATIONAL STATEMENT

This appeal arises following a final decision of a district court imposing injunctive relief against the Nevada Labor Commissioner. JA 0407-0416. Jurisdiction is proper under NRAP 3A(b)(1) and Nev. Const. art. 6 § 4.

II.

STATEMENT OF THE ISSUES

The appeal in this matter presents the following issues:

1. Whether NAC 608.100(1) conflicts with the Nevada Constitution when it uses the word "offer" to describe an employer's obligations to qualify to pay the lower-tier minimum wage rate.

2. Whether NAC 608.104 conflicts with the Nevada Constitution by stating that federal income tax laws be used to measure an employee's gross taxable income, when federal tax laws deem tips as taxable income.

III.

STATEMENT OF THE CASE

This case is an appeal from a decision of the Honorable James E. Wilson of the First District Court that granted declaratory and injunctive relief in favor of Respondent and Plaintiff below Cody Hancock against the Nevada Labor Commissioner. JA 0407-0416.

Hancock challenged two administrative regulations codified in Chapter 608 of the Nevada Administrative Code. JA 0097-0099. Hancock first claim contended that NAC 608.100(1)(a) was unconstitutional and in conflict with the provisions of Nev. Const. art. 15, § 16. JA 0097-0098. Hancock's second claim contended that NAC 608.104(2) was unconstitutional under the same theory. JA 0098.

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

Both Hancock and the Labor Commissioner agreed that the case presented a pure question of law and did not depend upon particular factual circumstances. JA 0136-0138. The parties agreed that discovery was not warranted and stipulated to a briefing schedule for dispositive motions. JA 0136-0138. The stipulation also scheduled oral arguments on the motions before Judge Wilson in August of 2015. JA 0137:14-16.

Hancock and the Labor Commissioner each moved for summary judgment before the district court. JA 0139-0163; 0245-0258. Although oral arguments had been scheduled for the afternoon of August 11, 2015, *see* JA 0338, on the eve of the scheduled hearing the district court cancelled the hearing and issued the decision in favor of Mr. Hancock. JA 0407-0416. The decision invalidated both NAC 608.100(1) and NAC 608.104(2) and enjoined the Labor Commissioner from enforcing either of the regulations. JA 0407-0416.

Notice of entry of the district court's order was provided on August 18, 2015. JA 0417-0418. This appeal then followed.

IV.

STATEMENT OF RELEVANT FACTS

This case turns on a pure question of law and does not depend upon factual findings. The district court's order did not include any specific factual findings. JA 0407-0416.

To the extent that factual matters are relevant, the Labor Commissioner did not dispute that Plaintiff Hancock was an employee affected by the operative portions of the minimum wage amendment and the Administrative Code.

Mr. Hancock is an employee in the state of Nevada. JA 0171, ¶ 3. He has been paid the lower-tier wage rate and had not been enrolled in an

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

employer-provided health plan at the time the complaint was filed. JA 0171, ¶¶ 3-4.

V.

SUMMARY OF ARGUMENT

When this Court expounds the constitution, it does so in a way that gives expression and meaning to each word and phrase of the constitutional text. This approach is a bedrock of constitutional interpretation.

The district court's decision should be reversed because it does not follow this fundamental canon and instead selectively emphasizes portions of the constitutional text while writing off other portions of the text entirely. Critically, those portions that were disregarded by the district court below support the administrative regulations at issue here.

The district court's interpretation of the minimum wage amendment in such a way that conditions payment of the lower-tier wage rate upon actual receipt of health insurance benefits disregards the constitutional text that defines "offering health benefits" to consist of an employer "...making health insurance available..." The district court reached this conclusion only after improperly isolating the terms "provides" and "offering" and considering these terms in the abstract rather than within the context of the minimum wage amendment. This further resulted in disregard for the constitutional text that specifies that an employer's provision of health benefits must be "as described herein", *i.e.* within the amendment itself. That internal description clearly specifies that the lower-tier wage rate is predicated upon an employer "making health insurance available."

NAC 608.100 is faithful to the constitutional text because the regulation specifies that in order to pay an employee the lower-tier wage rate an employer

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

must offer health insurance available to an employee by making it available to the employee.

NAC 608.104 is also faithful to the constitutional text because this regulation looks to federal income tax law to provide the measurement for an employee's "gross taxable income," and federal tax law is the only viable source of standards to measure an employee's taxable income. The district court's analysis of the 10 percent cost cap suffers from the same defect – it interprets the minimum wage amendment in a way that renders portions of the constitutional text meaningless. The district court emphasized the phrase "from the employer," but did so in such a way that it renders the antecedent condition of "gross taxable income" meaningless.

In contrast to the district court's order, the Labor Commissioner's regulations in NAC 608.100 and NAC 608.104 do not require the violation of any fundamental canon of constitutional interpretation. The Labor Commissioner's regulations achieve a systematic interpretation of the minimum wage amendment that does not disregard any portion of the text, and is consistent with the general purpose of the amendment.

V.

LEGAL ARGUMENT

A. Standard of Review

This case does not concern any factual dispute, and turns primarily on an interpretation of the Nevada constitution. This Court reviews matters of constitutional interpretation under a *de novo* standard, without any deference to the lower court's decision. *Hernandez v. Bennett-Haron*, 128 Nev. ____, 287 P.3d 305, 310 (Adv. Op. 54, 2012).

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

As such, the district court's decision in this matter does not merit deference on appeal and this Court should conduct an independent *de novo* review of the decision. *Id.*

B. Standards of Constitutional Interpretation

1. The Court Must Presume the Challenged Regulations to be Valid

"[T]he law cannot be declared unconstitutional unless it be clearly, palpably, and plainly in conflict with some of the provisions of the Constitution. This is a rule recognized by all the Courts, and probably has never been questioned." *Gibson v. Mason*, 5 Nev. 283, 299 (1869).

When a law is challenged as constitutionally invalid this Court indulges every presumption in favor of the law's validity and the law must be upheld unless it is in clear derogation of a constitutional provision. *Vineyard Land & Stock Co. v. Dist. Court of Fourth Judicial District*, 42 Nev. 1, 171 P. 166, 168 (1918). The same presumptions and standards applicable to constitutional challenges against statutes also apply with equal force to constitutional challenges to administrative regulations. 16A Am. Jur. 2d Constitutional Law § 167.

2. The Court Must Follow the Canons of Constitutional Interpretation

"In expounding a constitutional provision, such constructions should be employed as will prevent any clause, sentence or word from being superfluous, void or insignificant." *Youngs v. Hall*, 9 Nev. 212, 222 (1874); *see also State ex rel. Herr v. Laxalt*, 84 Nev. 382, 386, 441 P.2d 687, 690 (1968).

Under this fundamental canon of constitutional interpretation, a district court is not permitted to disregard the actual constitutional language in order to advance an interpretation that the court prefers as generating a more equitable result. *Cook v. Maher*, 108 Nev. 1024, 1026, 842 P.2d 729, 730 (1992).

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

Further, this Court prefers a construction that harmonizes constitutional provisions if possible. *E.g. Guinn v. Legislature*, 119 Nev. 460, 471, 76 P.3d 22, 29 (2003); *Ex parte Shelor*, 33 Nev. 361, 375, 111 P. 291, 293 (1910).

Regarding the minimum wage amendment in particular, this Court bases its construction on the actual text of the amendment rather than an abstract understanding of the purposes of the amendment. *Thomas v. Nevada Yellow Cab Corp.*, 130 Nev. ___, 327 P.3d 518, 522 (Adv. Op. 52, 2014).

The district court's decision in this case disregards these fundamental canons of constitutional interpretation in order to reach an interpretation of the minimum wage amendment that is undoubtedly more employee-friendly, but that disregards significant portions of the constitutional text.

C. Nevada's Two-Tiered Minimum Wage Amendment

1. The Two-Tier Wage Rate

In Nevada, the minimum wage is established by the state constitution. Nev. Const. art 15. § 16. This provision, which is commonly referred to as the "minimum wage amendment" sought primarily to raise the minimum wage in Nevada. *See Thomas*, 327 P.3d at 520. The portions of the minimum wage amendment that are critical to this appeal are contained in section A of the amendment and read as follows:

> Each employer shall pay a wage to each employee of not less than the hourly rates set forth in this section. The rate shall be five dollars and fifteen cents ($5.15) per hour worked, if the employer provides health benefits as described herein, or six dollars and fifteen cents ($6.15) per hour if the employer does not provide such benefits. Offering health benefits within the meaning of this section shall consist of making health insurance available to the employee for the employee and the employee's dependents at a total cost to the

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

> employee for premiums of not more than 10 percent of the employee's gross taxable income from the employer.
>
> Nev. Const. art 15. § 16(A).

At the time the amendment was adopted in 2006, the federal minimum wage rate was $5.15 per hour. *See* 29 U.S.C. § 206(a) (2006) (specifying a federal minimum wage of $5.15 per hour). The amendment raised the state minimum wage rate to $6.15 per hour, but also provided for a lower-tier wage rate that remained consistent with the prior federal wage rate of $5.15 per hour. This lower-tier wage rate created a residual exception to the amendment's general increase in wages by allowing employers the ability to continue to pay the same wage rate that had been in effect prior to the amendment's approval, provided that the employee be afforded access to affordable employer-provided health insurance. Nev. Const. art. 15 § 16(A). If an employee does not have access to such employer-provided health insurance, or if the health insurance does not satisfy the 10 percent cost cap, then the standard higher-tier wage rate applies. *Id.*

2. The Development of the Administrative Regulations

Prior to the amendment's final approval in the 2006 general election, the Labor Commissioner had sought and obtained an Attorney General opinion indicating that the Labor Commissioner would likely retain administrative enforcement authority over the new minimum wage amendment. Op. Nev. Att'y Gen. 2005-04 (March 2, 2005) (cited with approval in *Thomas*, 327 P.3d at 521, n. 2). In the wake of the amendment's approval, and in order to provide necessary guidance concerning compliance with the lower-tier exception, the Labor Commissioner invoked the rulemaking authority granted by NRS 607.160(1)(b) to promulgate emergency regulations that interpreted the new minimum wage amendment and provided guidance to Nevada

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

employers on the issue of compliance. JA. 0289-0297. The progenitors of NAC 608.100 and NAC 608.104 were part of these emergency regulations. JA 0294 §2(a); 0295 § 7. These emergency regulations were then converted to temporary regulations, and finally to the current permanent regulations.

In the legislative session immediately following the 2006 general election, while in the process of converting the emergency regulations into temporary regulations, then-Labor Commissioner Michael Tanchek appeared before the Senate Committee on Commerce and Labor to explain these administrative regulations and his view of the amendment. *See* Minutes of Hearing on Minimum wage before Senate Committee of Commerce and Labor, 2007 Leg. 74th Sess. (Feb. 8, 2007); JA 0299-0319.

Commissioner Tanchek provided the Senate committee with a written explanation of the Labor Commissioner's view of the amendment and the objectives of the administrative regulations. JA 0321-0337. Commissioner Tancheck identified the relation of health benefits to the two-tier structure as "the major area of confusion over the amendment." JA 0328 (emphasis in original). Commissioner Tanchek explained that in order to qualify for the lower-tier wage rate an employer must satisfy each of the following conditions: that insurance be made available to the employee; that it must be for the employee and dependents; and that it must fall within the 10 percent cost cap. JA 0328.

Commissioner Tanchek also addressed the question "what if the employee does not want health insurance" and explained that if an employee were to decline health insurance the employer would still meet its obligations under the amendment if it makes the insurance available. JA 0329.

Acting through the Administrative Procedures Act's full notice-and-comment rulemaking procedures, the Labor Commissioner codified

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

administrative regulations that are based upon these premises as the permanent regulations that were recently invalidated by the district court below. NAC 608.100; NAC 608.102; NAC 608.104.

D. The District Court's Order Is Internally Inconsistent

The district court's order is comprised of two main parts that are logically irreconcilable with each other.

The district court first held that the 10 percent cost cap applies to an employer's provision of health benefits such that an employer can only qualify to pay the lower-tier wage if the cost of health premiums does not exceed 10 percent of the wages paid to the employee, excluding tips. JA 0412:10-13. But the district court also held that the employer's provision of health benefits does not mean that the employer must make health insurance available to the employee in order to qualify to pay the lower-tier wage rate. Instead the district court held that "...the minimum wage amendment requires that employees actually receive qualified health insurance in order for an employer to pay [the lower-tier wage rate]." JA 0414:10-12. These two holdings expose a logical defect in the court's reasoning because in doing so the district court simultaneously applied and rejected elements of the constitutional definition of "offering health benefits."

The minimum wage amendment defines the term "offering health benefits" as follows: "Offering health benefits within the meaning of this section shall consist of making health insurance available to the employee for the employee and the employee's dependents at a total cost to the employee for premiums of not more than 10 percent of the employee's gross taxable income from the employer." Nev. Const. art. 15 § 16(A).

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

The constitutional definition of "offering health benefits" thus includes four discrete elements: health benefits must be (1) actual health insurance;[1] (2) must be made available to the employee; (3) must provide coverage for the employee and dependents; and (4) must satisfy the 10 percent cost cap.

Within the same order the district court held that the second of these elements (the "make available" requirement) did not apply to an employer's provision of insurance while at the same time finding that the fourth of these elements (the 10 percent cost cap) did apply. But both the "make available" requirement and the cost cap requirement are elements of the same definition of the term "offering health insurance."

There is no discernable basis in logic, linguistics or law to selectively apply one element of "offering health benefits" to an employer's provision of health benefits while simultaneously disregarding another element. Consistency demands that either the entirety of term "offering health benefits," with each of its attendant elements, applies to an employer's provision of health benefits under the amendment or it does not apply at all.

The Labor Commissioner's regulations hold that the term "offering health benefits" does apply and that each element of the definition must be satisfied in order for an employer to "provide health benefits" and qualify to pay the lower-tier wage rate. NAC 608.102; JA 0328. As set forth below, the Labor Commissioner's regulations do this in way that gives effect to each word and phrase of the constitutional text.

E. NAC 608.100 Does Not Conflict with the Amendment

NAC 608.100(1)(a) sets the minimum wage rate for a non-exempt employee by stating "[i]f an employee is offered qualified health insurance, is

[1] The word "insurance" does not appear anywhere else in the minimum wage amendment.

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

$5.15 per hour..." NAC 608.102(2) confirms that this means that "[t]he health insurance must be made available to the employee..." These administrative regulations are based upon the constitutional definition of "offering health benefits" and its stipulation that the employer must make health insurance available to the employee. Nev. Const. art. 15 § 16(A). There is no conflict between the regulations and this portion of the amendment.

The fundamental concern raised by this appeal is the relation between the amendment's directive for employers to "provid[e] health benefits" and the amendment's definition of the term "offering health benefits." If these two constitutional clauses are read together then the Labor Commissioner's regulations cannot conflict with the minimum wage amendment because the regulations mirror the same language and standards expressed in the definition of "offering health benefits." Only if these two constitutional clauses are divorced from each other, as the district court's order presumes, can there even arise any argument that the regulations conflict with the constitutional text.

1. The Meaning of Constitutional Terms Cannot be Divorced from Context

The cardinal error committed by the district court was that it isolated the terms "provides" and "offering" from the context of the rest of the minimum wage amendment, and then considered the meaning of these isolated terms in the abstract in order to justify its conclusion. This Court condemned just such an approach to statutory interpretation in *Midwest Livestock Commission Co. v. Griswold*, 78 Nev. 358, 372 P.2d 689 (1962). In *Griswold* this Court held that an issue of statutory interpretation cannot be properly decided by divorcing one particular statutory term from its context within an act as a whole and then considering the plain meaning of that term in isolation. *Id.* at 361, 372 P.3d at 691. Rather the correct approach is to derive the meaning by

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

considering the statutory term in context. *Id.* Although *Griswold* concerned a statutory term rather than a constitutional term, the rationale of *Griswold* is directly applicable to the question in this appeal.

a. *"As described herein" Must Have Some Meaning*

The constitutional text does not simply state that the lower-tier wage rate applies when an employer provides health benefits. In context, the clause states, "[t]he rate shall be five dollars and fifteen cents ($5.15) per hour worked, if the employer provides health benefits as described herein..." Nev. Const. art. 15 § 16(A) (emphasis added).

The phrase "as described herein" is a clear constitutional directive that the meaning of "provides health benefits" should not be considered in isolation and must be considered within the context of the amendment as a whole. The district court's order not only fails to account for this phrase, it deprives the phrase of any meaning or significance at all. If the phrase "as described herein" does not refer to the definition of "offering health benefits" that immediately follows in the text, then it lacks meaning because no other provision of the amendment plausibly offers a description that can correspond to the phrase "as described herein."

The remainder of section A of the amendment concerns the publication and adjustment of the annual wage rate, notice of adjustments to employees, and the rule that tips or gratuities cannot be used by an employer to satisfy the wage rate. Nev. Const. art. 15 § 16(A). None of these provisions can plausibly be deemed the subject of the phrase "provides health benefits as provided herein." Even looking beyond section A of the amendment to sections B, C or D does not suggest a description of what is meant by providing health benefits. *See* Nev. Const. art. 15, § 16.

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

Apart from this definitional clause, the term "offering health benefits" does not appear anywhere else in the amendment. If the phrase "as described herein" is to have any meaning, it must link the meaning of "provides health benefits" to the definition of "offering health benefits" that immediately follows it in the constitutional text.

If the constitutional text defining "offering health benefits" does not refer to an employer's provision of health benefits, then to what does this definition refer? The district court's order provides no answer. Rather the district court's order reduces this definition to the bizarre and superfluous status of defining a non-existent term.

The district court's rationale thus reduces both the amendment's phrase "as described herein" and the entire definition of "offering health benefits" to meaninglessness. This result cannot be reconciled with well-established directive to avoid just such an interpretation.

2. The District Court Placed a Disproportionate Emphasis On the Canon of Consistent Usage

The district court agreed with an argument advanced by Hancock that the terms "provide" and "offering" were not synonymous because of the presumption that use of a different term denotes a different idea. JA 0414, citing Antonin Scalia and Bryan A. Garner, *Reading Law: the Interpretation of Legal Texts*, 170 (Presumption of Consistent Usage) (1st ed. 2012).

While this general presumption of statutory interpretation can apply in principle to constitutional interpretation, *see Lorton v. Jones*, 130 Nev. ___, 322 P.3d 1051, 1056 (Adv. Op. 8, 2014), the district court greatly overemphasized its application to the present case. This presumption is not helpful to the constitutional interpretation presented in this case for three reasons.

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

First, this presumption is only a presumption, and a rather weak one that can be easily rebutted by context. *Barneck v. Utah Dept. of Transporation*, 353 P.3d 140, 150 (Ut. 2015) (citing Scalia & Garner at 171). As set forth above, the district court considered the terms "offering" and "provides" in isolation rather than accounting for the context within the rest of the amendment. A consideration in context that accounts for the phrase "as described herein" and accounts for the definition of "offering health benefits" plainly links the provision of health insurance with the requirement that it be made available. An in-context consideration easily overcomes this presumption.

Second, this presumption stands opposed to other, more forceful canons of interpretation that each word must be given meaning and that if possible harmonious construction should be achieved with an act. An overly rigid application of the presumption stands as a barrier to this canon. *See Sachs v. Republic of Austria*, 737 F.3d 584, 598, n. 13 (9th Cir. 2013) (discounting the presumption of consistent usage when it conflicts with other canons of statutory construction). In this case, the district court's construction fails to achieve a harmonious construction between the condition that employer "provides health benefits" and the definition of "offering health benefits."

Finally, the presumption is not particularly helpful in this case because unlike laws that are passed through the legislature and reviewed by the Legislative Counsel Bureau, the minimum wage amendment was not subject to a review for internal consistency before being submitted to the voters.[2] Thus,

[2] The minimum wage amendment was one of the final initiative petitions that did not first undergo a linguistic review for internal consistency by the Legislative Counsel Bureau. In 2007 the legislature altered the initiative process to provide for such a review and for technical suggestions to be made by the Legislative Counsel Bureau. NRS 295.015(3)(b), Act of June 13, 2007, ch. 476, § 24(b), 2007 Nev. Stat. 2543.

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

unlike laws that originate within a legislative body, an initiative measure is more susceptible to draftsman's error and weighs against application of this presumption. *E.g. People v. Skinner*, 704 P.2d 752, 759 (Cal. 1985) (recognizing inconsistent language in initiative measure was merely draftsman's error). Because there was no review for linguistic consistency, the presumption of an intent to deliberately signal a different concept is greatly diminished in this case.

3. The District Court's View Is Not Consistent with Plain Meaning

Even if isolated consideration of constitutional terms in the abstract were an acceptable approach to constitutional interpretation, the administrative regulations still would not create a conflict with the minimum wage amendment because the meaning of "offer" in NAC 608.100(1)(a) does not actually conflict with the abstract meaning of "provide."

The meaning of "offer" as used within the administrative regulations means "to make available." NAC 608.102(2). The dictionary definition of the "provide" likewise means "to make available." *Webster's New World College Dictionary*, 1155 (4th ed. 2002); *Merriam-Websters Collegiate Dictionary*, 941 (10th ed. 1999) (defining "provide" as "to make something available to"). The canon of harmonious construction holds that this Court will prefer an interpretation that harmonizes the constitution and statutory provisions where possible. *E.g. State v. Glusman*, 98 Nev. 412, 419, 651 P.2d 639, 644 (1982).

Thus, there is no substantive conflict between NAC 608.100(1)(a) and the minimum wage amendment, let alone the clear, palpable and plain conflict that is required before a law may be declared unconstitutional. *Gibson v. Mason*, 5 Nev. at 299.

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

4. Abstract Purpose Cannot Be Elevated Above Constitutional Text

The abstract purpose of the minimum wage amendment cannot be elevated over the actual constitutional text. *Thomas*, 327 P.3d at 522 (2014).

The district court below advanced policy reasoning as the primary support for its finding that employees must receive health insurance benefits, when it held that any other view of the amendment would thwart the purposes and benefits of the amendment. JA 0414. This holding cannot stand, either as a matter of sound rationalization or as a matter of constitutional interpretation.

The district court described the lower-tier wage rate of the amendment as reflecting an "inherent bargain." JA 0414. The amendment does indeed reflect an inherent bargain, but not the bargain found by the district court.

The administrative regulations construe that bargain to be that an employee must receive either higher wages or access to affordable employer-provided health insurance. The district court however determined that the bargain of the amendment was that employee receives either higher wages or is actually enrolled in employer-provided health insurance. JA 0414. Only one of these views is tied to the actual constitutional text.

In effect, the district court ignored the constitutional text in order to make a policy determination that merely receiving access to health insurance is not an adequate benefit for employees. It is not the prerogative of the courts to make policy choices such as this. *Sissions v. Sommers*, 24 Nev. 379, 389, 55 P. 829, 831 (1899); *see also N. Lake Tahoe Fire v. Washoe Cnty. Comm'rs*, 129 Nev. ____, 310 P.3d 583, 587 (Adv. Op. 72, 2013). Instead, the policy choice was made by Nevada voters in adopting constitutional text reflecting that an employer must either pay the higher wage rate or must make health insurance available. Nev. Const. art. 15§ 16(A).

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

5. Regulations Achieve Harmonious Reading of the Amendment

Each of the defects with the district court's order are avoided by the view advanced by the Labor Commissioner's regulations.

The Labor Commissioner's interpretation properly accounts for the context of the amendment by linking an employer's provision of health benefits with the definition of "offering health benefits." This approach achieves a harmonious construction of the amendment by recognizing that the term "provides health benefits as described herein," incorporates the definition of "offering health benefits," including the condition that an employer must make health insurance available to it employees. NAC 608.100(1)(a); NAC 608.102(2). Under this approach the terms "offers" and "provides" are synonymous as each has the same substantive meaning: to make insurance available. NAC 608.102(2); Nev. Const. art. 15 § 16(A). Thus, the terms are interchangeable.

The Labor Commissioner's regulations have in fact used the terms interchangeably. The first iteration of the emergency regulations stated that the lower-tier wage rate applies "...for employers who provide..." health benefits. JA 0294 § 2(A). This iteration also clarified that this meant the employer must make health insurance available. JA 0295 §5(A).

The current iteration states that the lower tier wage rate applies if the employer "offers" health benefits. NAC 608.100(1)(a). Like the emergency regulations, the current iteration likewise clarifies that this means an employer must make health insurance available. NAC 608.102(2). Even if the Labor Commissioner were to amend NAC 608.100(1) by substituting the word

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

"provides" for the word "offers," it would not result in any change to the substantive meaning of the regulation.[3] JA 0294-0295.

This approach gives meaning to each word and phrase of the constitutional text. The phrase "provides health benefits" has meaning because it serves as the predicate for the lower-tier wage rate to apply. The phrase "as described herein" has meaning as a bridge that ties the provision of health benefits to the succeeding definition of "offering health benefits." Each element of "offering health benefits" has meaning as a required element in order to satisfy the predicate of an employer's provision of health insurance. Thus under the Labor Commissioner's approach a harmonious construction that affords meaning to each word of the constitutional text is achieved.

6. The Court Should Follow the Labor Commissioner's Interpretation

The Labor Commissioner's interpretation of the minimum wage amendment was not reached as the result of an impulsive judgment. The Labor Commissioner's interpretation is reflected in codified administrative regulations.

These regulations were adopted only after public participation through the Administrative Procedures Act's notice-and-comment provisions and underwent review and with oversight by legislative counsel. *See Labor Commissioner v. Littlefield*, 123 Nev. 35, 43, 153 P.3d 26, 31 (2007) (describing the benefits of notice-and-comment rulemaking). As part of this process, the Labor Commissioner's interpretation has also been reviewed and

[3] Employing the word "offer" in NAC 608.100(1) does provide for some small amount of clarity by bridging the amendment's use of the two terms "provides" and "offering."

Attorney General's Office
555 E. Washington, Suite 3900
Las Vegas, NV 89101

Federal Poverty Level (FPL) Guidelines

Household Size	2010	2011	2012	2013	2014	2015	2016
1	$10,830	$10,890	$11,170	$11,490	$11,670	$11,770	$ 11,880
2	$14,570	$14,710	$15,130	$15,510	$15,730	$15,930	$ 16,020
3	$18,310	$18,530	$19,090	$19,530	$19,970	$20,090	$ 20,160
4	$22,050	$22,350	$23,050	$23,550	$23,850	$24,250	$ 24,300
5	$25,790	$26,170	$27,010	$27,570	$27,910	$28,410	$ 28,440
6	$29,530	$29,990	$30,970	$31,590	$31,970	$32,570	$ 32,580
7	$33,270	$33,810	$34,930	$35,619	$36,030	$36,730	$ 36,730
8	$37,010	$37,630	$38,890	$39,630	$40,090	$40,890	$ 40,890

Sources:

2010 https://aspe.hhs.gov/2010-hhs-poverty-guidelines

2011 https://aspe.hhs.gov/2011-hhs-poverty-guidelines

2012 https://aspe.hhs.gov/2012-hhs-poverty-guidelines

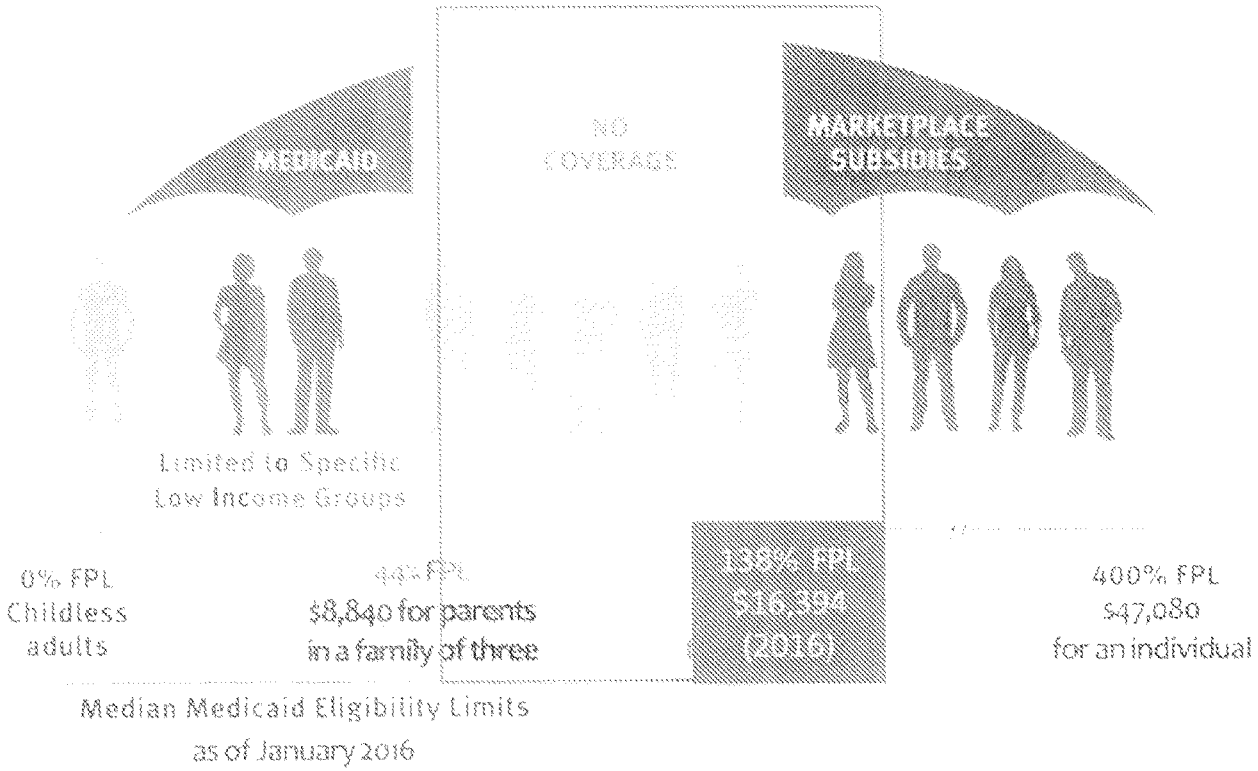
2013 https://aspe.hhs.gov/2013-poverty-guidelines

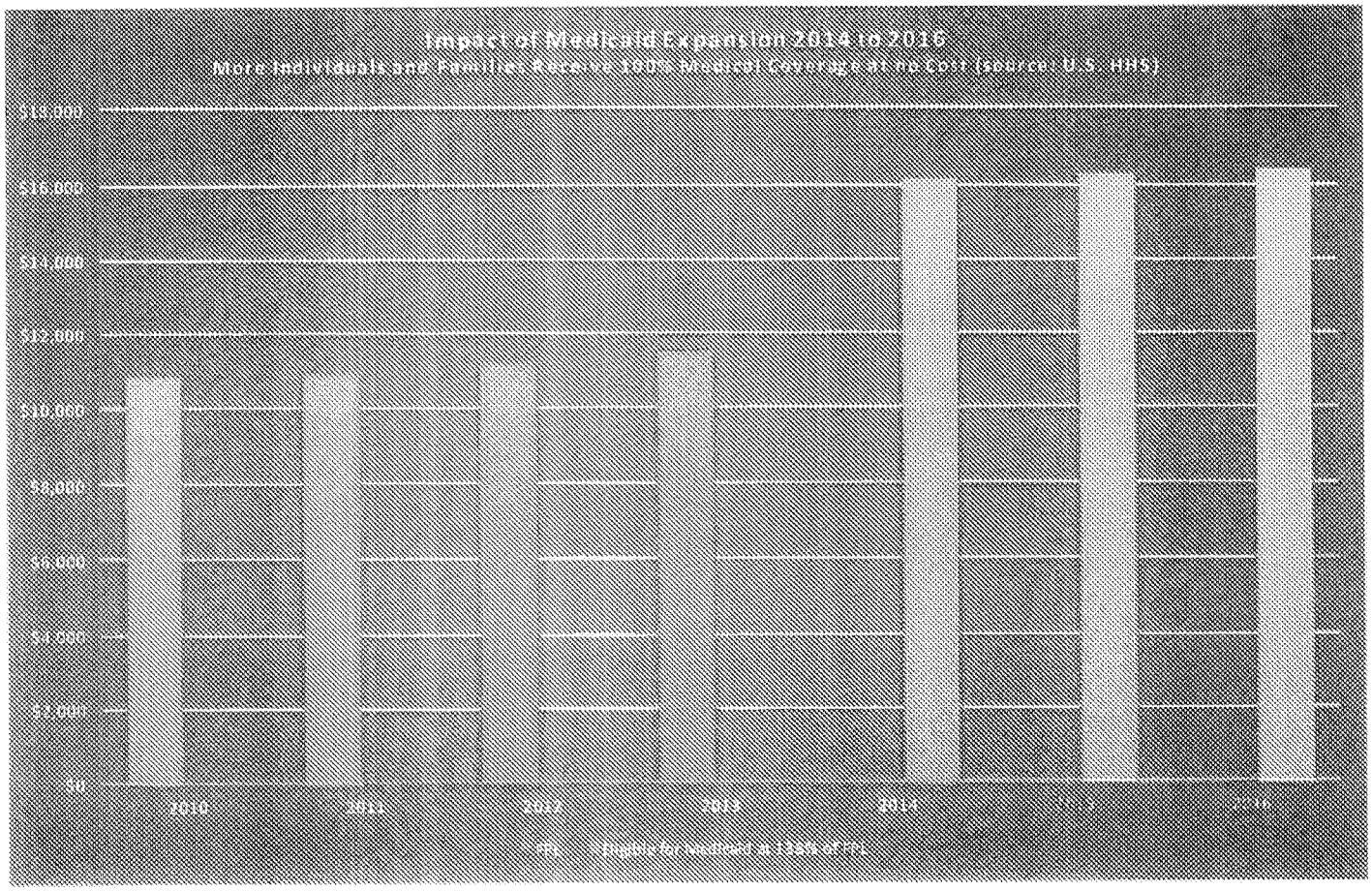
2014 https://aspe.hhs.gov/2014-poverty-guidelines

2015 https://aspe.hhs.gov/2015-poverty-guidelines

After Nevada Medicaid Expansion – Individual Closes the Gap on Health Insurance Coverage

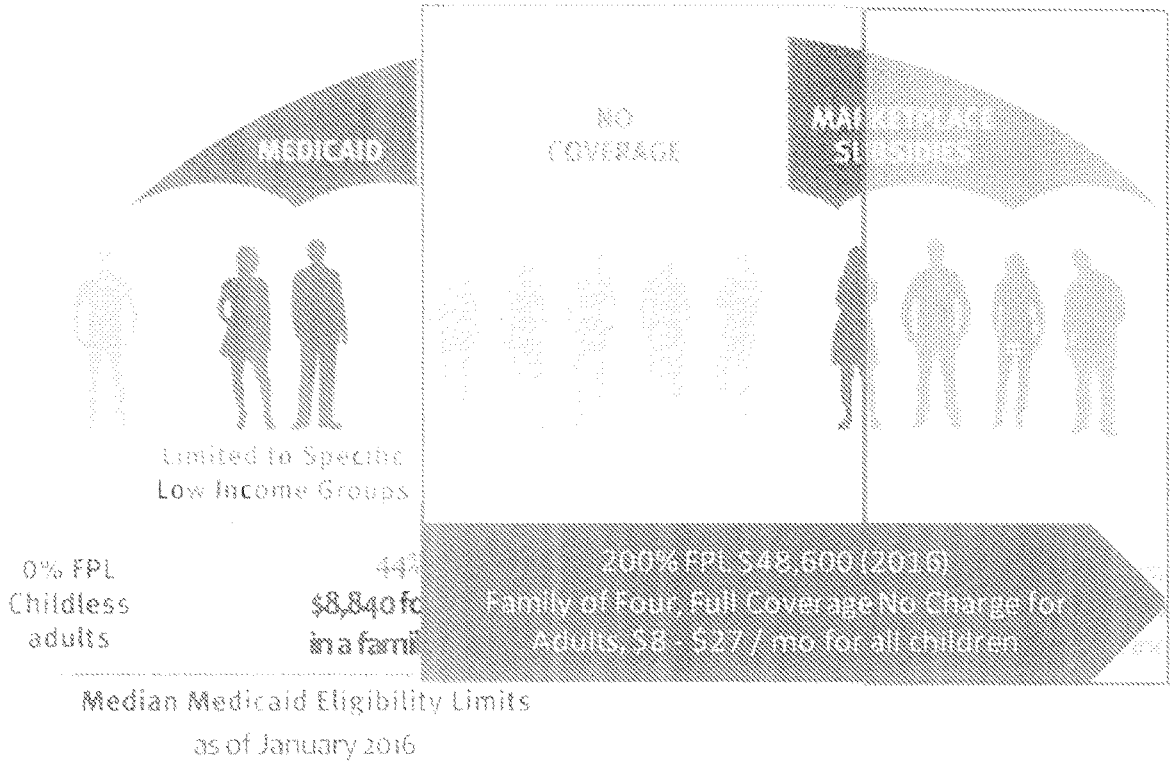
Individual may earn up to $16,394 and still get 100% medical coverage from Nevada Medicaid (Access) at no cost for premiums




Impact of Medicaid Expansion 2014 to 2016
More Individuals and Families Receive 100% Medicaid Coverage at No Cost (Source: U.S. HHS)
$16,000
$14,000
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$0
2010
2011
2012
2013
2014
2015
2016
Eligible for Medicaid at 138% of FPL

After Nevada Medicaid Expansion – Family of 4 (No Cost for 100% Health Care Coverage)

Family household of four may earn up to $48,600 and still get 100% medical coverage from Nevada Medicaid (Access) at no cost for premiums, children also covered at nominal cost



Median Medicaid Eligibility Limits as of January 2016

0483

No Penalty to Employers Failing to Provide MEC For Medicaid Covered Employees

Employers will not face tax penalties for failing to provide Minimum Essential Coverage (MEC) for those employees covered under Medicaid. In those States that expand Medicaid eligibility effectively to 138% of federal poverty level (FPL) for individuals they receive health insurance coverage at no cost, families may qualify for other benefits (pregnancy, child care, etc.) at zero or below $27 / month cost to the family.

Sources: IRS · Ernst & Young (Quality In Everything We Do) · Kaiser Family Foundation

- What counts as Minimum Essential Coverage? "... Medicaid Coverage, CHIP...." U.S. Internal Revenue Service (IRS)
  - https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
- Washington Council Ernst & Young Presentation February 2013
  - http://www.nahu.org/meetings/Annual/2013/attendees/jumpdrive/employer_aca_reference_deck_02_14_2013.pdf
- Kaiser Family Foundation "... firms will not face a penalty for workers who qualify for Medicaid .."
  - http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/

Calculations for Methods and Test Results

Do MDC Workers Earning $7.25 Per Hour Qualify for Medicaid Before Expansion? In my opinion, YES

Federal Poverty Level Calculations

High Income Case:

- $7.25 x 2,087 hours = $15,131

Low Income Case:

- $7.25 x 30 x hours x 50 weeks = $10,875 Low Case, (part time, because does not work 14 days)

Qualifies for Nevada Medicaid ("Access")

- Yes, in three of four cases. If the worker is working full-time equivalent in a 2 member household, may not qualify depending on other factors

- Yes

Do MDC Workers Earning $7.25 Per Hour Qualify for Medicaid After Expansion? In my opinion, YES

Federal Poverty Level Calculations	Qualifies for Nevada Medicaid ("Access")
High Income Case:	
• $7.25 x 2,087 hours = $15,131	• Yes
Low Income Case:	
• $7.25 x 30 x hours x 50 weeks = $10,875 Low Case, (part time, because does not work 14 days)	• Yes

2016 FPL Calculations for MDC $7.25 / Hour

Persons In Household	Nevada FPL 2016 (a)	MDC employee @ 30 hours / week x 50 wks x $7.25 (f)	MDC employee @ 2,087 hours / week x 52 wks x $7.25	100% of Medical Bills Covered, no Cost to Family	Nevada Children's Health Insurance Program (CHIP) "Nevada Check Up" at cost of between $8 and $27 per month (d) (e)
	2016			Medicaid 133% of FPL	Pregnant Care, Children in Household 133% of FPL to for CHIP 200% of FPL
1	$ 11,880	$ 10,875	$ 15,131	$ 15,800	$ 23,760
2	$ 16,020			$ 21,307	$ 32,040
3	$ 20,160			$ 26,815	$ 40,320
4	$ 24,300			$ 32,324	$ 48,600
5	$ 28,440			$ 37,832	$ 56,880
6	$ 32,580			$ 43,341	$ 65,160
7	$ 36,730			$ 48,858	$ 73,460
8	$ 40,890			$ 54,386	$ 81,780

Sources:

(a) Source: U.S. Health and Human Services Dept. 1/25/2016, lower 48 states, persons in household / persons in family

FPL = Federal Poverty level for lower 48 states

https://www.federalregister.gov/articles/2016/01/25/2016-01450/annual-update-of-the-hhs-poverty-guidelines#t-1

(b) U.S. HHS FPL timex 1.38, calculated by Michael Arrigo

(c') U.S. HHS FPL times 1.60 calculated by Michael Arrigo

(d) U.S. HHS FPL times 2.0, calculated by Michael Arrigo

(e) Nevada CHIP ("Check Up") for children states $25 to 80 cost per family per quarter. $25 / 3 = $8, $80 / 3 = $27 monthly cost is $25 to $80 divided by three

(f) 30 hours per week is considered "full time" since 2014. Annualized income @30 hours = 30 x (50 weeks of total 52 weeks posible to work) (high case assuming straight time, working every day except 14 days per year or 96.1% of the time)

Demographic Scenarios

METHODS

I. BEFORE MEDICAID EXPANSION MAN OR WOMAN WITH DEPENDENT, 2 IN

II. BEFORE MEDICAID EXPANSION WOMAN WITH DEPENDENT, 2 IN

III. BEFORE MEDICAID EXPANSION MAN OR WOMAN WITH DEPENDENT, 3 IN

IV. MEDICAID EXPANSION, 1 IN HOUSEHOLD (MORE IN HOUSEHOLD WOULD INCREASE MEDICAID ELIGIBLITY)

Method I.

I. BEFORE MEDICAID EXPANSION WOMAN WITH DEPENDENT, 2 IN	2010	2011	2012	2013	2014	2015	2016
.88 of FPL for Women with dependent children (2 in	$ 12,822	$ 12,945	$ 13,314	$ 13,649	n/a	n/a	n/a
MDC Workers Earning $7.25 per hour vs. Medicaid Qualificaiton Level (Green shading indicates MDC worker qualfies under given income level)							
Low income case: MDC worker, $7.25 / hr for 30 hours per week (50 weeks), 14 days	$ 10,875	$ 10,875	$ 10,875	$ 10,875	n/a	n/a	n/a
High income case: MDC worker $7.25 /hr x 2,087 hrs / year (Per U.S. OMB	$ 15,131	$ 15,131	$ 15,131	$ 15,131	n/a	n/a	n/a

Method II.

II. BEFORE MEDICAID EXPANSION WOMAN WITH DEPENDENT, 2 IN	2010	2011	2012	2013	2014	2015	2016
Pregnant women 185% FPL (2 in household)	$26,955	$27,214	$27,991	$28,694			
MDC Workers Earning $7.25 per hour vs. Medicaid Qualificaiton Level (Green shading indicates MDC worker qualfies under given income level)							
Low income case: MDC worker, $7.25 / hr for 30 hours per week (50 weeks), 14 days	$ 10,875	$ 10,875	$ 10,875	$ 10,875	n/a	n/a	n/a
High income case: MDC worker $7.25 /hr x 2,087 hrs / year (Per U.S. OMB	$ 15,131	$ 15,131	$ 15,131	$ 15,131	n/a	n/a	n/a

Method III.

III. BEFORE MEDICAID EXPANSION WOMAN WITH DEPENDENT, 3 IN	2010	2011	2012	2013	2014	2015	2016
.88 of FPL for Women with dependent children (3in	$ 16,113	$ 16,306	$ 16,799	$ 17,186	n/a	n/a	n/a
MDC Workers Earning $7.25 per hour vs. Medicaid Qualificaiton Level (Green shading indicates MDC worker qualfies under given income level)							
Low income case: MDC worker, $7.25 / hr for 30 hours per week (50 weeks), 14 days	$10,875	$ 10,875	$ 10,875	$ 10,875	n/a	n/a	n/a
High income case: MDC worker $7.25 /hr x 2,087 hrs / year (Per U.S. OMB	$ 15,131	$ 15,131	$ 15,131	$ 15,131	n/a	n/a	n/a

Method IV.

IV. MEDICAID EXPANSION 1 IN HOUSEHOLD	2010	2011	2012	2013	2014	2015	2016
FPL	$10,830	$10,890	$11,170	$11,490			
Eligible for Medicaid at 138% of FPL	n/a	n/a	n/a	n/a	$16,105	$16,243	$16,394
MDC Workers Earning $7.25 per hour vs. Medicaid Qualificaiton Level (Green shading indicates MDC worker qualfies under given income level)							
Low income case: MDC worker, $7.25 / hr for 30 hours per week (50 weeks), 14 days	n/a	n/a	n/a	n/a	$ 10,875	$ 10,875	$ 10,875
High income case: MDC worker $7.25 /hr x 2,087 hrs / year (Per U.S. OMB	n/a	n/a	n/a	n/a	$ 15,131	$ 15,131	$ 15,131

Test Results

METHODS	Qualifies for Medicaid?	
	Lower Income @$7.25 / hour (see assumptions and explanations)	Higher Income @$7.25 / hour (see assumptions and explanations)
I. BEFORE MEDICAID EXPANSION MAN OR WOMAN WITH DEPENDENT, 2 IN HOUSEHOLD	Yes	Possibly Not
II. BEFDRE MEDICAID EXPANSION WOMAN WITH DEPENDENT, 2 IN HOUSEHOLD PREGNANT	Yes	Yes
III. BEFORE MEDICAID EXPANSION MAN OR WOMAN WITH DEPENDENT, 3 IN HOUSEHOLD	Yes	Yes
IV. MEDICAID EXPANSION, 1 IN HOUSEHOLD (MORE IN HOUSEHOLD WOULD INCREASE MEDICAID ELIGIBLITY)	Yes	Yes

Conclusion: MDC Provided Reasonable Health Insurance Coverage for $7.25 /hr. workers

- Before 2014, MDC provided "health insurance coverage" via:
  - Starbridge

- From January 1, 2014 and thereafter MDC provided reasonable coverage, given that it is likely that 100% of the employees at $7.25 per hour would be below 138% of the Federal Poverty Level (FPL) and qualify for Medicaid, via:
  - Trans Choice
  - MVP

EXHIBIT 26

EXHIBIT 26

EIGHTH JUDICIAL DISTRICT COURT
IN AND FOR CLARK COUNTY, STATE OF NEVADA

PAULETTE DIAZ, an individual; et al.,

Plaintiffs,

vs.

No. A-14-701633-C

MDC RESTAURANTS, LLC, a Nevada limited liability Company; et al.,

Defendants.

DEPOSITION OF MICHAEL ARRIGO, a witness herein, noticed by WOLF, RIFKIN, SHAPIRO, SCHULMAN & RABKIN, LLP, at 600 West Broadway, San Diego, California, at 9:12 a.m., on Wednesday, March 30, 2016, before Amanda M. Murray, CSR 8981, RPR.

Job No.: 297622

APPEARANCES OF COUNSEL:

For Plaintiffs:

WOLF, RIFKIN, SHAPIRO, SCHULMAN & RABKIN, LLP
BY BRADLEY SCHRAGER
3556 East Russell Road, 2nd Floor
Las Vegas, Nevada 89120-2234
(702)341-5200

For Defendants:

MORRIS POLICH & PURDY LLP
BY NICHOLAS M. WIECZOREK
3800 Howard Hughes Parkway, Suite 500
Las Vegas, Nevada 89169
(702)862-8300

I N D E X

WITNESS: MICHAEL ARRIGO

Q. Anything else?

A. No.

Q. Now, in your --

A. However, this is a national issue as well as a state issue. I think we're talking about -- as Milone notes, he's citing federal rules such as the Affordable Care Act, which is a national issue.

Q. Understood. The sort of levels to which it's a state or federal issue, as you get down to the cases, is not a matter for you or I to resolve today.

A. But I did look at Timothy Mulliner's report, who practices in Nevada.

Q. I saw that too. I'm going to talk to him tomorrow. That will be great. I'll look forward to that.

Did you review Article 15, Section 16 of the Nevada Constitution, which I'll refer to as the minimum wage amendment?

A. No.

Q. You did not?

A. No.

Q. Did you review or study for the purposes of your report the Nevada Revised Statute 608 of the Labor Code?

A. Yes.

Q. Yes. What portions of it? All of it?

A. I skimmed all of it, and I looked specifically for the portions that mentioned insurance.

Q. Okay.

And there are portions that mention insurance; correct?

A. As I recall, yes.

Q. You didn't mention anything in your report regarding NRS Chapter 608, though, did you?

A. I don't believe that's correct.

Pages 69 through 72 detail the materials reviewed, both provided by counsel and documents independently accessed. And I know that one of the things that I reviewed was the Nevada Labor Commissioner's statement.

Q. Okay.

That's not the Labor Code, though, is it?

A. He is the labor commissioner.

Q. He was. But it's just a thing he said; right?

A. But for me, it was important because it was a determination as the commissioner at the time. So I reviewed the Nevada Department of Health and Human Services division of healthcare financing in the Nevada Department of Business Industry, which touches on that.

Q. Touches on what?

A. On the Labor Code and insurance.

I'm going to educate the trier of fact, they're left wondering from these vague statements what health insurance coverage is.

Q. Sure. Okay.

Did you review NRS Chapter 689-A regarding individual health insurance?

A. I relied on Mr. Mulliner's report, since he's an attorney practicing in Nevada, and I believe he stated that 689-A and B don't apply.

Q. Okay.

So the answer is no?

A. I did read them briefly, but I also believe they don't apply. Again since Mr. Mulliner is an attorney that practices in Nevada, I relied on his opinion there. And rather than focusing on 689-A and B, I focused on the national standards that are used to define health insurance coverage, since the Nevada minimum wage law doesn't say what health insurance coverage is.

Q. Well, you know, but say the Nevada minimum wage law, give me the specific citations of what you mean. What is the Nevada minimum wage law?

A. It requires as generally stated --

Q. No, no, no. What is it? What is the Nevada minimum wage law? We will get to what it requires. We

referenced by Mr. Milone.

Q. Yes.

A. But he chose not to mention that particular phrase.

Q. Okay. We'll get to all that. I also find that fascinating.

Earlier you agreed with me that 689-B appears to you to contain within it substantive coverage requirements for health insurance policies sold in the state of Nevada on the part of insurance companies; correct?

A. It's also my testimony that I don't think 689-A and B apply, and I did not use them in my opinions.

Q. No, no, that wasn't the question.

You agreed with that, though; correct?

A. They make certain requirements and I think they're completely antiquated now because of the Affordable Care Act.

Q. Antiquated is one thing. Are they preempted? Are they invalid?

A. Yes.

Q. So 689-A and 689-B in large part, given the things we're talking about, are now invalid?

A. Yes.

Q. And that's one of the reasons they don't apply?

A. Yes.

Q. A long way to get to that, isn't it. Okay. Just a couple more questions about this, and then I want to get into the meat of your opinion.

Did you look at any patient records in preparing your report?

A. None were provided, no.

Q. Okay.

Because you appeared at the end of your report to talk about looking at patient records and things like that. What I'm wondering was that aspect -- and there is sort of a lengthy -- there is a lengthy narrative about looking at patient records. I can go through them. It appears to be some sort of boilerplate information you would get at the end of any report?

A. Not any report. It's not boilerplate. It's part of the methodology I used to determine if health insurance coverage is being used to pay based on medical necessity, based on some of the requirements that I mention here. However, I don't think in discovery any of those records were provided, nor was there detailed records provided by the household income or specific combination of each individual.

Q. Which we'll get to.

A. And really, the fact that we're having this

discussion today at the deposition without that information is very interesting. The defense or the plaintiff didn't provide any of that.

Q. Well, thank you for your commentary on the conduct of the case. But if you stay within --

A. I didn't mean anything personal by it.

Q. No. Trust me, I've been doing this -- not as long as you've been doing what you do, but I've been doing this for a while, and we can get into why perhaps that didn't come up in discovery or something. We can do that later on. We've got plenty of time.

But when you say that you reviewed patient records in your report, that's actually not true; right?

A. I review records if it applies, if applicable. And I know that I stated "if applicable" as part of my methodology. In this case, it was much more a question of household income, hourly wage calculations, and Medicaid eligibility and coverage. And, of course, rebutting Mr. Milone's statements.

Q. Sure.

A. I'd be glad to review those records as well as household income. And if they were provided, it would probably add more.

Q. Not at your rates, buddy.

Let's see. On page 54, you talk about -- page 54

of your report, at the bottom. Do you see it there?

A. Are we talking about MDC001304?

Q. 55, actually. I have a 54 and a 55. I had two page numbers, because one of them was the --

A. Thank you. I have it now.

Q. Okay. Good.

At the bottom of the ICD-9 diagnosis, you say, "Some medical patient records in this case contain ICD-9 diagnosis codes." There are no medical records in the case; right?

A. I'm actually positive, if I were provided the medical records, they would include ICD-9 diagnosis rates.

Q. Because most medical records do?

A. Most, if not all.

Q. It does not matter. There are no medical records in this case, are there?

A. There are none that were provided to me. I don't know if they're in this case or not.

Q. Okay.

And on the next page, MDC001306, line 11, "I cross-referenced numeric references to codes found in documents provided by counsel and compared them with corresponding descriptive references to confirm descriptions of a medical procedure" -- so on and so on.

What documents are we talking about that were provided by counsel that have numeric reference to codes you're talking about?

A. The document provided by counsel, Mr. Milone's report, mentioned various types of diagnoses and procedures. And I cross-referenced numeric codes to those medical diagnoses and procedures as part of my work.

Q. Okay.

To determine what?

A. Mr. Milone references certain medical conditions and as part of my work, I looked at the medical codes for those medical conditions.

Q. Okay.

You didn't actually talk about that in your report, though, did you?

A. The medical codes in the cross-referencing, I did. I think I talked about it on page item -- line 11. I just did.

Q. Okay.

But this is not really the report anymore. This is -- I mean, I guess it's all your reports?

A. It is the report. It's the methodology for the report.

Q. Sure.

A. And any diagnosis actually has a precise code that's associated with it.

Q. Of course.

A. So I reviewed those when Mr. Milone mentioned certain medical conditions.

Q. Uh-huh.

A. So yes, I did.

Q. But that didn't show up -- I mean, any actual examples of that don't appear to show up in the report itself?

A. Correct.

Q. You say that you did that?

A. Correct.

Q. Just to close the loop, on the very next page, MDC001307 at the top, under the heading "Current Procedural Terminology ('CPT') codes," you see after the hyphen on line 2, "Some outpatient medical patient records in this case contain CPT procedure codes."

Again, there are no outpatient medical records in this case, are there?

A. I don't know if they're in this case or not. I mean, the whole case is about medical expense and whether or not they're reimbursed, and I normally am provided with that information. If people make broad statements that they do or do not have coverage, having

that information can be helpful. But in the same light, I looked at procedures that are outpatient procedures --

Q. Okay.

A. -- which is what CPT codes are looked for, as I was considering in formulating my opinions.

Q. Okay.

But you didn't actually review any outpatient medical records in this case, did you?

A. I've already stated that I did not review any medical records, that's correct. But I did review Mr. Milone's report which does mention medical conditions and medical procedures --

Q. Sure it does.

A. -- and those are tied to CPT codes and ICD-9 codes.

Q. Absolutely. Understood.

Now, as I read your report, there is two opinions that I'm interested in talking about because they go to what I think are the major issues in the case, which is do the plans in the end qualify MDC to pay less than 8.25 to their employees. That's the question we're trying to get to to help the judge answer, even if you're not trying to answer that question necessarily. All right?

A. I'm sorry. I disagree with your statement.

insurance plan, send us this, this and this."

A number of times in their objections, here is what they said to us: "Transamerica objects to this request, to the term 'health insurance plans,' 'policies' or 'products' as vague, ambiguous, confusing. Transamerica does not offer health insurance plans, policies or products. Rather, Transamerica underwrites supplemental health insurance products, including specifically group limited benefit hospital indemnity insurance."

Seems to me that they are -- several times in here they said to us, "We don't call this health insurance." This isn't health insurance. It's supplemental health insurance product, but it's not health insurance." How do you respond to that?

MR. WIECZOREK: Calls for speculation.

MR. SCHRAGER: It's not speculation.

THE WITNESS: I can't possibly respond to what was in the mind of an attorney writing that and objecting to your discovery, and what his objectives are. I think the only thing I see is, he's pointing to the fact that there is vagueness in the definition of many of these terms.

MR. SCHRAGER: No.

Q. It says, "Transamerica does not offer health insurance plans or policies or products."

A. I have no other opinion on that letter and don't know what the attorneys were thinking who wrote it.

Q. But you would disagree with that statement?

A. I wouldn't necessarily agree or disagree. I have no other opinion. I don't know what their strategy was in writing that, making those objections.

Q. That's not the point. It says, "Transamerica does not offer health insurance plans or policies or products" --

THE REPORTER: Excuse me. Please repeat.

MR. SCHRAGER:

Q. You pointed to the Transamerica 2014 plan as a health insurance plan, policy or product. And they're saying -- and this is not just a lawyer -- this is his client or her client, this is Transamerica Life saying this in a legal paper, that's not health insurance. It's not a hypothetical.

A. Are you saying an attorney didn't write that?

Q. It's got nothing to do with it.

A. I don't know. I have no other opinion on that. It certainly wasn't one of the documents that was given to me to consider in writing my report.

Q. That's true.

A. I have no other opinion.

Q. I'm just pointing out that the actual insurer says it's not health insurance and you say it is. We'll leave it at that. Okay?

A. Okay.

Q. Okay.

You know what a limited benefit health plan is; right?

A. I don't give opinions on limited benefit, comprehensive or any of those things. I look at what specifically is covered and what's not.

Q. But you know what a limited benefit plan is; right?

A. Define limited benefit plan. I mean, it could be used different ways. It's an imprecise term, in my opinion.

Q. But you've heard it before?

A. I've heard the phrase, but that does not mean I can define what it is.

Q. It's just a fairly common phrase in the industry, and it has been for many years, and you're acting like you haven't heard it before.

A. It's vague. It's a common term and it's vague. That's my opinion on it.

Q. Well, the way that other people have used it, do you understand what they mean by it?

STATE OF CALIFORNIA) ss

I, Amanda M. Murray, CSR 8981, RPR, do hereby declare:

That, prior to being examined, the witness named in the foregoing deposition was by me duly sworn pursuant to Section 2093(b) and 2094 of the Code of Civil Procedure;

That said deposition was taken down by me in shorthand at the time and place therein named and thereafter reduced to text under my direction.

I further declare that I have no interest in the event of the action.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

WITNESS my hand this 5th day of April, 2016.

Amanda M. Murray, CSR 8981, RPR

EXHIBIT 27

EXHIBIT 27

DISTRICT COURT

CLARK COUNTY, NEVADA

PAULETTE DIAZ, an individual; and LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, an individual; CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly-situated individuals,

Plaintiffs,

vs.

Case No. A-14-701633-C
Dept. No. XVI

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company, and DOES 1 through 100, inclusive,

Defendants.

DEPOSITION OF

TIMOTHY MULLINER

Las Vegas, Nevada

March 31, 2016

10:55 a.m.

Reported by: Heidi K. Konsten, RPR, CCR
Nevada CCR No. 845 - NCRA RPR No. 816435
JOB NO. 297623

Deposition of TIMOTHY MULLINER, Volume 1, taken at 3800 Howard Hughes Parkway, Suite 500, Las Vegas, Nevada, on March 31, 2016, at 10:55 a.m., before Heidi K. Konsten, Certified Court Reporter in and for the State of Nevada.

APPEARANCES OF COUNSEL

For the Plaintiffs:

BRADLEY SCHRAGER, ESQ.
JORDAN J. BUTLER, ESQ.
Wolf, Rifkin, Shapiro, Schulman & Rabkin
3556 East Russell Road
2nd Floor
Las Vegas, Nevada 89120
(702) 341-5200
(702) 341-5300 Fax
bschrager@wrslawyers.com

For the Defendants:

NICHOLAS M. WIECZOREK, ESQ.
DEANN L. FORBUSH, ESQ.
Morris, Polich & Purdy, LLP
3800 Howard Hughes Parkway
Suite 500
Las Vegas, Nevada 89169
(702) 862-8300
(702) 862-8400 Fax
nwieczorek@mpplaw.com

* * * * * *

can sort of whittle down the issues of what we're talking about.

A Fair enough.

Q Where I was going with this is, you know, you've laid out what health insurance is, and we've sort of talked about regulations, coverage requirements for particular purposes or particular products. But you've also said that dental insurance, seen the right way, is health insurance. So through this hypothetical, I think we can get to some of the questions and answers that I'm interested in.

Under the Minimum Wage Amendment, could an employer provide merely dental insurance as health insurance and qualify to pay less than 8.25 an hour?

A If the insurance commissioner had approved a plan to be marketed and sold in Nevada as insurance, yes.

Q As insurance or as health insurance?

A Same thing, but -- health insurance, that's how it would be blessed, yes.

Q So if the thing is legal, if you can sell it -- I mean, I think that's where I'm getting now. It seems like now you're bleeding

into if a product is legal in Nevada, can be sold in Nevada as an insurance product, as a health insurance product at all, it satisfies the Minimum Wage Amendment's requirement that you provide health insurance plans?

A Yes.

Q Okay. So a dental plan, I mean, I guess -- I don't know -- do vision plans count with that?

A Vision is a health benefit, yes.

Q Okay. So the logic of what you're saying -- and this is just stemming from the language of the Minimum Wage Amendment itself, not having to do with any other statutes or regulations. I want to sort of isolate this.

For purposes of the Minimum Wage Amendment, an employer could offer or provide his or her employees a dental insurance plan that was legal to be sold in Nevada, and that would qualify them as having provided health insurance under the Minimum Wage Amendment, and they could pay less than 8.25 an hour?

A And we're talking specifically about dental?

Q Yeah. That's the only thing X employer

offered, was a dental plan that was legal in Nevada.

A If 26 USC Section 213 includes as a category of expenses dental, and I believe it does, then the answer is yes.

Q Okay. Now, you're tying it to the regulations.

Do you consider NAC 608.100 through 108 -- you know, the ones that cover the Minimum Wage Amendment -- do you consider those to be determinative as an interpretation of what's required under the Minimum Wage Amendment?

A It is certainly an interpretation.

Q Is it determinative?

A When you say "determinative," what do you mean? Is it the authority?

Q Yeah.

A Does it impose its own requirements?

Q Yeah.

A I don't believe that that regulation would impose any requirements that don't exist within the Minimum Wage Amendment; however --

Q That's not exactly what I'm asking.

What I'm asking you is the weight and force of the regulations as opposed to -- I mean,

A Some of which is on that disk.

Q Okay. Excellent.

A In fact, the NRS, I gave you the full -- it's the whole chapter. The NAC, I don't know, but I think I have access to an archived version of it.

Q I actually have them all here.

A Actually, '11 --

Q Oh, okay. Understood.

A If you need to find them online, Justia.com has the archived version.

Q Okay. I appreciate that.

You know, we talked a little bit about ACA, mostly by analogy. Obviously Mr. Milone talks about ACA, because it seems that when he's searching for ways to define health insurance, he's sort of reaching for various standards from various sources of state law, but also federal and the ACA being one of those things; correct?

A Mr. Milone's report?

Q Yes.

A Yes.

Q You actually don't do that. In fact -- I just want to be clear. Your position appears to be that the ACA is irrelevant to the issues

presented.

A It is certainly irrelevant to the Minimum Wage Amendment and whether a particular insurance would entitle an employer to pay a lower minimum wage. I just want to look at the issues presented and make sure I can say that uncategorically, too, or categorically.

So the first issue presented, which is the standards used to exist what is health insurance as used in the Minimum Wage Amendment, yes, it's my opinion that the ACA is completely and totally irrelevant to that analysis.

Q Okay.

A The second issue presented is an analysis of plan documents produced in this case in light of those standards. So I'm not sure --

Q Well, if the standards don't have anything to do with the ACA, it's hard to say that the plan documents need to be applied to the standards.

A Yeah. The ACA doesn't have anything to do with -- so the first issue presented, which then I think the second one doesn't make any sense.

Q Logically, yeah.

Okay. So it's irrelevant to the issues in the case, as far as you're concerned?

A Absolutely.

Q That doesn't mean that it can't have value for understanding particular terms or any context, but for the -- but I understand what you're saying. In fact, you say it a couple of times in your report.

And sort of following on from that, does it not follow, then, that in your opinion, the Minimum Wage Amendment having been enacted in 2006, the Affordable Care Act having been enacted in 2010 but having various dates of effectiveness over the years, the Affordable Care Act did not change the duties and responsibilities of a Nevada employer under the Minimum Wage Amendment?

A That's correct.

Q Okay.

A You said it could be useful for other purposes. I don't think you asked me to confirm that. I frankly don't think it could be useful for any purposes. I just want to be clear.

Q You know, the only thing that crossed my mind -- and I'll be perfectly open with you about this -- is that there's a -- you know, there's a

CERTIFICATE OF COURT REPORTER

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

I, Heidi K. Konsten, Certified Court Reporter licensed by the State of Nevada, do hereby certify that I reported the deposition of TIMOTHY MULLINER, on March 31, 2016, at 10:55 a.m.

Prior to being deposed, the witness was duly sworn by me to testify to the truth. I thereafter transcribed my said stenographic notes via computer-aided transcription into written form, and that the transcript is a complete, true and accurate transcription and that a request was not made for a review of the transcript.

I further certify that I am not a relative, employee or independent contractor of counsel or any party involved in the proceeding, nor a person financially interested in the proceeding, nor do I have any other relationship that may reasonably cause my impartiality to be questioned.

IN WITNESS WHEREOF, I have set my hand in my office in the County of Clark, State of Nevada, this April 6, 2016.

Heidi K. Konsten, RPR, CCR No. 845

EXHIBIT 28

EXHIBIT 28

I. Introduction and Overview

I have been retained to provide my opinions in connection with the Expert Report of Matthew T. Milone dated October 12, 2015 (the "Milone Report", "Milone's Report" or the "Report") and the issues presented therein. Milone's Report characterizes the issues on which plaintiffs have requested his opinions as follows (hereafter, the "Issues Presented"):

a. The standards that exist to determine what is "health Insurance" as that term is used in Article 15, Section 16 of the Nevada Constitution; and

b. An analysis of "plan documents" produced in this case in light of these standards.

II. Qualifications and Disclosures

I have previously submitted my Curriculum Vitae and all other information required to be disclosed pursuant to N.R.C.P. 16.1, and will supplement all such information at the request of any party, or on my own initiative, as may be appropriate.

My fee schedule is attached hereto as Exhibit A, reflecting my compensation in connection with this matter at the generally applicable rate of $350 per hour for work in connection with this report and providing testimony, and $300 per hour in connection with my initial review and consideration of the case materials provided to me.

III. Documents and Materials Considered

In preparing this report and forming the opinions expressed herein, I have reviewed the documents, materials and other information set forth in the list of "Data or Other Information Considered" attached hereto as Exhibit B.

IV. Discussion of Relevant Authority

a. Enforcement of Insurance Versus Employment Laws

Milone's Report appears to misunderstand the boundary that exists at the state level with regard to the enforcement of health insurance laws (i.e., those within NRS Chapters 689A, 689B and 689C) versus employment laws (i.e., those within NRS Chapter 608). For example, the Report concludes that employers subject themselves to insurance coverage and payment requirements of NRS Chapters 689A and 689B upon making health insurance available to employees. In fact, each of Milone's opinions within the Report is premised on the notion that employers are personally responsible for ensuring that the insurance plans made available to employees are in compliance with insurance regulations.

However, unlike the federal administrative system providing for the dual enforcement of employee benefits laws (for example, making the Department of Labor responsible for the enforcement of laws governing group health insurance), Nevada's system assigns those distinct duties to either the Insurance Commissioner or the Labor Commission, not both. Under Milone's theory that employers have direct obligations under insurance coverage laws, the Insurance Commissioner would have to assert jurisdiction over the employer for purposes of enforcing those laws. Similarly, under Milone's theory that insurers must issue plans providing specific cove[illegible]
for plans offered in connection with the Minimum Wage Amendment, the Labor Commissioner

would be in the same position. Under Nevada law, however, each Commissioner is vested with exclusive jurisdiction to enforce the laws of his or her respective field.

Milone's suggestion that employers must select specific insurance plans in connection with the Minimum Wage Amendment also contradicts the pattern and practice of employers and insurers in employee benefits market. Having counseled hundreds of employers regarding their benefits practices, it has been universally true in my experience that employers do not participate in assembling their plans, but instead rely exclusively on the insurers to ensure coverage requirements are met. This is because insurers have not only the burden to ensure compliance, but also the expertise required to do so, not employers

b. Current Versus Prior Law

Milone's report fails to consider any authority other than that which exists today to determine compliance of plans that existed between one and six years ago. This flawed methodology appears to be responsible for some of the most significant false conclusions within the report. For example, Milone's analysis is based on Nevada insurance laws within NRS Chapters 689A, 689B and 689C exclusively (and almost exclusively just 689B), however he appears to have failed to consider the significantly different statutes that existed within those chapters prior to 2013. In other words, Milone applies the wrong law to his analysis of at least four (2010 through 2013) of the six plans at issue because Chapters 689A, 689B and 689C are markedly different now from what they were at relevant times. In fact, the statutes which authorized the 2010 and 2013 plans and exempted them from most coverage requirements no longer exist at all after amendments implementing the state's insurance exchange under the ACA.

c. State Versus Federal Law

While state law counterparts to the ACA have some relevance to the Issues Presented, the ACA itself provides no guidance whatsoever. Milone fails to provide any explanation or link between the federal law and Nevada's Minimum Wage Amendment to its Nevada Constitution[1] Yet, notwithstanding its inapplicability, Milone's report devotes a considerable amount of discussion to the ACA without offering any explanation of its perceived relevance.

Note: While Milone's analysis of essential health benefits ("EHB"), minimum essential coverage ("MEC"), annual and lifetime limits, and other features of the ACA have no bearing on the Issues Presented, his opinion that the 2014 and 2015 plans fail to meet EHB, MEC and other ACA requirements is misguided in any event. This opinion is at best unreliable, as Milone simply does not have all the information required to make this determination. For example, if any of the plans analyzed under the ACA have "grandfather" status, as does the 2013 plan, it is exempted from the requirements Milone claims are not met. More importantly, however, the analysis simply has no bearing on the issues of this case.

Note: Milone's suggestion that the 2014 plan fails to meet also-irrelevant requirements of COBRA is similarly false. Milone claims the plan is deficient because: (1) it provides a period of only 31-days to elect continuation coverage, whereas COBRA requires a 60-day period; and (2) it

[1] Additionally, Milone's report focuses exclusively on coverage requirements under the ACA that were not even effective until 2014.

states that the cost of continuation coverage will include unstated "administrative cost"; whereas COBRA permits a maximum charge of only 102% of the total premium.

As for the first issue, the 2014 plan actually provides a period of at least 62 days after coverage ends for the insured to elect continuation coverage, not 31 days. This is because the plan includes a "grace period" of 31 days during which coverage will continue automatically even if a premium is missed. The 31-day period Milone refers to does not start to run until after the grace period expires, effectively providing a total period of 62 days. As for the cost of continuation coverage, the additional 2% of the cost (for a total of 102% the premium amount) is permitted specifically to cover the administrative costs no longer borne by an employer. Thus, the plan language is entirely consistent with COBRA.

d. ERISA Preemption

Milone's discussion of federal preemption under the Employee Retirement Income Security Act of 1974 ("ERISA") addresses only part of what must be considered. The preemptive effect that ERISA has on state laws, and on state insurance laws in particular, is a complex topic, a lengthy discussion of which is neither necessary nor beneficial to the expert reports produced in this case. However, in order to form correct opinions concerning the Issues Presented, and especially to explain them, it is critical that any expert consider at least three major components effecting the issue of preemption, as follows: (1) ERISA's general preemption of state laws that "relate to" employee benefit plans[2]; (2) the "savings clause" which provides the only exception to ERISA preemption, saving state laws that "regulate insurance" from preemption; and (3) the "deemer clause" which limits the scope of the savings clause, thereby limiting insurance laws which can survive preemption Milone's report addresses only the first two.

An understanding of the third component, the "deemer clause", is of critical importance in forming an opinion as to the effect of state insurance laws whenever those laws potentially apply employer-sponsored benefit plans. While this area alone has been the subject of entire treatises, it is only necessary to understand two concepts that belie the opinions in Milone's Report to understand why those opinions are inaccurate. First, the "deemer clause" states that self-insured employers cannot be deemed insurers, and thus be subjected to state insurance regulations, simply because they provide benefits in the same manner as insurance companies under benefit plans. The second fundamental concept of the deemer clause is provided through the Supreme Court's 1985 opinion in Metropolitan Life Ins. Co. v. Massachusetts, holding that state insurance laws are not entirely preempted simply because they "relate to" employee benefit plans, but will only apply to the extent benefits are provided by an insurer, i.e. a third-party providing a policy of insurance. Conversely, benefit plans that are self-funded are not subject to state laws because there is not an insurance policy to regulate.

V. Issues Common to All Deficiencies of the Reoprt

[2] Lawyers and laypersons alike often refer to only a portion of employer-sponsored benefit plans as "ERISA plans", most commonly those relating to pensions rather than health benefits, those associated with the Act's more complex provisions, and/or those maintained for the benefit of members of a labor organization under the terms of a collective bargaining agreement. In reality, all employer-sponsored plans providing benefits to an employee (i.e. including both pension benefit plans and employee health and wellness plans) are governed by ERISA, however only some of them are shielded from preempted regulation at the state-level.

a. The Report Does Not Apply Factors or Standards as Promised

Milone's report claims to resolve the Issues Presented by applying industry standards to determine whether the plans provide "health insurance" as that term is used in the Minimum Wage Amendment. However, the "standards" Milone applies are not industry standards at all, but a mere recitation of the coverage requirements found in 689B that he believes apply. This methodology presents at least two significant problems with each of Milone's opinions.

First, I do not consider Milone's application of statutory requirements in checklist fashion to be an expert opinion. This methodology does not require any heighted level of expertise and assist in providing an understanding of the issues beyond that which other similarly situated persons could provide. Secondly, because this the statutory requirements Milone applies in his analysis are inapplicable, the conclusions provided after performing his analysis are necessarily inaccurate as a result.

b. Apparent Biases

While this report focuses primarily on the substantive flaws of Milone's Report, the apparent biases that are evident throughout the Report cannot be overlooked. These biases are so pervasive, and appear to drive Milone's analysis so significantly, that they demonstrate more than merely the unreliability of Milone's opinions – they explain the very bases upon which he reached many of his conclusions.

As an example, Milone's analysis relies heavily on NAC 608.104 to support his conclusion that the term "health insurance", as used within the Nevada Minimum Wage Amendment, means only insurance policies which provide coverage for every category of health care expense that would otherwise be tax-deductible by an individual. Milone reaches this result through his own gratuitous additions to the language of NAC 608.104(a)(1) which merely servers to identify a "health insurance plan" as an insurance plan which covers "those categories of health care expenses generally deductible by an employee on his individual federal income tax return." NAC 608.104(a)(1). Specifically, Milone's report alters this language when quoting the regulation in his analysis of the health insurance plans at issue in this case, concluding that the plans are not "health insurance" because they do not cover "all of the 'categories of health care expenses' referred to in the regulation." This significant alteration of NAC 608.104 is either a gross misunderstanding of the import of the regulation or a means of reaching pre-determined conclusions that serve his and/or plaintiff's own interests. Either way, Milone's conclusions premised on his alternate form of the regulation are unfounded.

Milone's apparent bias in favor of requiring employers to pay the higher minimum wage within Nevada's two-tier system are also demonstrated through his characterization of that system. For example, Milone refers to this higher amount as "the standard minimum wage" and the lower amount "the reduced minimum wage", yet these terms are not found anywhere within the actual language of the amendment.[3] In case this nomenclature is not telling enough, Milone's report also

[3] The actual language of the Minimum Wage Amendment provides, in relevant part,

> The rate shall be five dollars and fifteen cents ($5.15) per hour worked, if the employer provides health benefits as described herein, or six dollars and fifteen cents ($6.15) per hour if the employer does not provide such benefits.

describes the operation of the two-tier system in a manner clearly favoring the plaintiffs' interests in this case. To that end, Milone's Report includes the following statements:

> [A]n employer earns the privilege of paying employees a minimum wage of $1.00 less than the standard minimum wage if the 'employer provides health benefits.
>
> [T]he employer must offer a health insurance plan in order to earn the privilege identified in Article XV, section 16 of the Nevada Constitution[.]
>
> This report addresses the requirement in Article XV, Section 16 of the Nevada Constitution that "health insurance" be provided to the employee in order for the employer to obtain the benefit of paying a reduced minimum wage[.]"[4]

Just as the terms "standard rate" or "reduced minimum wage" are absent from the Minimum Wage Amendment, the Amendment similarly does not include reference to any "privilege" or "benefit" which must be "earned" or for which an employer must "qualify." "right under the cons under the of paying either amount,

VI. Additional, Specific Errors of the Report

a. Health Insurance is Health Insurance – It Does Not Imply Coverage Details

The Minimum Wage Amendment does not create a heightened level of coverage for "health insurance" that must accompany Nevada's lower minimum wage rate. It is common among lawyers, scholars and other professionals specializing in these areas to generally refer to "health insurance" as any contract for insurance between an employer and third-party insurer pursuant to which an employee health benefit plan ("EHBP") is administered. All EHBP's are comprised of two basis parts: (1) an employer's plan to offer its employees' health benefits, usually as part of a larger benefits package made available by the employer to the employee; and (2) someone to administer the plan through the payment of claims submitted by employers under the plan. When the employer pays these claims directly, the plan is considered self-insured and a health insurance plan is not present. However, when the employer contracts a third-party, an insurer, to pay the claims, that contract is considered a "health insurance plan" among industry professionals.

Based on my knowledge and experience in the employee benefits and health care industries, the term "health insurance" does not describe any details about the plan or its coverage other than as described above. It is my opinion that the term "health insurance" is used within the Minimum

---

Notably, neither of the rates provided are discussed in terms of a "standard" or "reduced" wage.

[4] To the contrary, the actual language of the Minimum Wage Amendment describing the rates of its two-tier system could not be more matter-of-fact:

> Each employer shall pay a wage to each employee of not less than the hourly rates set forth in this section. The rate shall be five dollars and fifteen cents ($5.15) per hour worked, if the employer provides health benefits as described herein, or six dollars and fifteen cents ($6.15) per hour if the employer does not provide such benefits.

Wage Amendment in the same manner and has the same meaning as I have described, and that the term "health insurance" does not impose or imply any coverage requirements for specific health services. In other words, health insurance simply refers to an insurance plan which provides coverage for services related to one's health, such as medical, dental, surgical, and many other forms of treatment. Any insurance plan which provides coverage for these expenses incurred in connection with such services is a "health insurance plan" and commonly referred to as "health insurance."

The Minimum Wage Amendment does not itself require any particular form of health insurance or specify any particular coverage requirements. To the contrary, the Amendment uses the more general term "health benefits" then describes the particular form of health benefits to which it refers, specifically a health insurance plan which is made available to a specific group of people (employees and their dependents) at a specific cost (no more than 10% of the employee's AGI). Given the specificity provided for those other aspects of the "health insurance plan", it is not reasonably to conclude that the voters intended, but failed to include, specificity as to the coverage which must be provided.

Each of the 2010 through 2015 plans are "health insurance plans" suitable and permissible in connection with the Nevada Minimum Wage Amendment.

b. Neither the NAC nor NRS Chapter 608 Requires A Heightened Level of Coverage

NAC 608.102 does not mandate specific coverage for health insurance plans under the Minimum Wage Amendment. Milone's opinion to the contrary – that the Labor Commissioner intended to insert coverage requirements of his own – is not reasonable. This is especially true given the disparity in the level of authority as between the Nevada Constitution and administrative rule making. Milone's opinion is therefore further unreasonable in that it requires one to adoption the notion that neither the Legislature nor the language chosen to amend the Constitution saw fit to impose requirements about the coverage which must be required, but then-Commissioner Michael Tanchek did. Based on my considerable dealings with Commissioner Tanchek on employee benefits issues, I know this position to be untenable.

Milone's opinion in particular – that health insurance plans must cover "each of the" the categories of health care expenses described in 26 U.S.C. § 213 – would compel the absurd result that employers are required to provide the most expansive coverage imaginable, and coverage which was not required under identical statutes and regulations previously, at a cost to the employee of less than 10% of his AGI. In my opinion, very few employers would be able to meet these requirements and even fewer would likely make the decision to do so. In fact, given the cost the employer would be required to bear in order to provide this level of insurance, the employer would be far better off paying an additional $1.00 per hour to its minimum wage employees.[5] It is unreasonable to conclude that this was the intent of NAC 608.102.

Further, based on my considerable dealings with Commissioner Tanchek and each of the Commissioners since, I am certain that Milone's view is contrary to the Office of the Labor

[5] Employers would likely attribute as much of the cost of this insurance to the employee, assuring that the insurance would only be available to employees at a cost of 10% of their total gross income for the year. Milone's interpretation of NAC 689C.102 would thus also make insurance unaffordable for many of those workers, the individuals who were intended to benefit from the Minimum Wage Amendment in the first place.

Commissioner's interpretation of NAC 689C.102(a)(1). As explained above, the regulation's reference to those categories of health care expenses" set forth in the Tax Code is not a coverage mandate, but a means of identifying "health insurance", as opposed to myriad other types of insurance, by providing a fixed reference to the types of services which fall under the umbrella of "health" or "health care" services. Thus, if an insurance plan covers those types of expenses generally, it is "health insurance" for purposes of the Minimum Wage Amendment. This is not only my opinion based on my experience and expertise in this area, but also consistent with the view of the Labor Commissioner's Office since the Minimum Wage Amendment was enacted.

In sum, neither the Minimum Wage Amendment nor NAC 608.102 increased or otherwise changed the coverage requirements applicable to health insurance plans that are made available by employers to their employees.

c. NRS 608.1555 Does Subject All Health Insurance Plans to Chapters 689A and 689B – In Fact, the Statute Does Not Apply at All

Milone's suggestion that NRS 608.1555 applies to all health benefits plans, including health insurance plans, is also untenable. Upon reviewing the statute, it is clear that it was never intended to apply to benefit plans which are already administered through an insurance plan. To the contrary, the purpose of this statute was to compel self-insured employers to pay providers and otherwise administer the plan in the manner preferred by doctors and dentists, the manner utilized by insurance companies.

Second, the legislative history of the act creating NRS 608.1555 confirms this result. Third, any suggestion that this statute enacted 21 years before the Minimum Wage Amendment explains what coverage must be provided in connection with the Amendment. Fourth, if you attempt to apply NRS 608.1555 to insurance plans, as opposed to self-insured plans, the result is illogical, essentially mandating that insurance policies issued pursuant NRS Chapters 689A or 689B are subject to those chapters. Finally, it is my opinion that NRS 608.1555 is not enforceable against self-insured plans, the only plans to which its application could have been intended because it is preempted by ERISA. This opinion is further supported by the fact the statute was enacted in 1985, as case law making its preemption clear had not yet been issued.

d. The 2010 through 2013 Plans Are Individual, Not Group, Plans and Are Exempt from Coverage Requirements

Coverage requirements are not derived from the Minimum Wage Amendment at all, but rather from the statutes and regulations which govern the terms of a particular plan. This is where Milone's report is most flawed, as his opinions are based entirely on the premise that Chapter 689B governs each of the policies at issue when it does not.

Though his reasons for doing so are unclear, Milone determined that each of the policies at issue are "group health plans" and thus governed by NRS Chapter 689B when in reality the 2010, 2011, 2012 and 2013 plans are all "individual health plans" governed by NRS Chapter 689A. To the extent this conclusion is an opinion rather than verifiable fact, I have based it on a comparison of the terms set forth in the plan documents against the definitions provided in Chapter 689A, the express terms of the policies which reference individual coverage throughout, and by observing who is the "policyholder" under those policies. Unlike group plans under which the employer is the policyholder, the employees are the policyholders under individual plans such as the 2010 through 2013 policies. Further, where individual plans are made available to individuals through their

employer, the employer is identified as the plan "sponsor" as defendants are listed just as sponsors under the 2010 through 2013 plans.

In my opinion, that the plans offered by MDC changed from individual plans to a group plan after 2013 because of significant changes to NRS Chapters 689A, 689B and 689B, among others, at that time as the state's health insurance exchange was implemented in connection with the ACA. Most significant of those changes for purposes of addressing the Issues Presented is the Legislature's repeal of individual health benefit plans originally introduced to Nevada's insurance market in 1997 under HIPAA and Assembly Bill 521. Under AB 521, and Chapter 689A as it existed from 1997 to 2013, employers had the option to make "individual health benefit plans" available to employees. Insurers providing such coverage were required to make two types available to individuals in Nevada: (1) its basic plan, and (2) its standard plan. These plans were in all respect health insurance plans under Nevada law.

The 2010 through 2013 plans are "basic health benefit plans" as defined by NRS 689A.480. As such, they are not subject to coverage requirements pursuant to the express terms of NRS 689C 950, as follows:

> Notwithstanding any specific statute to the contrary, a statute that requires the coverage of a specific health care service or benefit, or the reimbursement, utilization or inclusion of a specific category of licensed health care practitioner, is not applicable to a basic health benefit plan delivered or issued for delivery to small employers or eligible persons in this state pursuant to this chapter or chapter 689A of NRS.

The entirety of Milone's report analyzing the compliance of the 2010 through 2013 plans is inapplicable. These plans are health insurance plans and comply with Nevada law in all respects, including in connection with the Minimum Wage Amendment.

e. The 2014 and 2015 Plans Meet All Applicable Coverage Requirement

Milone's report resorts exclusively to the irrelevant discussion of the ACA because these plans comply with all applicable coverage requirements. I have personally reviewed these plans to confirm this result.

VII Conclusion

Each of the 2010 to 2015 plans at issue in this case are "health insurance plans" providing "health insurance" as those terms are used in Nevada, including in connection with the Nevada Minimum Wage Amendment. It is my opinion that, if an employer made these policies available to employees during their respective plan years on the terms set forth in the Nevada Minimum Wage Amendment and NAC 608.102 (i.e. for a cost of 10 percent or less of the employees AGI, etc.), the applicable minimum wage would be the lesser of the two rates in Nevada's two-tier system.

Dated this 14th day of March 2016

Timothy R. Mulliner Signed 3/14/16

EXHIBIT 29

EXHIBIT 29

yes

From: Jeremy Thompson <JThompson@mpplaw.com>
Date: Wednesday, March 9, 2016 at 2:30 PM
To: Timothy Mulliner <tmulliner@mullinerlaw.com>, Michael Arrigo <marrigo@noworldborders.com>
Subject: RE: diaz

Typo!

- ? Whether or not defendants' plans are "qualifying health insurance" as contemplated by the MWA
- ? Whether the benefits the defendants' are providing are health insurance as health insurance is defined and used within the industry

Jeremy Thompson
Associate

500 South Rancho Drive
Suite 17
Las Vegas, NV 89106-4847

Direct: 702.697.7527
Main: 702.862.8300
Fax: 702.862.8400

JThompson@mpplaw.com

Morris Polich & Purdy LLP

Los Angeles - San Francisco - San Diego - Las Vegas
www.mpplaw.com

From: Jeremy Thompson
Sent: Wednesday, March 09, 2016 2:25 PM
To: Timothy Mulliner (tmulliner@mullinerlaw.com); marrigo@noworldborders.com
Subject: diaz

Guys,

Deanna wanted me to make sure you guys are focusing on the following issues:

- ? Whether or not defendants' plans are "qualifying health insurance" as contemplated by the MWA
- ? Whether the benefits the defendants' are providing being health insurance under the definition used within the industry

Thanks again for all of your help!

Jeremy

Jeremy Thompson
Associate

EXHIBIT 30

EXHIBIT 30

IN THE IOWA DISTRICT COURT IN AND FOR LINN COUNTY

PAULETTE DIAZ, an Individual, et al, Plaintiffs, v. MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company; and DOES 1 through 100, Inclusive, Defendants.	CASE NO. _____ Underlying Action: Case No. A-14-701633-C DEPT. NO. XVI Eighth Judicial District Court In and for Clark County, Nevada **RESPONSE TO SUBPOENA DUCES TECUM SERVED ON NON-PARTY TRANSAMERICA LIFE INSURANCE COMPANY**

In Response to a Subpoena Duces Tecum Served on Non-Party Transamerica Life Insurance Company ("Transamerica") on or around March 18, 2015, which was later narrowed by agreement, Transamerica states as follows:

> Category No. 1: This request is limited to any final health insurance plans, policies, and/or products that Transamerica may have provided to MDC, LAGUNA and/or INKA, or someone acting on behalf of Defendants (such as Mancha Development). This request does not include internal Transamerica emails/documents/communications. This request does not include any employee-specific documents.

Response No. 1: Transamerica objects to this request as the term "final health insurance plans, policies, and/or products" is vague, ambiguous and confusing. Transamerica does not offer "health insurance plans, policies, and/or products"; rather, Transamerica underwrites supplemental health insurance products, including specifically group limited benefit hospital indemnity insurance. Subject to and without waiving said objection, Transamerica will interpret this request as seeking documents related to the three (3) benefit levels of the TransChoice® Advance group hospital indemnity insurance offered to the employees of Mancha Development through employer group policyholder, MDC Restaurants, LLC. See confidential documents produced subject to the May 15, 2015 Protective Order entered in the underlying action which are Bates stamped 0001-0196.

Category No. 2: This request is limited to any final proposal for health insurance benefits plans, policies, and/or products sent by Transamerica to MDC, LAGUNA and/or INKA, or someone acting on behalf of Defendants (such as Mancha Development). This request does not include internal Transamerica emails/documents/communications. This request does not include any employee-specific documents.

Response No. 2: Transamerica objects to this request as the term "final health insurance plans, policies, and/or products" is vague, ambiguous and confusing. Transamerica does not offer "health insurance plans, policies, and/or products"; rather, Transamerica underwrites supplemental health insurance products, including specifically group limited benefit hospital indemnity insurance. Subject to and without waiving said objection, Transamerica will interpret this request as seeking documents related to any proposal of TransChoice® Advance coverage for the employees of Mancha Development. See confidential documents produced subject to the May 15, 2015 Protective Order entered in the underlying action which are Bates stamped 0197-0203.

Category No. 3: This request is limited to the master policy(ies) for any health insurance plan(s) issued to MDC, LAGUNA and/or INKA, or someone acting on behalf of Defendants (such as Mancha Development). This request does not include internal Transamerica emails/documents/ communications.

Response No. 3: Transamerica objects to this document request as the term "health insurance plans" is vague, ambiguous and confusing. Transamerica does not offer "health insurance plan(s)"; rather, Transamerica underwrites supplemental health insurance products, including specifically group limited benefit hospital indemnity insurance. Subject to and without waiving said objection, Transamerica will interpret this request as seeking documents related to the Group Master Policy of TransChoice® Advance group hospital indemnity insurance issued to MDC Restaurants, LLC, effective January 1, 2014. See confidential documents produced subject to the May 15, 2015 Protective Order entered in the underlying action which are Bates stamped 0204-0268.

Category No. 4: This request is limited to summaries of any health insurance plans, policies, and/or products that Transamerica may have provided to MDC, LAGUNA and/or INKA, or someone acting on behalf of Defendants (such as Mancha Development). This request does not include internal Transamerica emails/documents/communications.

Response No. 4: Please see Objections and Response to Category No. 2, above.

Category No. 5: This request is limited to any chart or demonstrative provided by Transamerica to MDC, LAGUNA and/or INKA, or someone

acting on behalf of Defendants (such as Mancha Development), that identifies the premium cost to be paid by Defendants' hourly employees for health insurance. This request does not include internal Transamerica emails/documents/communications.

Response No. 5: Please see Objections and Response to Category No. 2, above.

Category No. 6: This request is limited to any formal application tendered by MDC, LAGUNA and/or INKA, or someone acting on behalf of Defendants (such as Mancha Development), for a health insurance group policy. This request does not include internal Transamerica emails/ documents/communications. This request does not include any employee-specific documents.

Response No. 6: Transamerica objects to this request as the term "health insurance group policy" is vague and ambiguous. Transamerica does not offer a "health insurance group policy;" rather, Transamerica underwrites supplemental health insurance products, including specifically group limited benefit hospital indemnity insurance. Please see confidential documents produced subject to the May 15, 2015 Protective Order entered in the underlying action which begins at page 57 (Bates stamped 0260-0268) of the group master policy produced in response to Category No. 3, above, for the Life and Health Group Application and Agreement completed by or on behalf of MDC. See confidential documents produced subject to the May 15, 2015 Protective Order entered in the underlying action which are Bates stamped 0204-0268.

Category No. 7: This request is limited to any employee census submitted by MDC, LAGUNA and/or INKA, or someone acting on behalf of Defendants (such as Mancha Development), to Transamerica. This request does not include internal Transamerica emails/documents/ communications. This request does not include any employee-specific documents.

Response No. 7: Transamerica objects to this request as it is internally inconsistent, i.e., an employee census necessarily includes employee-specific data. Subject to and without waiving said objection, Transamerica has no responsive documents.

Category No. 8: This request is limited to documents that identify the premium cost that MDC, LAGUNA and/or INKA, or someone acting on behalf of Defendants (such as Mancha Development), would pay for health insurance coverage for its employees. This request includes communications (letters, emails or other written correspondence) between Defendants or someone acting on behalf of Defendants (such as Mancha Development) and/or Transamerica concerning the foregoing subject

matter. This request does not include internal Transamerica emails/ documents/communications.

Response No. 8: Transamerica objects to this request as the term "health insurance coverage" is vague and ambiguous. Transamerica does not offer "health insurance;" rather, Transamerica underwrites supplemental health insurance products, including specifically group limited benefit hospital indemnity insurance. Subject to and without waiving said objection, Transamerica will interpret this request as seeking documents related to premium cost for TransChoice® Advance coverage for the employees of Mancha Development and responds that it has no information which establishes there was any employer contribution for said coverage.

Category No. 9: This request is limited to any final insurance benefits contracts between Transamerica and MDC, LAGUNA and/or INKA, or someone acting on behalf of Defendants (such as Mancha Development). This request does not include internal Transamerica emails/documents/ communications.

Response No. 9: Transamerica objects to this document request as the term "final insurance benefit contracts" is vague, ambiguous and confusing. Transamerica underwrites supplemental health insurance products, including specifically group limited benefit hospital indemnity insurance. Subject to and without waiving said objection, please refer to the confidential documents produced subject to the May 15, 2015 Protective Order entered in the underlying action which are identified in response to Category Nos. 1 and 3, above.

Category No. 10: This request is limited to any communications (letters, emails or other written correspondence) from MDC, LAGUNA and/or INKA, or someone acting on behalf of Defendants (such as Mancha Development), to Transamerica, in which Defendants or Mancha Development (on behalf of Defendants) solicit or request proposals for health insurance benefits for its employees. This request does not include internal Transamerica emails/documents/communications.

Response No. 10: Transamerica objects to this document request as the term "health insurance benefits" is vague, ambiguous and confusing. Transamerica underwrites supplemental health insurance products, including specifically group limited benefit hospital indemnity insurance. Subject to and without waiving said objection, Transamerica has no documents responsive to this request.

Category No. 11: This request is limited to communications (letters, emails or other written correspondence) between Transamerica and MDC, LAGUNA and/or INKA, or someone acting on behalf of Defendants (such as Mancha Development), concerning the lawsuit. This request does not include internal Transamerica emails/documents/communications.

Response No. 11: Transamerica has no documents responsive to this request.

Category No. 12: This request is limited to communications (letters, emails or other written correspondence) between Transamerica and MDC, LAGUNA and/or INKA, or someone acting on behalf of Defendants (such as Mancha Development), concerning Article XV, Section 16 of the Nevada Constitution and/or N.A.C. Chapter 608. This request does not include internal Transamerica emails/documents/communications.

Response No. 12: Transamerica has no documents responsive to this request.

Category No. 13: This request is limited to communications (letters, emails or other written correspondence) by Transamerica concerning Article XV, Section 16 of the Nevada Constitution and/or N.A.C. Chapter 608 as they relate to the health insurance plans, policies, and/or products selected by MDC, LAGUNA and/or INKA, or someone acting on behalf of Defendants (such as Mancha Development). This request does include internal Transamerica emails/documents/communications.

Response No. 13: Transamerica objects to this request on the grounds it is vague, ambiguous and unintelligible.

Category No. 14: Withdrawn

Response No. 14: No response is required.

/s/ Amy L. Reasner
AMY L. REASNER, AT0006390
of
LYNCH DALLAS, P.C.
526 Second Avenue SE
P.O. Box 2457
Cedar Rapids, Iowa 52406-2457
Telephone: 319.365.9101
Facsimile: 319.866.9721
E-Mail: areasner@lynchdallas.com

ATTORNEYS FOR TRANSAMERICA
LIFE INSURANCE COMPANY

CERTIFICATE OF SERVICE

I certify that I served the foregoing document upon the following person(s) by e-mailing pursuant to Iowa Rule of Civil Procedure 1.442(2) on the 19th day of May, 2015.

Rick D. Roskelley (rroskelley@littler.com)
Roger Grandgenett (rgrandgenett@littler.com)
Katie Blakey (kblakey@littler.com)
Littler Mendelson, P.C.
3960 Howard Hughes Parkway
Suite 300
Las Vegas, NV 89169

Don Springmeyer (dspringmeyer@wrslawyers.com)
Bradley Schrager (bschrager@wrslawyers.com)
Daniel Bravo (dbravo@wrslawyers.com)
Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP
3556 E. Russell Road, Second Floor
Las Vegas, NV 89120

/s/ Amy L. Reasner

Electronically Filed
04/19/2016 03:42:26 PM

CLERK OF THE COURT

SAO
DON SPRINGMEYER, ESQ.
Nevada State Bar No. 1021
BRADLEY SCHRAGER, ESQ.
Nevada State Bar No. 10217
JORDAN BUTLER, ESQ.
Nevada Bar No. 10531
WOLF, RIFKIN, SHAPIRO, SCHULMAN & RABKIN, LLP
3556 E. Russell Road, 2nd Floor
Las Vegas, Nevada 89120-2234
Telephone: (702) 341-5200/Fax: (702) 341-5300
Email: dspringmeyer@wrslawyers.com
Email: bschrager@wrslawyers.com
Email: jbutler@wrslawyers.com
Attorneys for Plaintiffs

EIGHTH JUDICIAL DISTRICT COURT

IN AND FOR CLARK COUNTY, STATE OF NEVADA

PAULETTE DIAZ, an individual; and LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, an individual; CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly-situated individuals,

Plaintiffs,

vs.

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company, and DOES 1 through 100, Inclusive,

Defendants.

Case No: A-14-701633-C

Dept. No.: XVI

STIPULATION AND ORDER AMENDING BRIEFING DEADLINES AND RE-NOTICING HEARING RE: PLAINTIFFS' RENEWED MOTION FOR PARTIAL SUMMARY JUDGMENT ON LIABILITY REGARDING DEFENDANTS' HEALTH BENEFITS PLANS

The parties, by and through their counsel of record, hereby stipulate, as follows:

IT IS HEREBY STIPULATED AND AGREED that Plaintiffs will have up to and including **April 18, 2016** to file Plaintiffs' Renewed Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Plans (the "Motion")

IT IS FURTHER STIPULATED AND AGREED that Defendants will have up to and including **May 13, 2016** to file an opposition to Plaintiffs' Renewed Motion for Partial Summary

Judgment.

IT IS FURTHER STIPULATED AND AGREED that Plaintiffs will have up to and including **May 20, 2016** to file a reply in support of Plaintiffs' Renewed Motion for Partial Summary Judgment.

IT IS FINALLY STIPULATED AND AGREED that the Motion will come on for hearing before this honorable Court on **May 31, 2016 at 9:00 a.m.**

IT IS SO STIPULATED.

Dated this 12th day of April, 2016.

MORRIS POLICH & PURDY LLP

By: _____

NICHOLAS M. WIECZOREK, ESQ.
Nevada State Bar No. 6170
DEANNA L. FORBUSH
Nevada State Bar No. 6646
JEREMY J. THOMPSON
Nevada State Bar No. 12503
3800 Howard Hughes Parkway, Suite 500
Las Vegas, Nevada 89169
Attorneys for Defendants

Dated this 13th day of April, 2016.

WOLF, RIFKIN, SHAPIRO, SCHULMAN & RABKIN, LLP

By: _____

DON SPRINGMEYER, ESQ.
Nevada State Bar No. 1021
BRADLEY SCHRAGER, ESQ.
Nevada State Bar No. 10217
JORDAN BUTLER, ESQ.
Nevada State Bar No. 10531
3556 E. Russell Road, Second Floor
Las Vegas, Nevada 89120
Attorneys for Plaintiffs

ORDER

IT IS SO ORDERED.

DATED this 14th day of April, 2016.

_____

DISTRICT COURT JUDGE

Electronically Filed
04/27/2016 01:13:32 PM

CLERK OF THE COURT

ARJT

DISTRICT COURT

CLARK COUNTY, NEVADA

PAULETTE DIAZ, an individual; and LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, and individual; CHARITY FITZLAFF, an individual, on behalf of themselves and all similarly situated individuals, Plaintiffs, vs. MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company and DOES 1 through 100, inclusive, Defendants.	Case No. Dept No.	A-14-701633-C XVI

APR 27 2016

2nd AMENDED ORDER SETTING CIVIL JURY TRIAL, PRE-TRIAL/CALENDAR CALL

IT IS HEREBY ORDERED THAT:

A. The above entitled case is set to be tried to a jury on a five-week stack in District Court, Dept. 16, to begin, on the 6th day of **March, 2017**, at **9:30** o'clock A.M.

B. A Pre-Trial/Calendar Call with the designated attorney and/or parties in proper person will be held on the ~~17th~~ 16th day of **February, 2017**, at **10:30** o'clock A.M.

C. The joint Pre-trial Memorandum must be filed prior to the Pre-Trial/Calendar Call, with a courtesy copy delivered to Department XVI Chambers. All parties, (Attorneys

TIMOTHY C. WILLIAMS
DISTRICT JUDGE

DEPARTMENT SIXTEEN
LAS VEGAS NV 89155

and parties in Proper Person) MUST comply with All REQUIREMENTS of E.D.C.R. 2.67, 2.68 and 2.69.

Counsel should include in the Memorandum an identification of orders on all motions in limine or motions for partial summary judgment previously made, a summary of any anticipated legal issues remaining, a brief summary of the opinions to be offered by any witness to be called to offer opinion testimony as well as any objections to the opinion testimony.

D. All discovery deadlines, deadlines for filing dispositive motions and motions to amend the pleadings or add parties are controlled by the previously issued Scheduling Order and/or any amendments or subsequent orders.

E. Pursuant to EDCR 2.35, a motion to continue trial due to any discovery issues or deadlines must be made before the Discovery Commissioner.

F. Pursuant to EDCR 2.47, all motions in limine to exclude or admit evidence must be in writing and **filed** not less than **45 days** prior to the date set for trial and must be heard not less than **14** days prior to trial. ORDERS SHORTENING TIME WILL NOT BE SIGNED EXCEPT IN EXTREME EMERGENCIES.

An upcoming trial date is not an EXTREME EMERGENCY.

Failure of the designated trial attorney or any party appearing in proper person to appear for any court appearances or to comply with this Order shall result in any of the following: (1) dismissal of the action (2) default judgment; (3) monetary sanctions; (4) vacation of trial date; and/or any other appropriate remedy or sanction.

Counsel is asked to notify the Court Reporter at least two (2) weeks in advance if they are going to require daily copies of the transcripts of this trial. Failure to do so may result in a delay in the production of the transcripts.

. . .

. . .

. . .

. . .

TIMOTHY C. WILLIAMS
DISTRICT JUDGE

DEPARTMENT SIXTEEN
LAS VEGAS NV 89155

Counsel must advise the Court immediately when the case settles or is otherwise resolved prior to trial. A Stipulation which terminates a case by dismissal shall also indicate whether a Scheduling Order has been filed and if a trial date has been set, and the date of that trial. A copy should be given to Chambers.

DATED: April 27, 2016

TIMOTHY C. WILLIAMS
District Court Judge, Dept. XVI

CERTIFICATE OF SERVICE

I hereby certify that on or about the date e-filed, this document was electronically served to all registered parties for Case Number A701633 as follows:

Morris Polich & Purdy LLP

Name	Email
Beth A. Kahn, Esq.	bkahn@mpplaw.com
Deanna L. Forbush, Esq.	DForbush@mpplaw.com
Debbie Surowiec	dsurowiec@mpplaw.com
Jeremy J. Thompson, Esq.	jthompson@mpplaw.com
Lisa Woodruff	lwoodruff@mpplaw.com
Maria T. Escobedo	MEscobedo@mpplaw.com
Natasha Martinez	nmartinez@mpplaw.com
Nicholas M. Wieczorek, Esq.	nwieczorek@mpplaw.com

Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP

Name	Email
Bradley S. Schrager, Esq.	bschrager@wrslawyers.com
Christie Rehfeld	crehfeld@wrslawyers.com
Dan Hill, Esq.	dhill@wrslawyers.com
Daniel Bravo	dbravo@wrslawyers.com
Dannielle Fresquez	dfresquez@wrslawyers.com
Don Springmeyer	dspringmeyer@wrslawyers.com
E. Noemy Valdez	nvaldez@wrslawyers.com
Justin Jones, Esq.	jjones@wrslawyers.com
Lorrine Rillera	Lrillera@wrslawyers.com

Wolf, Rifkin, Shapiro, Schulman & Rabkin, LLP.

Name	Email
Jennifer Finley	jfinley@wrslawyers.com

Lynn Berkheimer
Judicial Executive Assistant

Electronically Filed
05/13/2016 04:00:57 PM

CLERK OF THE COURT

ONSJ
NICHOLAS M. WIECZOREK
Nevada Bar No. 6170
DEANNA L. FORBUSH
Nevada Bar No. 6646
JEREMY J. THOMPSON
Nevada Bar No. 12503
MORRIS POLICH & PURDY LLP
3800 Howard Hughes Parkway, Suite 500
Las Vegas, Nevada 89169
Telephone: (702) 862-8300
Facsimile: (702) 862-8400
NWieczorek@mpplaw.com
DForbush@mpplaw.com
JThompson@mpplaw.com

Attorneys for Defendants, MDC RESTAURANTS, LLC; LAGUNA RESTAURANTS, LLC; INKA, LLC

DISTRICT COURT

CLARK COUNTY, NEVADA

PAULETTE DIAZ, an individual; LAWANDA GAIL WILBANKS, an individual; SHANNON OLSZYNSKI, an individual; and CHARITY FITZLEFF, an individual, on behalf of themselves and all similarly-situated individuals,

Plaintiffs,

v.

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS, LLC, a Nevada limited liability company; INKA, LLC, a Nevada limited liability company, and DOES 1 through 100, Inclusive,

Defendants.

Case No.: A-14-701633-C
Dept. No.: XVI

DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT ON LIABILITY REGARDING DEFENDANTS' HEALTH BENEFITS PLANS

Hearing Date: May 31, 2016
Hearing Time: 9:00 a.m.

Defendants MDC Restaurants, LLC, Laguna Restaurants, LLC and Inka, LLC (hereinafter collectively referred to as "Defendants"), by and through their counsel of record Morris Polich & Purdy LLP, hereby provide their Opposition to Plaintiffs' Renewed Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans.

No._____
(Clark County District Court No. A-14-701633-C)

In the Supreme Court of the State of Nevada

MDC RESTAURANTS, LLC; LAGUNA RESTAURANTS, LLC; AND INKA, LLC,

Defendants and Petitioners,

VS.

EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA IN AND FOR THE COUNTY OF CLARK; THE HONORABLE TIMOTHY C. WILLIAMS, DISTRICT JUDGE

Respondents,

PAULETTE DIAZ; LAWANDA GAIL WILBANKS; SHANNON OLSZYNSKI; AND CHARITY FITZLAFF, all on behalf of themselves and all similarly-situated individuals,

Plaintiffs and Real Parties in Interest.

APPENDIX TO PETITION FOR WRIT OF MANDAMUS OR OTHER EXTRAORDINARY RELIEF
VOLUME 3 OF 6

REQUEST FOR TEMPORARY STAY

Petition From an Order Deeming Petitioners' Health Benefits Plans Invalid Under Article XV, Section 16(A) of the Nevada Constitution

MORRIS POLICH & PURDY LLP
Nicholas M. Wieczorek, No. 6170
Deanna L. Forbush, No. 6646
Jeremy J. Thompson, No. 12503
3800 Howard Hughes Parkway, Suite 500
Las Vegas, Nevada 89169
Telephone: (702) 862-8300

Attorneys for Defendants and Petitioners
MDC RESTAURANTS, LLC; LAGUNA RESTAURANTS, LLC; INKA, LLC.

Chronological Index

Alphabetical Index

Document No.	Document	Date	Page No.
12. Cont.	Notice of Lodgment of Exhibits to Defendants' Opposition to Plaintiffs' Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans	05/13/16	1047
7.	Order Granting Class Certification, Designating Class Representatives, and Designating Class Counsel	10/16/15	0051
8.	Plaintiff's Renewed Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans	04/19/16	0056
8. Cont.	Plaintiff's Renewed Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans	04/19/16	0207
8. Cont.	Plaintiff's Renewed Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans	04/19/16	0417
13.	Plaintiffs' Reply in Support of Their Renewed Motion for Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans	05/20/16	1161
14.	Reporter's Transcript of Motion Before The Honorable Judge Timothy C. Williams, District Court Judge	05/31/16	1174
10.	Second Amended Order Setting Civil Jury Trial, Pre-Trial/Calendar Call	04/27/16	0543
9.	Stipulation and Order Amending Briefing Deadlines and Re-Noticing Hearing Re: Plaintiffs' Renewed Motion For Partial Summary Judgment on Liability Regarding Defendants' Health Benefits Plans	04/19/16	0541
5.	Summons	06/20/15	0038

ATTACHMENT D (page 2 of 2)

State HHS Eligibility Systems and Jurisdictions

Jurisdiction	State Systems and Processes
Alaska	Eligibility Information System (EI)
Arizona	Arizona Technical Eligibility Computer System (AZTECS)
Georgia	SHINES, COMPASS, Vitale Events, Medicaid Data Broker
Hawaii	Hawaii Automated Welfare Information System (HAWI)
Kansas	Kansas Automated Eligibility & Child Support Enforcement System (KAECSES)
Louisiana	Medicaid Eligibility Data System (LA MEDS)
Massachusetts	Mass 21st Century Disability Policy (MA-21)
Minnesota	MAXIS – state, county eligibility for public assistance, health care; exchanges data with Medicaid Management Information System (MMIS), MN Employment and Economic Development, MN Dept. of Finance, and US Social Security Admin
Mississippi	Mississippi Applications Verification Eligibility Reporting Information and Control System (MAVERICS)
Pennsylvania	COMPASS – health care, cash, long-term, home, supplemental nutrition (SNAP) eligibility
Rhode Island	INRhodes and] UHIP data and functions for the Family Independence Program, Food Stamps, Child Support Enforcement, Medicaid Eligibility, Child Care, Public Assistance
South Carolina	Family Independence Financial System (FIFN)
Tennessee	TennCare and SSI (Supplemental Security Income Under Social Security Administration)
Vermont	ACCESS
Washington DC	Automated Client Eligibility Determination System (ACEDS)
Wyoming	EPICS (Eligibility Payment Information Computer System)

ATTACHMENT E

Meaningful Use of Electronic Health Records

Mr. Arrigo manages a team that has worked with over 100 electronic medical records vendors and health care providers regarding achieving Meaningful Use (MU) under the HITECH Act as well as MU audit defense v. CMS, OIG and CMS Auditors

Meaningful Use (**MU**) is composed of a complex list of Objectives, including HIPAA privacy, Personal Health Information Safeguards, Clinical Quality Measures (**CQMs**), clinical decision support (**CDS**), transitions of care, data portability, auditable events, patient engagement, and other measures. Mr. Arrigo has opined as an Expert regarding MU provides opinions and guidance on all of the following factors:

- Authorized Testing and Certifications Bodies (ATCBs) and processes
- Eligible Hospital (EP) and Eligible Provider (EP) attestations and audit defense under Medicare and Medicaid in Civil and Criminal defense cases.
- Stimulus funds, OIG, CMS auditors
- HHS OCR, HIPAA breaches, State CMIA breaches and stimulus eligibility
- Modular and Complete E.H.R. certifications
- Discrete data structures
- HIPAA Privacy and Security Assessments as a Component of MU and the Administrative, Physical, Technical Safeguards of HITECH Act as well as Operational Policies, Procedures and Documentation and HIPAA overlapping requirements.
- Clinical workflow for both acute care and ambulatory E.H.R.s

Meaningful Use Stage 1:

Eligible professionals:

- 13 required core objectives
- 5 menu objectives from a list of 9
- Total of 18 objectives

Eligible hospitals and CAHs:

- 11 required core objectives
- 5 menu objectives from a list of 10
- Total of 16 objectives

Meaningful Use Stage 2:

Eligible professionals:

- 17 core objectives
- 3 menu objectives that they select from a total list of 6
- Total of 20 objectives

Eligible hospitals and CAHs:

- 16 core objectives
- 3 menu objectives that they select from a total list of 6
- Total of 19 objectives

ATTACHMENT F
Healthcare Business Transactions, Supporting HIPAA X12 Electronic Transactions

1. Health Care Eligibility Benefit Inquiry and Response – EDI 270/271
2. Health Care Claim Status Request / Response – EDI 276/277
3. Health Care Services Request for Review / Response (Prior Authorization) – EDI 278
4. Payroll deductions for premiums – EDI 820
5. Benefit enrollment and maintenance – EDI 834
6. Health care claim: Payment / Advice – EDI 835, Health Care Claim: institutional, professional / dental – EDI 837, Pharmacy claim (NCPDP) – D.0

ATTACHMENT G

Revenue Cycle Management, Clinical Documentation and Coding Processes

Lead team that implements hospital system assessments for ICD-10 and CPT coding compliance and quality, including:

CDI (Clinical Documentation Improvement) strategy and alignment between HIM department, coders, nursing, physicians. Benefits of coder-physician collaboration, and securing results in improved coding. Engage case managers to focus on CDI trends, work with physicians that are the largest admitters. Understanding of key processes including:

Patient intake
Patient assessment
Documentation of care
Insurance coverage determination
Discharge activities
Provider communications
Referrals
Prior authorizations
Coding
Charge capture, super bills
Billing
Revenue collection
Vendor impacts
EHR and other system readiness to support CDI
IT plans
Impact on concurrent initiatives
Reporting
Quality improvement efforts
Payor readiness and processes; medical policy assumptions for contracting
Institutional Review Board (IRB) impact review for ICD-10
Data warehouse and business intelligence "retooling" of analytics required.

ATTACHMENT H – Drug Pricing Practices

Experience using analytics to identify UCR (aka Fair Market Value (FMV)) in Pharmaceutical Pricing

- Re-Defining AWP
- % Factor
- NDC price reporting
- Mark-Ups & Price Spreads
- Backroom Processor Schemes
- Rebate Schemes
- Flat, Access, Market Share
- Rebate Disguising
- Rebate Pumping
- Re-Defining "Brand" and "Generic"
- Formulary Steering
- Pre-Authorization Schemes
- Clinical Rules & Protocols
- Mail-Order Schemes
- Leveraging Captive Facility
- Multiple MAC Lists
- Drug Switching
- Drug Repackaging
- Fraudulent Plan Design
- Zero Cost Scripts
- Higher Than Logic
- Pocketing Refunds, Reversals and Returns
- Payor Account Crediting Tricks
- Specialty Drug Issue

ATTACHMENT I

HIPAA Privacy Rule and HIPAA Security Rule, HITECH Act Information Safeguards

Lead team that assesses and advises regarding industry best practices and implementation of HIPAA Privacy and Security as well as HITECH Act, including:

Security best practices for HIPAA Covered Entities

HHS Security Standards:

1. **Administrative** Safeguards
2. **Physical** Safeguards
3. **Technical** Safeguards
4. **Organizational Policies and Procedures** and Documentation Requirements

---

[1] Although the name 'health informatics' only came into use in about 1973 (Protti 1995) it is a study that is as old as healthcare itself. It was born the day that a clinician first wrote down some impressions about a patient's illness, and used these to learn how to treat their next patient. The world is aging and there are increasing numbers of people with chronic disease; it is recognized that the only sustainable option is planning and delivery of healthcare through technology innovation. Biomedical Informatics seeks to discern the difference between data, information, knowledge and wisdom by increasing sharing and comprehension. Professor Enrico Coiera of the Macquarie University argues that health informatics is the logic of healthcare. Dr. Mark Musen MD PhD Professor, Medicine - Biomedical Informatics Research at Stanford points out that that digital information has made knowledge infinitely larger for clinicians, and they are now are in a knowledge management crisis – getting the right information at the right time is the challenge.

Exhibit B – Methodology

This methodology uses authorities from scientific, economic and standards based organizations, as well as rules, guidelines and statutes noted herein which are publicly available. The process of applying these uses authorities from scientific, economic and standards based organizations, as well as rules and statutes for the purpose of writing an expert opinion, and assessing the quality of the calculations to arrive at a Usual Customary and Reasonable cost of care is © copyright Michael F. Arrigo and No World Borders, Inc. Test results are based on the methodology, application of the methodology and are documented so that an expert with similar data, knowledge, education, experience and training could reasonably arrive at similar results. Current Procedural Terminology or CPT® codes and descriptions, are copyrights of the American Medical Association. All Rights Other trademarks are the property of their respective owners.

General Approach – Industry Best Practices and Generally Accepted Methods

There are industry best practices and customary methods that are used to document the condition of a patient, render a diagnosis and bill for medical procedures. Health care providers ("providers") as well as Medicare, Medicaid, and private health insurance companies ("payors") use these methods to pre-determine the amount they will bill and the amount they will pay for medical procedures.

Generally accepted methods are used as documented below, which are re-testable, and would yield the same or very similar results if tested by another individual with similar knowledge, skills, training, and experience. These methods are accepted, tested, and capable of drawing conclusions regarding the usual customary and reasonable costs for medical care. Conclusions are drawn and estimated with reasonable certainty from the data collected in the documentation provided and via scientific, international standards, and federal and state rules as annotated in this report. Where applicable, reasonable, or possible based on the information provided to me, documentation is organized chronologically by date and organized by medical care provider. Documents containing HIPAA protected information are managed as secure password protected or encrypted methods, or if in paper form in a locked room.

Reimbursement contracts to pre-determine methods and amounts for reimbursement including "in-network" contracts and "out of network" reimbursement procedures may or may not be used. A provider is considered "in-network" with a payor when it enters into an agreement to follow standard procedures for documentation and billing and in return it receives a maximum allowable amount from a payor for the specific medical procedure. Providers enter into such in-network agreements because they expect to receive increased volume of patients and prompt reimbursement. When a provider bills for a procedure and has no in-network agreement with the patient's health insurance company, the provider is subject to unpredictable amounts and timing of reimbursement. In this case the provider may seek alternative intermediaries who will accelerate reimbursement in exchange for a discounted amount and a transaction fee. These arrangements are called out of network discounted reimbursement contracts.

Federal Policy Level (FPL) Calculations and Medicaid Eligibility – Income Scenarios

I calculated two possible scenarios for MDC worker annual income at $7.25 per hour. From those two possible scenarios, I calculated four possible eligibility outcomes.

Income Scenarios

A. According to ACA and U.S. OMB standards, a full-time employee: Defined as an employee who works on average 30 hours per week, or 130 hours of service per calendar month I used 30 hours per week times $7.25 per hour, times 50 weeks for a low-case scenario of income, in other words, just below what industry standards best practices and statutes would discern as full-time.

B. I created a second scenario using 2,087 hours, a full-time equivalent number of annual hours worked, times $7.25 to arrive at a high case of income.

Federal Poverty Level (FPL) Calculations, Medicaid Eligibility – Demographic Scenarios

I used Federal guidelines on the poverty level (FPL) published by U.S. Health and Human Services:

Household Size	2010	2011	2012	2013	2014	2015	2016
1	$10,830	$10,890	$11,170	$11,490	$11,670	$11,770	$ 11,880
2	$14,570	$14,710	$15,130	$15,510	$15,730	$15,930	$ 16,020
3	$18,310	$18,530	$19,090	$19,530	$19,970	$20,090	$ 20,160
4	$22,050	$22,350	$23,050	$23,550	$23,850	$24,250	$ 24,300
5	$25,790	$26,170	$27,010	$27,570	$27,910	$28,410	$ 28,440
6	$29,530	$29,990	$30,970	$31,590	$31,970	$32,570	$ 32,580
7	$33,270	$33,810	$34,930	$35,619	$36,030	$36,730	$ 36,730
8	$37,010	$37,630	$38,890	$39,630	$40,090	$40,890	$ 40,890

Sources:

2010 [illegible]
2011 https://aspe.hhs.gov/2011-hhs-poverty-guidelines
2012 https://aspe.hhs.gov/2012-hhs-poverty-guidelines
2013 https://aspe.hhs.gov/2013-poverty-guidelines
2014 https://aspe.hhs.gov/2014-poverty-guidelines
2015 [illegible]

Using the income scenarios described in the prior section above, I considered demographic scenarios that represent likely characteristics of MDC workers earning $7.25 per hour, including:

I. BEFORE MEDICAID EXPANSION MAN OR WOMAN WITH DEPENDENT, 2 IN

II. BEFORE MEDICAID EXPANSION WOMAN WITH DEPENDENT, 2 IN

III. BEFORE MEDICAID EXPANSION MAN OR WOMAN WITH DEPENDENT, 3 IN

IV. MEDICAID EXPANSION, 1 IN HOUSEHOLD (MORE IN HOUSEHOLD WOULD INCREASE MEDICAID ELIGIBILITY)

I confirmed Nevada and Federal policy regarding eligibility. For example, as of 2015, Medicaid in Nevada is available to the following legally-present residents[40]:

- Adults with household income up to 133 percent of poverty (really 138 percent with the 5 percent income disregard).
- Pregnant women with household income up to 160 percent of FPL.

Children, depending on age, with household income up to 133 percent or 160 percent of FPL; all children are eligible for CHIP with income up to 200 percent of FPL.

- Adults between 19-64 whose household income is at or below 138% of the Federal Poverty Level (FPL. See chart).
- ▸ Children.

- ▸ Pregnant Women whose household income

is less than 165% of the FPL.

- ▸ Parent Caretakers with income at or below 138% of the FPL.
- ▸ Supplemental Security Income recipients.
- ▸ Certain Medicare beneficiaries.

Evaluation of Multiple Time Periods, Plans

There are two important time periods and three different plans that I considered. The first period is 2010 to 2013, the second is 2014 and beyond. The three health plans considered are Starbridge, Trans Choice, and MVP. I considered these plans in light of the Medicaid qualifications noted in the prior sections, and the fact that each of the list various medical coverage determination policies ("benefits") provided for premiums collected.

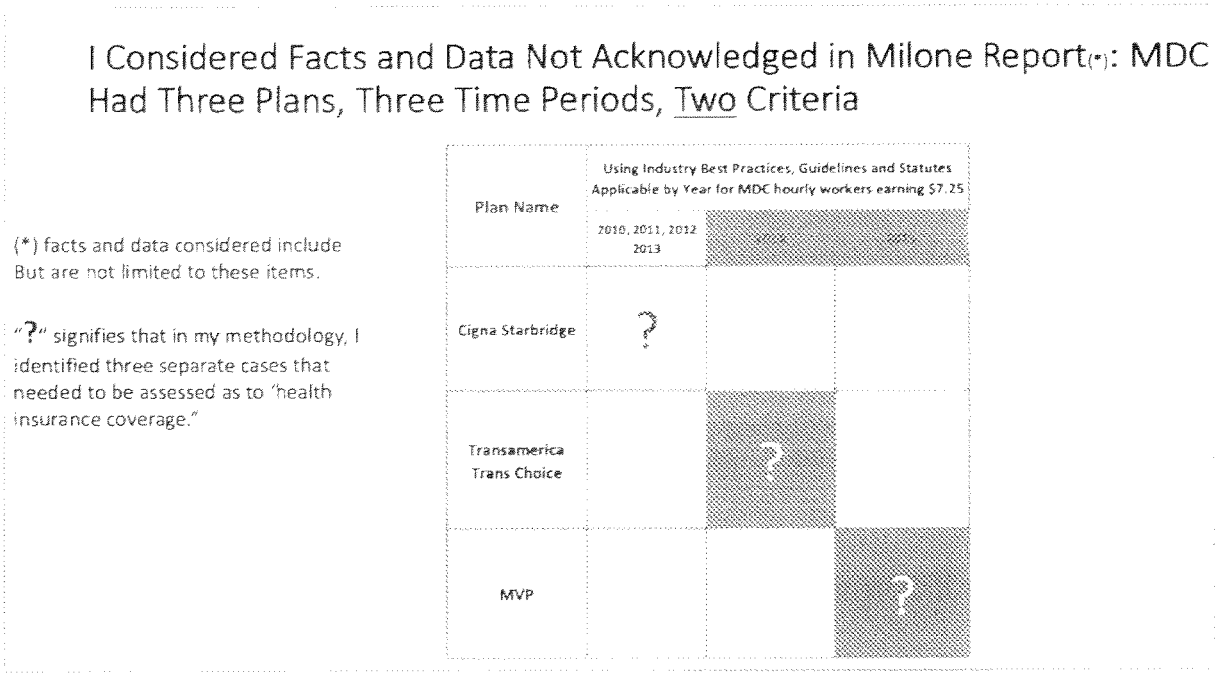


Figure 7 - Multiple Time Frames and Three Plans

Evaluation of Regulatory Frameworks Applicable to Different Plans, Time Periods

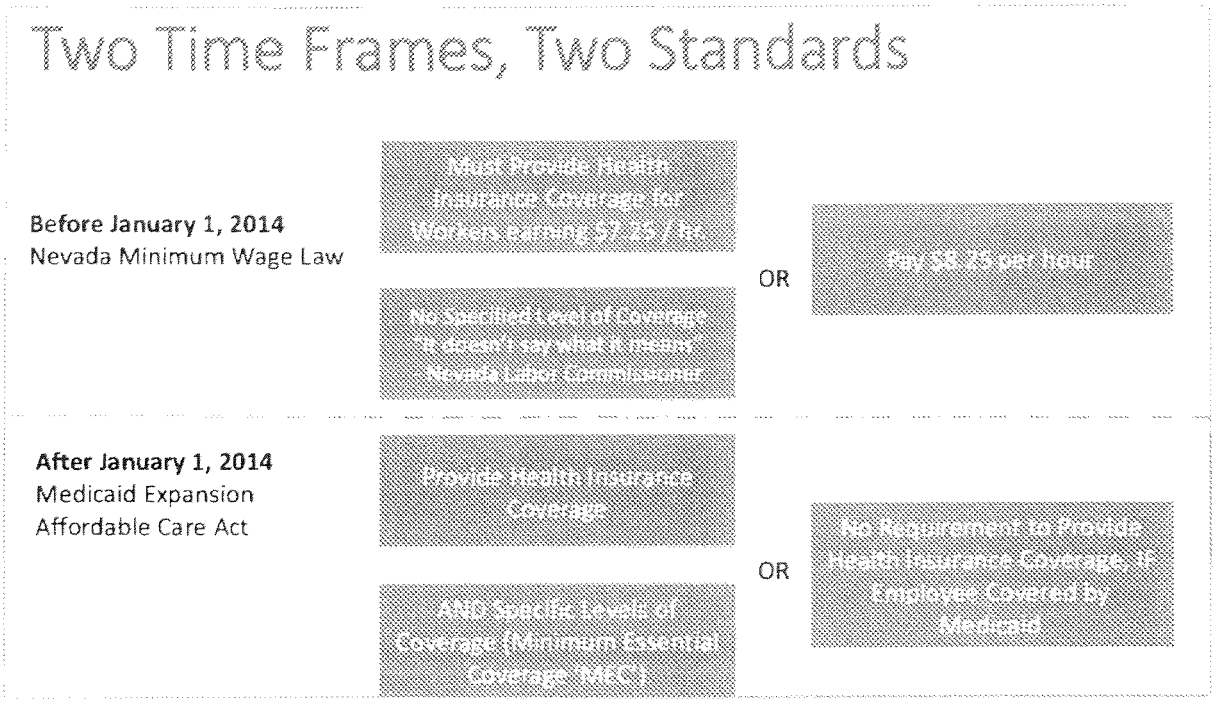


Figure 8 - Regulatory Framework

Medical Coding Review, Where Applicable

One component in determining medical costs is accomplished by reviewing medical codes provided in patient documentation. Medical diagnosis codes (usually ICD-9 or ICD-10) are entered by coders at health care providers as a result of a licensed physician's diagnosis at the health care providers involved in this case. Procedure codes (usually CPT or HCPCS) are used to describe billable medical procedures that are translated into economic value for health care claims. I am relying on the diagnosis and the codes that exist in the documentation and I review the documentation and coding for the way they are used to derive medical costs.

ICD-9 Diagnosis and Procedure Codes for inpatient procedures - Some medical patient records in this case contain ICD-9 diagnosis codes which are used for both inpatient and

outpatient diagnosis, and ICD-9 procedure codes which are used exclusively for inpatient procedures. (ICD-9 stands for the International Classification of Diseases, 9th edition from the World Health Organization[ii], localized for the U.S. market). The U.S. developed its own procedure coding system (ICD-9-CM, Volume 3) for inpatient hospital services in the late 1970's to use with ICD-9-CM, Volumes 1 and 2 for diagnoses. Since 1979, procedures performed in hospitals have been coded for hospital statistics and on hospital claims, using ICD-9-CM, Vol. 3 and the ICD-9 standard is managed under the authority of the NCVHS. NCVHS is authorized under Section 306(k) of the Public Health Service Act, as amended, and codified at Title 42, Chapter 6A, Subchapter II, Part A, § 242k. The Committee is governed by provisions of Public Law 92-463, as amended, (5 U.S.C. App. 2), which sets forth standards for the formation and use of advisory committees. I cross-referenced the numeric references to codes found in documents provided by counsel and compared them with corresponding descriptive references to confirm descriptions of a medical procedure performed in the inpatient setting and the cost of those procedures locally and nationally, the coverage determinations and reimbursement rates under the patient's health plan, and Medicare reimbursement rates. The ICD-9 diagnosis code(s) and correlated ICD-9 procedure codes are examined for reasonableness and peer-reviewed by an AHIMA[iii] certified coder under my direction and control.

[ii] The World Health Organization (WHO) is the authoritative body that directs and coordinates international health within the United Nations' system. The World Health Assembly is the supreme decision-making body for WHO. WHO generally meets in Geneva in May each year, and is attended by delegations from all 194 Member States including the United States. Source: http://www.who.int/governance/en/

[iii] AHIMA – The American Health Information Management Association is an accepted standards education and certification organization for medical coder certification, especially for inpatient coding.

Current Procedural Terminology ("CPT") codes for outpatient procedures and professional fees charged by physicians - Some outpatient medical patient records in this case contain CPT procedure codes, (Current Procedural Terminology or CPT®[iv] codes and descriptions). The ICD-9 (see below) diagnosis code(s) correlated with the CPT-4 procedure codes are examined for reasonableness and peer-reviewed by an AAPC[41] certified coder under my direction and control.

Outpatient Prospective Payment System (OPPS), Medicare GAF

Some types of procedures are adjusted geographically for local markets using U.S. Office of Management and Budget (OMB) statistical data adjusted annually for wage indices using Medicare Geographic Adjustment Factors (MGAF). In 2007, payment for the technical component (TC) portion of a radiology service was limited to the lesser of the Medicare Physician Fee Schedule (MPFS) amount or the Outpatient Prospective Payment System (OPPS) amount. Effective January 1, 2012, CMS applied a 25 percent payment reduction for the professional component (PC) of second and subsequent imaging services furnished by the same provider including physicians in a group practice to the same patient in the same session on the same day. The basis for MPFS in determining the value of work is 42 CFR Parts 405, 410, 411, 414, 423, and 425.

Professional Components, Technical Components, Relative Value Units

Where applicable for imaging services, charges are split into technical and professional components (the TC and PC), each separately billable[42].

A relative value is a numeric ranking assigned to a procedure relating it to other procedures in terms of the time, work and costs associated with the procedure. The Medicare relative value units are based on the Resource Based Relative Value Scale (RBRVS) update and published yearly by CMS. The total value is the sum of three components: a work value, a

[iv] CPT is a registered trademark of the American Medical Association (AMA)

practice expense (PE) value, and a malpractice (MP) expense value. The PE value has been further subdivided into a facility value and a non-facility value. The basis for RVUs in determining the value of work is 42 CFR Parts 405, 410, 411, 414, 423, and 425.

The RVU ratio between TC and PC can vary by type of diagnostic image, and the ratios are published by the Centers for Medicare and Medicaid.

The PC is indicated in claims using a "Modifier 26." Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number or CPT code[43].

Inpatient Prospective Payment System (IPPS), DRGs

For inpatient procedures, or for outpatient (ambulatory or physician professional fee) procedures performed within a three days window prior[44] to an inpatient procedure that must be bundled into episodic inpatient procedures, Section 1886(d) of the Social Security Act sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. This payment system is referred to as the inpatient prospective payment system (IPPS) or shortened to the Prospective Payment System (PPS) and uses DRGs. The Act provides the following in Section D to establish the DRG standard:

> *"Computing DRG-specific rates for hospitals. —For each discharge classified within a diagnosis-related group, the Secretary shall establish for the fiscal year a national DRG prospective payment rate and shall establish a regional DRG prospective payment rate for each region which is equal—*
>
> *(i) for fiscal years before fiscal year 2004, for hospitals located in a large urban area in the United States or that region (respectively), to the product of—*

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C)) for the fiscal year for hospitals located in such a large urban area in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group;

(ii) for fiscal years before fiscal year 2004, for hospitals located in other areas in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C)) for the fiscal year for hospitals located in other areas in the United States or that region, and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group; and

(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group."

Therefore, under the IPPS, each inpatient case is categorized into a DRG. Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. The base payment rate is divided into a labor-related and non-labor share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located, and if the hospital is located in Alaska or Hawaii, the non-labor share is adjusted by a cost of living adjustment factor. This base payment rate is multiplied by the DRG relative weight[45]. If the hospital treats a high-percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on, known as the

disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payment for hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculation.

DRGs can be derived by using the diagnosis and procedures for the patient to arrive at a finite, maximum amount that a hospital is eligible to be reimbursed for a group of episodic inpatient procedures. To determine which DRG applies to a patient, one needs the diagnosis codes, which are determined based on a physician's diagnosis, and entered as a code by a physician or a medical coder, and the medical procedure codes, which are also entered by the physician or a medical coder.

The IPPS system of DRGs uses a flat fee according to diagnosis related groups within one of about 600 DRGs. A DRG is adjusted for outliers (extraordinarily complex cases with exceptionally high costs) and "disproportionate share" adjustments made for hospitals that serve a larger than usual portion of indigent patients. DRG weights are recalculated to account for changes in technology, practice patterns, and other trends. Congress typically adjusts the monetary conversion factor for each year. From time to time, the Medicare Payment Advisory Commission (MEDPAC) proposes technical changes in the definition of DRGs and in payment and adjustment details. Private insurers typically use Medicare's list of DRGs[46].

Authoritative Economic, Scientific and Standards Organizations for CPT, ICD, DRGs

Current Procedural Terminology or CPT Codes for Outpatient Procedures

Current Procedural Terminology or CPT® codes and descriptions, are copyrights of the American Medical Association Current Procedural Terminology (CPT®), Fourth Edition, is a standardized listing of descriptive terms and identifying codes for reporting medical services and procedures. The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby serves as an effective means for reliable

nationwide communication among physicians and other healthcare providers, patients, and third parties[47].

CPT was first developed by the AMA in 1966 and is used for the billing of physician services and non-inpatient medical procedures in the U.S. The current version, CPT-4 is maintained by the AMA and is an accepted standard by the National Committee on Vital Statistics or NCVHS[48]. NCVHS is authorized under Section 306(k) of the Public Health Service Act, as amended, and codified at Title 42, Chapter 6A, Subchapter II, Part A, § 242k. The Committee is governed by provisions of Public Law 92-463, as amended, (5 U.S.C. App. 2), which sets forth standards for the formation and use of advisory committees. I cross-referenced the numeric references to codes found in documents provided by counsel and compared them with corresponding AMA references to confirm descriptions of a medical procedure performed in the outpatient setting and the cost of those procedures locally and nationally, the coverage determinations and reimbursement rates under the patient's health plan, and Medicare reimbursement rates.

The CPT Editorial Panel is tasked with ensuring that CPT codes remain up to date and reflect the latest medical care provided to patients. In order to do this, the Panel maintains an open process and convenes meetings three times per year to solicit the direct input of practicing physicians, medical device manufacturers, developers of the latest diagnostic tests, and advisors from over 100 societies representing physicians and other qualified healthcare professionals.

International Classification of Diseases (ICD) for all diagnoses and inpatient procedures

The World Health Organization (WHO) establishes and maintains the standards for the International Classification of Diseases, version 9 and version 10. WHO performed an independent study to establish whether DRGs are a standard in developed countries to determine if their use should be applied in all hospital payment scenarios in all countries, citing additional research from the World Bank and other researchers on patient classification systems. According to WHO, "Payment systems based on diagnosis-related groups (DRGs) are one type of hospital payment mechanisms, along with capitation payments, global budgets and a

combination thereof. Although DRG-based payment systems are mainly understood as a reimbursement mechanism, their original purpose was to enable performance comparisons across hospitals"[49 50 51 52]. WHO continues, "Today DRGs are used primarily by purchasers to reimburse providers for acute inpatient care, but in principle they can also be used to reimburse them for non-acute inpatient care. By definition, DRGs classify cases according to the following variables: principal and secondary diagnoses, patient age and sex, the presence of co-morbidities and complications and the procedures performed. Cases classified as belonging to a particular DRG are characterized by a homogenous resource consumption pattern and, at the same time, DRGs are clinically meaningful. Thus, cases within the same DRG are economically and medically similar[53]."

Diagnosis Related Groupings (DRGs) for Inpatient Facility Charges Where Relevant

DRGs are based on codes. The following elements are taken into consideration when grouping a DRG:

1. ICD-9-CM diagnosis codes[54]
2. ICD-9 procedure codes[v] used for inpatient hospital procedures
3. Discharge disposition as defined by CDC medical vocabularies[55]
4. Patient gender
5. Patient age

6. Code sequencing which may include a principal diagnosis[56] and secondary diagnosis as set forth in the Coding definitions as defined by the Uniform Hospital Discharge Data Set (UHDDS)

The economic value of a DRG is determined by entering the diagnosis codes, procedure codes, discharge disposition, gender, age and principal diagnosis as well as any other diagnosis in a software system called an *encoder*. Title 42: Public Health Part 412—Prospective Payment Systems for Inpatient Hospital Services, defines encoding as follows:

> "*Encode* means entering data items into the fields of the computerized patient assessment software program."

Several vendors provide encoders. Leading companies include Optum[57] and 3M[58]. In performing these calculations, the 3M encoder or the Optum encoder are used[59]. The encoder in turn uses a DRG grouper determined by CMS[60]. When creating a DRG, the patient's case is classified into one of the 25 major diagnostic categories (MDC) and assigns them to one of 499 DRGs[61]. Most of the MDCs are based on the body system involved and disease types. For example, MDC 1 involves diseases and disorders of the nervous system and MDC 2 involves diseases and disorders of the eye. A few MDCs involve more than one organ system. For example, MDC 22 is the classification for burns and involves more than one organ system, such as the respiratory and circulatory systems. MDCs are based on the coding sequence (principal (first) diagnosis and, with a few exceptions, are based on body systems, such as the female reproductive system). Once a case has been assigned into an MDC (with the exception of the transplant pre-MDCs), it is determined to be either medical or surgical.

All inpatient services are included in the DRG, including any surgically implanted devices, diagnostic imaging (including but not limited to medical supplies, anesthesia, operating room time, recovery room time, Magnetic Resonance Imaging (MRI), CT Scans, PET Scans or other diagnostic images). Devices and diagnostic imaging are not charged separately using the DRG method; they are considered a component of a lump sum for bundled services. Therefore, DRG payments are advantageous to health care consumers, because they are a complete flat fee charge

with no separate charges for procedures, test, supplies, etc. If procedures were performed during a hospitalization, or up to a window of three days prior[vi] in a facility owned by the hospital, they would be included in the billing and DRG and not charged separately. This tends to significantly reduce the cost of care performed by facilities immediately before admitting a patient.

Medical Policy and Coverage Determinations from the Payor

I may consider Medical Policies and guidelines of payors applicable in the geography where medical procedures are rendered may provide claims payment determination for procedures identified by CPT, HCPCS and ICD-9[vii], ICD-10 CM or ICD-10 PCS coding. Reimbursement guidelines are developed by clinical staff that work with payors and include yearly coding updates, periodic reviews of specialty areas based on input from specialty societies and physician committees and updated logic based on current coding conventions.

I may consider when applicable the benefits and eligibility provided under contract with payors in the geography where medical procedures are rendered and may provide reimbursement guidelines that I consider if noted in the **FACTS** section.

I may consider when applicable the benefits that may be determined by any relevant group contract or the applicable subscriber certificate that is in effect at the time medical services are rendered if noted in the **FACTS** section.

[vi] The Three-Day Payment Window ***requires the bundling*** [italics, bold and underlined added for emphasis] along with payment for inpatient services of certain preadmission services provided to a Medicare beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital, within three days prior to and including the date of the beneficiary's admission. See 42 CFR 412.2(c)(5). § 412.2 "Basis of payment" provides that "...hospitals are paid a predetermined amount per discharge for inpatient hospital services..." While these standards were originally intended for Medicare and Medicaid, "Basis of Payment" and other rules require private insurance companies to use the same methods, and they have been adopted by the entire industry since Social Security Amendments (Public Law 98-21 approved April 20, 1983[vii]).

[vii] ICD-9 coding standard in effect until October 1, 2015 and replaced by ICD-10

I review, when applicable and noted in the **FACTS** section opinions of clinical and medical professionals that may be provided by counsel if they apply to whether procedures are medically necessary, which may have bearing on the cost of care in URC opinions.

Out of network "non par" payments are made by payors to providers who are not in the payor's contracted provider network. These providers' payments may be subject to delays. Furthermore, out of network payments may be subject to higher special investigation unit (SIU) examinations.

Therefore, as a solution to delayed payments, some Providers are willing to accept reimbursement via a discount settlement network by signing an agreement in perpetuity that they will accept a lower reimbursement for all future procedures of the same type (usually described by CPT code or ICD-9 or ICD-10 code) when the claim is submitted for a specific payor in lieu of delays for pended claims. Only claims that are adjudicated by the payor and meet the initial policy plan design are forwarded for discount settlement so the payor is ensured that the procedure meets initial UM, COB, Case Management and medical necessity review.

So called "out of network" discount settlement payments provide data points to help determine what the free market value of a procedure are because the provider has a choice to wait or accept reimbursement quickly at a discount.

Exhibit C – Test Results

MDC workers earning $7.25 per hour qualify before and after Medicaid Expansion, except possibly for a single person in a household of one member at a higher income scenario. If there are 2 or more in the household, a pregnant mother, or other factors, Medicaid ("Nevada Access") as well as Medicaid Waivers and Children's Health Insurance Programs mitigate the employee's cost of healthcare. This leads to the conclusion that MDC's health insurance coverage would not necessarily be needed from 2010 to 2013 and would be replaced for this cohort of workers from 2014 forward under the ACA.

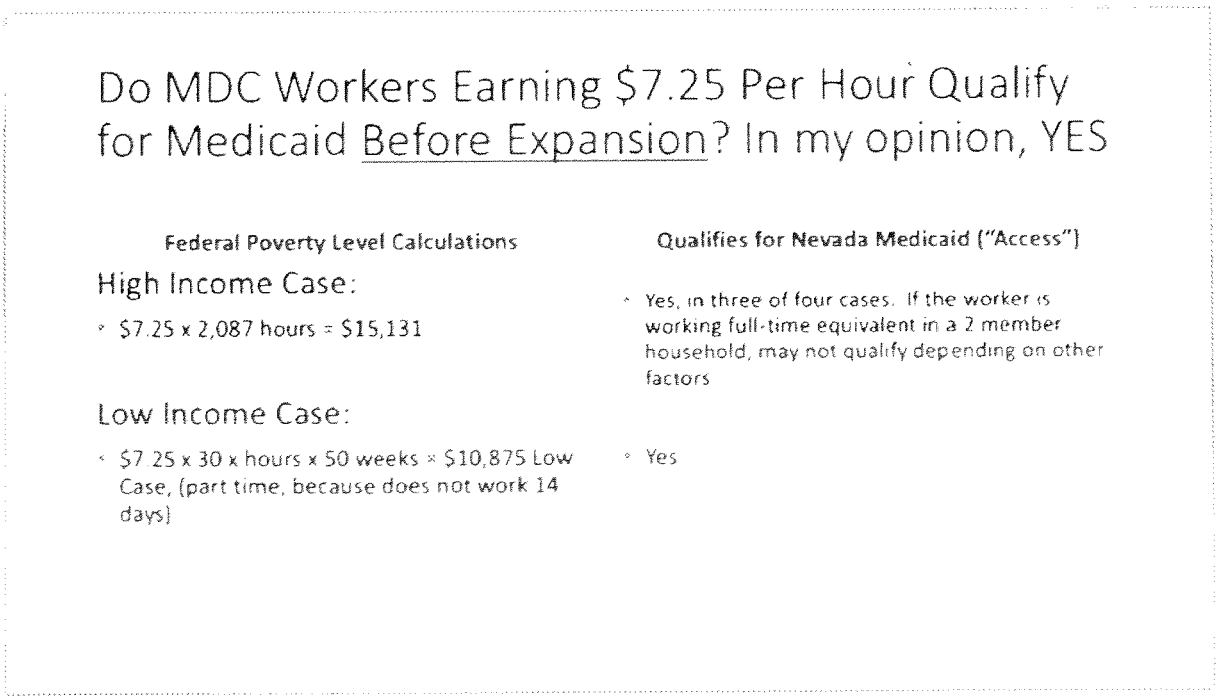


Figure 9 – MDC workers earning $7.25 per hour before Medicaid expansion, two income scenarios, two eligibility outcomes

Do MDC Workers Earning $7.25 Per Hour Qualify for Medicaid After Expansion? In my opinion, YES

Federal Poverty Level Calculations	Qualifies for Nevada Medicaid ("Access")
High Income Case: • $7.25 x 2,087 hours = $15,131	• Yes
Low Income Case: • $7.25 x 30 x hours x 50 weeks = $10,875 Low Case, (part time, because does not work 14 days)	• Yes

Figure 10 - MDC workers earning $7.25 after Medicaid Expansion qualify for Medicaid in all scenarios

METHODS	Qualifies for Medicaid? Lower Income @$7.25 / hour (see assumptions and explanations)	Higher Income @$7.25 / hour (see assumptions and explanations)
I. BEFORE MEDICAID EXPANSION MAN OR WOMAN WITH DEPENDENT, 2 IN	Yes	Possibly Not
II. BEFORE MEDICAID EXPANSION WOMAN WITH DEPENDENT, 2 IN	Yes	Yes
III. BEFORE MEDICAID EXPANSION MAN OR WOMAN WITH DEPENDENT, 3 IN	Yes	Yes
IV. MEDICAID EXPANSION, 1 IN HDUSEHOLD (MORE IN HOUSEHOLD WOULD INCREASE MEDICAID ELIGIBLITY)	Yes	Yes

Figure 11 - Table of Outcomes: two income scenarios, four demographic scenarios for health insurance coverage

Evaluation of Multiple Time Periods, Plans

As noted in the Methodology section, Exhibit B – there are two important time periods and three different plans that I considered. The first period is 2010 to 2013, the second is 2014 and beyond. The three health plans considered are Starbridge, Trans Choice, and MVP. I considered these plans in light of the Medicaid qualifications noted in the prior sections, and the fact that each of the list various medical coverage determination policies ("benefits") provided for premiums collected and

concluded that since a) MDC employees at $7.25 per hour more likely than not would qualify for Medicaid and b) the benefits provided in Starbridge, Trans Choice, and MVP are not inconsistent with industry best practices, guidelines and statutes that all three are "health insurance coverage."

Exhibit D – Table of Figures

Exhibit E – Materials Reviewed

Materials Provided by Counsel

a) Amici Curiae's Brief in Support of Petition for Write of Mandamus or Prohibition filed August 24, 2015
b) Declaration of Matthew T. Milone dated August 24, 2015
c) Expert report of Matthew T. Milone dated October 12, 2015
d) Plaintiff's motion for partial summary judgment on liability regarding defendant's regarding defendant's health benefits plans filed August 25, 2015, including within the document:
   - Starbridge Health Insurance Coverage
   - Trans Choice Health Insurance Coverage
   - MVP Health Insurance Coverage
e) Defendant's 2010-2015 health insurance plans,
f) Defendants Opposition to Plaintiff's MPSJ
g) Plaintiff's Reply in support of MPSJ
h) Amended Class Action Complaint, filed June 5, 2014
i) "Discussion of the Impacts of the New Minimum Wage Law" – Senate Commerce and Labor Committee, February 8, 2007

Documents Independently Accessed

Information considered includes but is not limited to:

a) U.S. Centers for Medicare and Medicaid (CMS) department of Health and Human Services CHIP Program Information, FPL and MAGI calculations for eligibility
b) Medicaid.gov Basic Health Program (BHP), Section 1331 of the Affordable Care Act, federal poverty level (FPL) guidelines.
c) Nevada Department of Health and Human Services Medicaid Eligibility, Nevada Medicaid, Check Up, and the high risk pool alternative
d) Nevada Health Link Federal Poverty Level(s), https://www.nevadahealthlink.com/glossary/federal-poverty-level/
e) Nevada Health Link, https://www.nevadahealthlink.com/individuals-

families/medicaidnevada-check-up/

f) Nevada Department of Health and Human Services Division of Health Care Financing and Policy, A Minimum Wage Guide for Employers, The Business Advocate, a publication of The Nevada Department of Business and Industry https://www.leg.state.nv.us/Division/Research/Publications/PandPReport/23-HCHI.pdf

g) Standard annual work hours are equal to 2,087 according to the U.S. Office of Personnel Management and A General Accounting Office study published in 1981 demonstrated that over a 28-year period (the period of time it takes for the calendar to repeat itself) there are, on average, 2,087 work hours per calendar year. The Omnibus Budget Reconciliation Act of 1982 (Public Law 97-253, Sept. 8, 1982) temporarily changed the divisor for computing the hourly rate from 2,080 work hours to 2,087 work hours in fiscal years 1984 and 1985. The Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, April 7, 1986) made this change permanent by amending 5 U.S.C. 5504(b).

h) U.S. HHS. Centers for Medicare and Medicaid, Nevada Medicaid Waiver programs, Medicaid.gov (https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nv/nv-comprehensive-care-waiver-fs.pdf)

i) Average annual costs for adults with incomes between 138 and 200 percent FPL: BHP vs. subsidized coverage in the exchange, by state http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412412-Using-the-Basic-Health-Program-to-Make-Coverage-More-Affordable-to-Low-Income-Households-A-Promising-Approach-for-Many-States.PDF

j) U.S. HHS. Centers for Medicare and Medicaid, NV Medicaid Waiver programs, Medicaid.gov NV HCBW for Persons w/Physical Disabilities (4150.R05.00) https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/Waiver-Descript-Factsheet/NV-Waiver-Factsheet.html#NV0125

k) U.S. HHS. Centers for Medicare and Medicaid, Nevada Medicaid Waiver programs, Medicaid.gov NV HCBW for Persons w/ID and Related Conditions (0125.R06.00) https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/Waiver-Descript-Factsheet/NV-Waiver-Factsheet.html#NV0125

l) Nevada Health Link, https://www.nevadahealthlink.com/individuals-families/medicaidnevada-check-up/

m) District court issues stay of decision affecting enforcement of Nevada Minimum Wage Provisions, Carson City, NV - October 16, 2015 http://business.nv.gov/News_Media/Press_Releases/2015/Labor/District_Court_issues_stay_of_decision_affecting_enforcement_of_Nevada_minimum_wage_provisions/

n) U.S. HHS. Centers for Medicare and Medicaid, Nevada Medicaid Waiver programs, Medicaid.gov (https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nv/nv-comprehensive-care-waiver-fs.pdf)

o) Nevada Health Link, https://www.nevadahealthlink.com/individuals-families/medicaidnevada-check-up/

p) U.S. HHS Reports and Kaiser Family Foundation of DSH payments http://kff.org/medicaid/state-indicator/federal-dsh-allotments/

q) Nevada §1915(i) Home and Community Based Services (HCBS) State Plan Services http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/LTC/Section3-1AttachmentG.pdf

r) Letter from Cigna to MDC stating that the insurance provided meets the requirements for the Nevada Minimum Wage law.

s) Minimum Essential Coverage, Healthcare.gov, U.S. Department of Health and Human Services

t) THOMAS et al v. NEVADA YELLOW CAB CORPORATION et al 130 Nev. Adv. Op. 52 (2014)

u) Department of Labor's Advisory Opinions, including AO 94-26A (July 11, 1994), AO 94-22A (July 1, 1994), AO 90-08A (April 11, 1990), and AO 83- 03A (January 17, 1983) and regulations in 29 C.F.R. 2510.3-1(j). (Arrigo note: has no specific guidelines on what medical services should be covered)

v) Hotel Employees & Rest. Employees Int'l Union, AFL-CIO v. State ex rel. Nevada Gaming Control Bd., 103 Nev. 588,591, 747 P.2d 878, 880 (1987); http://law.justia.com/cases/nevada/supreme-court/1987/17168-1.html (Arrigo note: has nothing to do with health insurance)

Citations

[i] What counts as Minimum Essential Coverage? "… Medicaid Coverage, CHIP...." U.S. Internal Revenue Service (IRS) https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision

[ii] Washington Council Ernst & Young Presentation February 2013 http://www.nahu.org/meetings/capitol/2013/attendees/jumpdrive/employer_aca_reference_deck_02_14_2013.pdf

[iii] Kaiser Family Foundation "… firms will not face a penalty for workers who qualify for Medicaid …"http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/

[iv] Elizabeth M. Patchias and Judy Waxman, National Women's Law Center and The Commonwealth Fund, Women and Health Coverage: The Affordability Gap (Apr. 2007), http://www.nwlc.org/pdf/NWLCCommonwealthHealthInsuranceIssueBrief2007.pdf.

[v] Economic Research Service of the USDA, Rural Labor and Education: Nonmetro Earnings and Low-Wage Workers (Jan. 2007), http://www.ers.usda.gov/Briefing/LaborAndEducation/earnings.htm#top.

[vi] Source: National Women's Law Center calculations based on health insurance data for women and men ages 18-64 from the Current Population Survey's 2008 Annual Social and Economic Supplement, using CPS Table Creator, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

[vii] Source: Kaiser Family Foundation, Women's Health Insurance Coverage (Oct. 2009), http://www.kff.org/womenshealth/upload/6000-08.pdf

[viii] Kaiser Family Foundation, Health Insurance Coverage of Women Ages 18-64, by State, 2007-2008 (Oct. 2009), http://www.kff.org/womenshealth/upload/1613-09.pdf

[ix] Source: Tanchek, Michael, former Nevada State Labor Commissioner "Discussion of the Impacts of the New Minimum Wage Law Senate Commerce and Labor Committee February 8, 2007 page 8 of 17.

[x] Source: Nevada Labor Commissioner, www.laborcommissioner.com Employer FAQs

[xi] Source: Source: Department of Labor's Advisory Opinions, including AO 94-26A (July 11, 1994) http://www.dol.gov/ebsa/programs/ori/advisory94/94-26a.htm

[xii] Source: Internal Revenue Service, Minimum Value and Affordability, updated March 3, 2016 https://www.irs.gov/Affordable-Care-Act/Employers/Minimum-Value-and-Affordability

[xiii] Source: 45 CFR Parts 144, 146, 147, et al. Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Final Rule May 27, 2014 published in the Federal Register/Vol. 79, No. 101/Tuesday, May 27, 2014/Rules and Regulations https://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf, accessed March 8, 2016.

[xiv] Source: Program Memorandum Insurance Commissioners Insurance Issuers Transmittal No. 99-02, Date June 1999 https://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/downloads/HIPAA-99-02.pdf

[xv] Source: CMS.gov, Glossary of Health Coverage and Medical Terms https://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf accessed March 5, 2016.

[xvi] Source: CMS.gov, Glossary of Health Coverage and Medical Terms https://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf accessed March 5, 2016.

[xvii] Medicaid & Nevada Check Up – Nevada Health Link can help you determine if you or your family members qualify for government supplied healthcare Source: https://www.nevadahealthlink.com/individuals-families/medicaidnevada-check-up/

[xviii] Source: Nevada Department of Welfare Services BACKGROUND & EXPLANATION of policy changes/clarifications/updates For November 1, 2015https://dwss.nv.gov/pdf/EP_MTL-2015-11.pdf accessed March 9, 2016

[xix] Definitions in the ACA regarding '*Health Insurance Coverage*' refer to 45 CFR 144.103.[xix] 45 CFR Subtitle A, Subchapter B - REQUIREMENTS RELATING TO HEALTH CARE ACCESS, Part 144 – Requirements Relating to Health Insurance Coverage, Definitions ([62 FR 16955, Apr. 8, 1997, as amended at 63 FR 57558, Oct. 27, 1998; 64 FR 45795, Aug. 20, 1999] 45 CFR 144.103[xix] (amended again in March 12, 2014 and again in 2015)

[xx] 45 CFR Parts 144, 146, 147, *et al.* Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Final Rule includes the same definition of "health insurance coverage" as defined by CFR 144.103 (*See* Federal Register/Vol. 79, No. 101/Tuesday, May 27, 2014/Rules and Regulations, 30246)

[21] Source: U.S. HHS Reports and Kaiser Family Foundation of DSH payments http://kff.org/medicaid/state-indicator/federal-dsh-allotments/

[22] Nevada §1915(i) Home and Community Based Services (HCBS) State Plan Services http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/LTC/Section3-1AttachmentG.pdf

[23] Medicaid & Nevada Check Up – Nevada Health Link can help you determine if you or your family members qualify for government supplied healthcare Source: https://www.nevadahealthlink.com/individuals-families/medicaidnevada-check-up/

[24] Source: Nevada Department of Welfare and Supportive Services https://dwss.nv.gov

[25] Healthinsurance.org contact the Nevada Division of Welfare and Supportive Services at 1-800-992-0900 if you have questions (they make Medicaid eligibility determinations). Contact with operator "Elizabeth" March 8, 2016 at 12:38pm Pacific Standard Time.

[26] Medicaid & Nevada Check Up – Nevada Health Link can help you determine if you or your family members qualify for government supplied healthcare Source: https://www.nevadahealthlink.com/individuals-families/medicaidnevada-check-up/

[27] Medicaid & Nevada Check Up – Nevada Health Link can help you determine if you or your family members qualify for government supplied healthcare Source: https://www.nevadahealthlink.com/individuals-families/medicaidnevada-check-up/

[28] Source: Nevada Check Up, Authorized under Title XXI of the Social Security Act, Nevada Check Up (NCU) is the State of Nevada's Children's Health Insurance Program (CHIP) http://www.nevadacheckup.nv.gov

[29] Source: Metal Plan Levels in the Health Insurance Marketplace http://www.cigna.com/individuals-families/understanding-health-care-reform-metal-levels Cigna.

[30] 3 things to know before you pick a health insurance plan Healthcare.gov https://www.healthcare.gov/choose-a-plan/comparing-plans/

[31] If an employee receives a premium tax credit under the Affordable Care Act, then the employer's 'shared responsibility' penalty is in theory triggered. A tax is "hereby imposed" when the employee properly receives a credit under Section 36B. See also, e.g., Dep't of

Treasury, Shared Responsibility for Employers Regarding Health Coverage, 78 F.R. 218, 220 (Jan. 2, 2013) (explaining relationship between Sections 4980H(b) and section 36B).

[32] Grewal, Andy, Associate Professor of Law University of Iowa - College of Law The IRS Rewrites the ACA Shared Responsibility Tax Published in the Yale Journal on Regulation http://www.yalejreg.com/blog/the-irs-rewrites-the-aca-shared-responsibility-tax-by-andy-grewal

[33] Section 4980H(b) shared responsibility tax for employers which requires them to pay a penalty under certain circumstances.

[34] Treas. Reg. 54.4980H-5(e) essentially allows large employers to avoid their shared responsibility obligations when they take reasonable efforts to offer affordable health coverage. The regulation states that relief "applies even if the applicable large employer member's offer of coverage . . . is not affordable for a particular employee under section 36B(c)(2)(C)(i) and an applicable premium tax credit or cost-sharing reduction is allowed." Treas. Reg. 54.4980H-5(e)(2). Employers can also challenge the Section 4980H(b) tax when employee credits are improperly allowed, see Section 4980H(d)(3) and ACA Section 1411(f)(2)(A) (authorizing establishment of appeal procedures), but the IRS regulation eliminates the employer tax even though the statutory criteria are squarely satisfied and the employee is unambiguously entitled to a credit.

[35] Rev. Rul. 69-545, 1969-2 C.B. 117. https://www.irs.gov/pub/irs-tege/rr69-545.pdf

[36] Tanchek, Michael State Labor Commissioner "Discussion of the Impacts of the New Minimum Wage Law Senate Commerce and Labor Committee February 8, 2007 page 8 of 17.

[37] Source: Kaiser Family Foundation, "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update"

[38] Source: http://gov.nv.gov/News-and-Media/Press/2012/Governor-Sandoval-Statement-on-Medicaid-Expansion/

[39] Source: https://www.healthinsurance.org/nevada-medicaid/

[40] Source: http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Resources/NVHealthBrochure_final.pdf

[41] AAPC (American Academy of Professional Coders) is an accepted standards education and certification organization for medical coder certification, especially for outpatient coding.

[42] Source: CMS, coverage of imaging services. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Radiology_FactSheet_ICN907164.pdf accessed August 10, 2015

[43] Medicare Claims Processing Manual Chapter 23 -Fee Schedule Administration and Coding Requirements

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

The Three-Day Payment Window ***requires the bundling*** [italics, bold and underlined added for emphasis] along with payment for inpatient services of certain preadmission services provided to a Medicare beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital, within three days prior to and including the date of the beneficiary's admission. See 42 CFR 412.2(c)(5). § 412.2 "Basis of payment" provides that "...hospitals are paid a predetermined amount per discharge for inpatient hospital services..." While these standards were originally intended for Medicare and Medicaid, "Basis of Payment" and other rules require private insurance companies to use the same methods, and they have been adopted by the entire industry since Social Security Amendments (Public Law 98-21 approved April 20, 1983[44]).

[45] Wage-adjusted DRG operating payment is the applicable average standardized amount adjusted for resource utilization by the applicable MS-DRG relative weight and adjusted for

differences in geographic costs by the applicable area wage index (and by the applicable cost-of-living adjustment for hospitals located in Alaska and Hawaii). This amount includes an applicable payment adjustment for transfers under CFR 42 §412.4(f).

[46] Bartlette, L. A. and I. F. Lawson (2008). Health care policies. New York, Nova Science Publishers.

[47] American Medical Association http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt.page? Accessed November 15, 2015

[48] Source: http://www.ncvhs.hhs.gov/meeting-calendar/agenda-of-the-december-9-10-2003-ncvhs-subcommittee-on-standards-and-security-hearing/consolidated-health-informatics-initiative-final-recommendation-information-sheet-billingfinancial-for-the-december-9-2003-ncvhs-subcommittee-on-standards-and-security-hearing/ accessed May 28, 2015

[49] Bulletin of The World Health Organization, Inke Mathauer & Friedrich Wittenbecher (Submitted: 29 November 2012 – Revised version received: 03 June 2013 – Accepted: 06 June 2013 – Published online: 06 August 2013.) http://www.who.int/bulletin/volumes/91/10/12-115931/en/ accessed June 2, 2015.

[50] Park M, Braun T, Carrin G, Evans DB. Provider payments and cost-containment lessons from OECD countries. Geneva: World Health Organization; 2007.

[51] Kobel C, Thuilliez J, Bellanger M, Pfeiffer K-P. DRG systems and similar patient classification systems in Europe. In: Busse R, Geissler A, Quentin W, Wiley M, editors. Diagnosis-related groups in Europe: moving towards transparency, efficiency and quality in hospitals. Maidenhead: Open University Press; 2011. p. 371. p

[52] Langenbrunner JC, Cashin C, OC, On C, O S, editors. Designing and implementing provider payment systems: how to manuals. Washington: The World Bank; 2009.

[53] Ibid

[54] According to the U.S Department of Health and Human Services (HHS) Centers for Disease Control (CDC) National Center for Health Statistics (NCHS), International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9 CM) has been used for coding National Hospital Discharge Survey (NHDS) data since 1979. Conducted annually by the NCHS, the Survey is a principal source of information on inpatient hospital utilization in the United States. The classification system undergoes annual updating, which involves the assignment of new diagnostic and procedure codes, fourth or fifth digit expansion of existing codes, as well as code deletions. Changes are contained in addenda developed by the ICD-9-CM Coordination and Maintenance Committee and approved by the Director of NCHS and the Administrator of the Centers for Medicare and Medicaid Services (formerly HCFA). Addenda to the ICD-9-CM become effective on October 1 of the calendar year and have been released for 1986 through 2009, except for 1999 when there was no addendum due to concerns about possible complications for instituting coding changes prior to the millennium crossover." Source: U.S Department of Health and Human Services Centers for Disease Control and Prevention National Center for Health Statistics, Ambulatory and Hospital Care Statistics, Branch 3311 Toledo Road Hyattsville, MD 20782 http://www.cdc.gov/nchs/nhds.htm Published March 2011, accessed May 12, 2015.

[55] The disposition of the patient at time of discharge (i.e., discharged to home, transferred to another facility [type of facility is required] expired, etc.). Source: US Centers for Disease Control, CDC web site, Vocabulary Access Distribution System (VADS) Discharge Disposition data, https://phinvads.cdc.gov/vads/ViewValueSet.action?id=29D34BBC-617F-DD11-B38D-00188B398520 accessed May 2015.

[56] The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care". According to CMS, "As with all codes, clinical evidence should be present in the medical record to support code assignment. The Uniform Hospital Discharge Data Set (UHDDS) Guidelines for coding and reporting secondary diagnosis allow the reporting of any condition that is clinically evaluated, diagnostically tested for, therapeutically

treated, or increases nursing care or the length of stay of the patient. Principal diagnosis is defined in the UHDDS as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital. When determining the principal diagnosis, all documentation by licensed, treating physicians in the medical record must be considered. Source: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1121.pdf page 3, accessed May 2015.

[57] Optum is owned by United Healthcare, one of the largest insurance firms in the U.S.

[58] 3M acquired the company that invented the DRG originally at Yale. 3M license its algorithms and data to the U.S. HHS Centers for Medicare and Medicaid to calculate DRGs for all Medicare beneficiaries.

[59] Basis for this information: I served as an expert witness in litigation before the U.S. Federal Trade Commission regarding ICD-10 coding and the use of encoders. This information was provided by respective vendors who were parties to the litigation.

[60] The Grouper Contractor, 3M Health Information Systems (3M-HIS), develops and maintains the DRG Grouper, software package effective for discharges on or after the date of a Grouper release year. The Medicare Code Editor (MCE) selects the proper internal code edit tables based on discharge date. Source: CMS, publication, Inpatient Prospective Payment System (IPPS) Change Request update document http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8900.pdf accessed May 2015.

[61] Source: Medicare Hospital Prospective Payment System – How DRG Rats are Calculated and Updated, Office of Inspector General, Office of Evaluation and Inspections (August 2001), and 65 CFR 47025, 47057 (Aug. 1, 2000).

Re: Paulette Diaz, Lawanda Gail Wilbanks, Shannon Olsynski; and Charity Fitzlaff on behalf on themselves and all similarly-situation individuals, Plaintiffs, vs. MDC Restaurants, LLC; Laguna Restaurants, LLC; Inka, LLC; and DOES 1 through 100, inclusive, Defendants. (Hereinafter Diaz v. MDC)

Expert Rebuttal of Milone Report

Michael F. Arrigo

March 14, 2016

(addendum to Expert Rebuttal Dated March 14, 2016)

Topics

- Rebuttal to Milone Report regarding industry best practices, guidelines, HIPAA, ACA
- Rebuttal to conclusions in Milone report regarding "health insurance coverage"
- Correct calculations and methods in my opinion regarding "health insurance coverage"
- Test Results
- Conclusions

The Milone Report - Summary

Summary	Rebuttal Report Page
Standards for Determining What is "Health Insurance"	5
Programs for Women	6
Ambiguity of Standards	6
Insurance for Expenses that Would Have Been Borne by Employee Not Addressed	6
Unhelpful Regarding Education or Guidance to Employers on ERISA	7
Federal Government Regulations of State Health Insurance	8
Understated Benefits for MDC Employees	8
Minimum Essential Coverage Standard Applied without Considering All Possible Outcomes	8
Insurer Certification of Compliance with Minimum Wage Act	9
Affordability and Best Efforts to Provide Insurance	10
Flaws in Methodology and Testing	10
Flaws in Methodology and Testing of Milone	10

The Milone Report

- Milone report points to HIPAA (1996) and the Affordable Care Act ("ACA") of 2010 as Standards
  - However:
    - HIPAA applied in 1996 forward
    - Affordable Care Act effective 2014 ignores most important part of the ACA
    - Ignores Medicaid Expansion and assumes employer is subject to penalty
    - Provides no consistent methodology for 2010, 2011, 2012, 2013, and ACA (2014-15)
- Confusing list of other rules, ERISA, Nevada Constitution, etc.

I Considered Facts and Data Not Acknowledged in Milone Report(*): MDC Had Three Plans, Three Time Periods, Two Criteria

(*) facts and data considered include But are not limited to these items.

"?" signifies that in my methodology, I identified three separate cases that needed to be assessed as to 'health insurance coverage."

Plan Name	Using Industry Best Practices, Guidelines and Statutes Applicable by Year for MDC hourly workers earning $7.25		
	2010, 2011, 2012 2013	2014	2015
Cigna Starbridge	?		
Transamerica Trans Choice		?	
MVP			?

In My Opinion, Appropriate Standards for Health Insurance Coverage in Nevada Must be Viewed in Two Separate Periods, Milone Report Only Considers One

A reasonable employer must turn to guidance that is different for two periods in question:

- Industry best practices and guidelines 2010 to 2013
- Industry best practices and guidelines 2014 forward after January 1, 2014 Medicaid Expansion

Two Time Frames, Two Standards

Before January 1, 2014
Nevada Minimum Wage Law

- Must Provide Health Insurance Coverage for Workers earning $7.25 / hr.
- No Specified Level of Coverage "It doesn't say what it means" - Nevada Labor Commissioner

OR

- Pay $8.25 per hour

After January 1, 2014
Medicaid Expansion
Affordable Care Act

- Provide Health Insurance Coverage
- AND Specific Levels of Coverage (Minimum Essential Coverage "MEC")

OR

- No Requirement to Provide Health Insurance Coverage, IF Employee Covered by Medicaid

Nevada Insurance Commissioner Michael Tanchek:

"What is health insurance?

That a very good question. The [minimum wage] amendment doesn't say what it is, just that the employer has to offer it in order to take advantage of the lower rate. As pointed out earlier, there are all sorts of different kinds of health benefits that are available. Think of group health, HMO's, PPO's, self-funded plans, cost reimbursement plans, and the list goes on.

You have to be careful with this question, because it is really easy to get bogged down in the complexity Insurance."

Source: Tanchek, Michael State Labor Commissioner
"Discussion of the Impacts of the New Minimum Wage Law Senate Commerce and Labor Committee
February 8, 2007 page 8 of 17.

OPINION: MDC Provided Reasonable Health Insurance Coverage Based Industry Best Practices, Guidelines and Statutes

In 2010 to 2013, MDC meets "Health Insurance Coverage" standard.

In 2014, MDC is not obligated to insure employees earning below FPL guidelines who would qualify for Medicaid, but did offer insurance through a group plan as an option for workers earning $7.25 / hour.

Plan Name	Using Industry Best Practices, Guidelines and Statutes Applicable by Year for MDC hourly workers earning $7.25		
	2010, 2011, 2012 2013	2014	2015
Cigna Starbridge	MDC Meets Standard as "Health Insurance Coverage"		
Transamerica Trans Choice		MDC Provides Reasonable Insurance; "Minimum Essential Coverage" Does not Apply, Coverage Met Through Medicaid	
MVP			MDC Provides Reasonable Insurance; "Minimum Essential Coverage" Does not Apply, Coverage Met Through Medicaid

[illegible]

What is Health Insurance Coverage?

In my opinion, health insurance is a method of providing reimbursement for healthcare services received, via the functions of a health insurer providing *health insurance coverage* which include:

1. publishing a **medical coverage determination policy** ("**benefits**") for medical care, to prospective employers or individual insureds, and healthcare providers who agree to provide services under the health insurer's benefits plan
2. **enrollment** of those who wish to have these benefits, (thereby becoming 'members' or insureds of a health plan)
3. **collecting premiums** from insured members,
4. **redistributing premium funds** collected to those members with medical claims for healthcare received by providers ("**reimbursement**") by determining :
    a) what claims are in compliance with the **medical policy** (#1 above)
    b) for those claims determined to be medically necessary
    c) and to **pay, pend or deny claims based on these criteria**

Opinion

In my opinion, my definition of "health insurance coverage" is compatible with industry best practices, guidelines and statutes including:

- HIPAA (1996)
- ERISA
- U.S. Dept. HHS (CMS)
- Medicaid Expansion (2014) and the ACA*

Therefore, MDC made reasonable efforts to provide health insurance coverage

* While it is true that the ACA regulates States to provide minimum essential coverage ("MEC") that requirement does not apply if employee is receiving MEC under Medicaid (see references in rebuttal report and these slides elsewhere)

What Does the ACA Require for "health insurance coverage" IF employees do not qualify for Medicaid? *

- These essential health benefits include at least the following items and services (HEALTHCARE.GOV):
- Outpatient care—the kind you get without being admitted to a hospital
- Trips to the emergency room
- Treatment in the hospital for inpatient care
- Care before and after your baby is born
- Mental health and substance use disorder services: This includes behavioral health treatment, counseling, and psychotherapy
- Your prescription drugs
- Services and devices to help you recover if you are injured, or have a disability or chronic condition. This includes physical and occupational therapy, speech-language pathology, psychiatric rehabilitation, and more.
- Your lab tests
- Preventive services including counseling, screenings, and vaccines to keep you healthy and care for managing a chronic disease.
- Pediatric services: This includes dental care and vision care for kids

* However Medicaid Also Covers these Benefits and IS considered "MEC"

PROGRAM MEMORANDUM
INSURANCE COMMISSIONERS
INSURANCE ISSUERS

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. 00-06 **Date** November 2000

Title: Insurance Standards Bulletin Series--INFORMATION

Subject: Circumstances Under Which Health Insurance Regulated As "Individual" Coverage Under State Law Is Subject To The Group Market Requirements Of The Health Insurance Portability And Accountability Act Of 1996 (HIPAA)

0466

III. Discussion of Factors Relevant to Determining Whether Coverage is Offered in Connection With a Group Health Plan.

---

[1] In this Bulletin, unless otherwise indicated, the term "insurance policy" refers to any insurance policy or other contract (including contracts issued by a health maintenance organization) that provides "health insurance coverage" as defined in Section 2791(b)(1) of the PHS Act. "Health insurance coverage" is defined in that section as:

> benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

Of course, to the extent the policy offers an excepted benefit, whether it is in the group or individual market, neither the group market nor the individual market rules under Title XXVII apply to it.

HIPAA Definition of Health Insurance Coverage Applicable 1996 to 2013

"HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means **benefits** consisting of **medical care** (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under **any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer**."

Source: Health Insurance Portability and Accountability and Accountability Act of 1996 ("HIPAA"), "health insurance coverage" as defined in Section 2791(b)(1) of the PHS Act 2791. DEFINITIONS (b) DEFINITIONS RELATING TO HEALTH INSURANCE.— https://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthinsReformforConsume/downloads/HIPAA-00-06.pdf dated November 2000

Department of Labor / ERISA Definition of Health Insurance Coverage ("employee welfare benefit plan")

- Section 3(1) of Title I of ERISA defines the term "employee welfare benefit plan" to include:
- [A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of **providing for its participants or their beneficiaries**, through the purchase of insurance or otherwise, (A) **medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident**, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 [29 USCS section 186(c)] (other than pensions on retirement or death, and insurance to provide such pensions).

Source: Department of Labor's Advisory Opinions, including AO 94-26A (July 11, 1994)
http://www.dol.gov/ebsa/programs/ori/advisory94/94-26a.htm

Affordable Care Act Uses Same Definition of "Health Insurance Coverage"

FEDERAL REGISTER

Vol. 79 Tuesday,
No. 101 May 27, 2014

Part II

Department of Health and Human Services

45 CFR Parts 144, 146, 147, *et al.*
Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Final Rule

Register relating to health care quality in the Exchanges,[6] enrollee experience measures and domains,[7] and the QRS, which provided valuable feedback on quality reporting and quality rating requirements.[8] We considered all of the public input as we developed the policies in this final rule.

C. Structure of Final Rule

The regulations outlined in this final rule will be codified in 45 CFR parts 144, 146, 147, 148, 153, 154, 155, 156, and 158. Part 144 outlines requirements relating to health insurance coverage. limit on cost-sharing for years after 2014; minimum certification standards; standards for recognition of certain types of coverage as minimum essential coverage; quality standards for QHPs; and other QHP issuer responsibilities. Part 158 outlines standards related to the MLR program, including standards related to treatment of ICD–10 conversion costs, standards related to adjustments for issuers affected by the HHS transitional policy and issuers that incurred costs due to the technical issues during the implementation of the Exchanges, and standards related to

discussed nearly all of the proposed policies in the preamble to the HHS Notice of Benefit and Payment Parameters for 2015 final rule published on March 11, 2014 (79 FR 13744).[9] HHS believes that interested stakeholders had adequate opportunity to provide comment on the policies established in this final rule.

A. Part 144—Requirements Relating to Health Insurance Coverage

Definitions of Product and Plan (§ 144.103)

Source: U.S. Government Publishing Office, Affordable Care Act Final Rule Exchange and Insurance Market Standards for 2015 and Beyond
https://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf

Affordable Care Act Final Rule 2015 Definition of *"Health Insurance Coverage"*

Health insurance coverage means benefits consisting of medical care (pro- vided directly, through insurance or re- imbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

COMPARISON OF 'HEALTH INSURANCE COVERAGE' DEFINITIONS

"HIPAA" DEFININTION

2000 MEMORANDUM

"HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer."

Source: https://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthinsReformforConsume/downloads/HIPAA-00-06.pdf

AFFORDABLE CARE ACT DEFINITION

2015 FINAL RULE

Health insurance coverage means bene- fits consisting of medical care (pro- vided directly, through insurance or re- imbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

https://www.gpo.gov/fdsys/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-sec144-103.pdf

Centers for Medicare and Medicaid (CMS)

"A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium."

Where Premium is defined as The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly

- Source: CMS.gov, Glossary of Health Coverage and Medical Terms https://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf accessed March 5, 2016.

Milone Report Omits Centerpiece of ACA

A centerpiece of the Patient Protection and Affordable Care Act—often referred to as "Obamacare"—is the expansion of Medicaid eligibility to people with annual incomes below 138 percent of the federal poverty level.

What is Medicaid?

- State healthcare
- Funding provided by Federal government
- 100% free healthcare with no premiums to qualifying adults in household
- Children can receive care for $8 to $27 per month for all children in the household
- Before 2014, only those earning less than $8,840 could qualify for Medicaid

What is Medicaid Expansion?

2014 to 2016 – Nevada is a Medicaid Expansion State

- Nevada's Governor Brian Sandoval announced in December 2012 that the state would expand Medicaid starting in 2014

- Nevada expanded Medicaid in 2014

Nevada is a Medicaid Expansion State: Relevance Starting in 2014

1. After 2014 in Nevada, works can make from $16,394 for an individual to $48,600 for a family of four and qualify for 100% medical coverage at no cost.
2. If workers qualify for Medicaid, their employer is not required to provide them with insurance.

Before Medicaid Expansion – Individual Coverage