IN THE SUPREME COURT OF THE STATE OF NEVADA

MDC RESTAURANTS, LLC, a Nevada limited liability company; LAGUNA RESTAURANTS LLC, a Nevada limited liability company; and INKA LLC, a Nevada limited liability company,

Petitioners,

vs.

THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA in and for the County of Clark and THE HONORABLE TIMOTHY WILLIAMS, District Judge,

Respondents,

and

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

Real Parties in Interest.

Case No.: 71289

Eighth Judicial District Court
Case No.: A-14-701633-C

REAL PARTIES IN INTEREST'S ANSWER TO PETITION FOR WRIT OF MANDAMUS

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N.R.A.P. 26.1 DISCLOSURE

Pursuant to N.R.A.P. 26.1, the undersigned counsel of record certifies that there are no persons or entities as described in N.R.A.P. 26.1(a) that must be disclosed.

Dated this 30th day of December 2016.

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I. INTRODUCTION

Petitioners' first position, that the district court has no jurisdiction over this action, is defeated by the text of article XV, section 16 of the Nevada Constitution (the "Minimum Wage Amendment" or the "Amendment"). "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 …" Nev. Const. art. XV, § 16(B). If Real Parties in Interest ("Real Parties") have claimed violation of the Amendment here—and they have, by alleging that Petitioners' health benefits plans do not qualify them to pay the sub-minimum wage established by the provision—then the Nevada Constitution gives them the right to sue in district court, period. The private right of action contained in the Minimum Wage Amendment is express and complete, and there are no violations of this constitutional section that are not properly brought in the courts of Nevada. This aspect of the writ petition need not detain us much.

The more important issue presented by the writ petition concerns the appropriate standards for determining what health benefits—what kind of "health insurance," actually—must an employer make available to its employees under the Minimum Wage Amendment in order to qualify to pay those employees below the upper-tier hourly minimum wage rate. The Amendment states that

> 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.

Nev. Const. art. XV, § 16(A) (emphasis supplied). The term "health insurance," as the specific form of "health benefits" that must be made available to employees, has to have some specific, substantial legal meaning.

Although Petitioners' arguments about the Nevada Labor Commissioner having primary jurisdiction in this action are unsuccessful, they contend that the standard set forth in the Commissioner's regulation, N.A.C. 608.102, is what the district court ought to have applied in deciding whether Petitioners' health benefits plans met the mandates of the Nevada Constitution. As is demonstrated below, the Commissioner's regulatory standard is not only inappropriate for use by the district court here, it is confusing and unworkable as a means to implement the requirements of the Amendment.

In contrast, in determining what the Amendment means when it requires provision of "health insurance" to employees in exchange for the ability of employers to pay the sub-minimum wage, the district court looked to Nevada statutes regarding substantive requirements for group and/or employer-provided health insurance, and found Petitioners' plans lacking under those standards. As matters of public policy, public health, and consumer protection, the Nevada Legislature has established minimum requirements for health insurance. This is no surprise, and is reflective of the State's interests and prerogatives in regulating a field crucially important to so many of its citizens. These insurance statutes, contained in N.R.S. Chapters 689A, 689B, and 608, are not hidden bombshells sprung upon unwary employers; they have been on the books for many years, and employers like Petitioners have long experience with their provisions. Those statutes mandate, for example, certain minimum coverage requirements for a number of health conditions, disorders, and events. They ensure, in other words, that an employee's health insurance actually function as *health insurance*, meaning that it shifts the risk for the costs of health events in a person's life to the insurer.

The district court here determined that Petitioners' plans did not meet the basic legal criteria to be health insurance under the Amendment.

II. THE PROPRIETY OF WRIT RELIEF

The question of the district court's jurisdiction in this matter is, arguably, a proper subject for extraordinary writ relief, as Petitioners can maintain that they have no "plain, speedy and adequate remedy in the ordinary course of law." N.R.S. 34.170. A jurisdictional challenge of this nature would, necessarily, re-route the legal proceedings, and as such, if successful, would be within the range of issues for which writ relief is designed.

The issue of the district court's application the statutory standard for "health insurance" to find Petitioners in violation of the Minimum Wage Amendment, however, is a different matter. "Neither mandamus nor prohibition will issue where petitioner has plain, speedy, and adequate remedy, such as appeal, in the ordinary course of law." *Hickey v. District Court*, 105 Nev. 729, 731, 782 P.2d 1336, 1338 (1989). Petitioners' disagreement with the district court here over what standard to apply to the subject health benefits plans is certainly appealable, and that remedy would, in the normal course, be plain, speedy, and adequate. Petitioners are not entitled to a speedier remedy than that which the normal course of litigation would offer them. In isolation, this portion of Petitioner's writ would be denied by the Court and they would be directed to seek relief on appeal at the close of the case.

As the Court is aware, however, this case does not exist in isolation. There are a number of similar cases whose resolution would benefit greatly from clarity on the question of standards for health insurance plans under the Amendment. Therefore, even if Petitioners' writ does not perfectly situate that question for final resolution across all such cases, in keeping with its established practices the Court "may exercise its discretion to consider a writ petition that presents an issue of statewide importance when principles of sound judicial economy weigh in favor of

consideration of the petition." *Lorton v. Jones*, 130 Nev. Adv. Op. 8, 322 P.3d 1051, 1053 (2014). Here, the statewide importance of the underlying issue is manifest, and judicial economy is served by setting out clear guidance to the courts of Nevada for interpretation of the requirements of the Minimum Wage Amendment.

III. SUMMARY OF THE ARGUMENT

Real Parties maintain that the term "health insurance," as used in the Minimum Wage Amendment, necessarily means health insurance lawful for the purposes it is offered. Health insurance is highly regulated in this state, as it is in every state. Accordingly, Petitioners' plans must comply with the basic legal requirements of health insurance in Nevada. In this state, health insurance offered by employers to their employees is regulated by N.R.S. Chapters 608 (Labor Code), 689A (Individual Health Insurance), and 689B (Group and Blanket Health Insurance) and, therefore, Petitioners' plans must comply with those provisions of law in order to be lawful "health insurance." The drafters of the Amendment did not create some new category of virtually unregulated and substandard insurance acceptable for paying workers less in hourly wages; rather, it intends that the "health insurance" provided to minimum wage employees for the purposes of reducing their wages be meaningful health insurance, just as the Legislature had required of any employer providing health insurance to employees to meet coverage and procedural minimums so that the health insurance in question functions as *health insurance*.

Petitioners, on the other hand, believe that "health insurance" under the Minimum Wage Amendment means virtually any health benefits they select, with no substantive requirements whatsoever. In other words, Petitioners argue that the Amendment takes "health insurance" out of its customary regulatory world entirely, and that there is no floor or lower limit to the type or quality of benefits

that such plans may contain in order for employers to withhold a dollar per hour from their employees. The standard they propose for qualifying health insurance is, in the end, no standard at all.

Petitioners are forced to take this kind of extreme position, due to the objectively poor quality of the health benefits plans they offered their minimum wage employees. These were limited-benefits plans and hospital indemnity plans, featuring low benefits limits and hideous exclusions. For example, Petitioners' 2015 plan excluded all inpatient services, and did not even cover stitches to close a simple laceration. Collectively, the plans in no way comply with any meaningful standard for "health insurance." In fact, most of the plans say so expressly, on their faces.[1]

In sum, Real Parties argue that when the drafters of the Amendment, in 2006, used the term "health insurance," they had to know and mean health insurance within the meaning of state and federal law. Insurance generally, and health insurance specifically, is among the most highly regulated fields in our society. In Nevada, any group or individual health insurance provided by employers to employees has fundamental requirements under N.R.S. Chapters 608, 689A, and 689B, and the drafters of the Amendment must be presumed to have known that and to have intended it. The district court so ruled, and did so correctly.

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[1] For example, Petitioners' 2014 plan carries the following bolded disclaimer:

> **THIS IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE.**
>
> **IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT.**

See 1 App. 201 (emphasis in original).

IV. PROCEDURAL HISTORY

This case is among the group of cases in which important issues of first impression regarding the claims of plaintiffs challenging employers' abilities to pay the lesser wage figure have made their way to this Court—issues, for example, like the appropriate statute of limitations on such claims, the meaning of "provide" in the Amendment, and whether tips and gratuities may be included in a the constitutional cap on premium costs to minimum wage employees. *See, e.g.*, *MDC Restaurants, LLC v. District Court*, 132 Nev. Adv. Op. 76, 383 P.3d 262 (2016) ("*Diaz I*"); *MDC Restaurants, LLC v. District Court*, No. 67631, 2016 WL 6902179 (Nov. 22, 2016) ("*Diaz II*"); *Perry v. Terrible Herbst, Inc.*, 132 Nev. Adv. Op. 75, 383 P.3d 257 (2016).

This writ petition comes to the Court following a ruling, in July of 2016, granting Real Parties' motion for partial summary judgment, arguing the health benefits plans offered by Petitioners were legally insufficient as "health insurance" to qualify Petitioners to pay employees the constitutional sub-minimum hourly wage. *See* 6 App. 1241-1251.

This is a class action. The district court has, pursuant to N.R.C.P. 23, certified a class of all Petitioner's employees who were paid less than the upper-tier hourly wage of $8.25 and were offered the health benefits plans the district court found non-qualifying under the Minimum Wage Amendment. Real Parties' motion for partial summary judgment below came about as the result of Petitioners' demand that the issue of what constitutes qualifying health insurance under the Amendment be decided prior to any class certification determination. The district court granted Real Parties' motion and, subsequently, granted a motion to certify the class. The district court has now stayed the case, and notice to the class, pending the outcome of this writ petition.

In *Diaz I*, this Court determined that employers need only offer the required health benefits described in the Amendment in order to pay employees below the upper-tier wage. *Diaz I*, 132 Nev. Adv. Op. 76, 383 P.3d 262. In this matter, the parties seek a final and crucial piece of the Amendment's legal puzzle: Can the offered health benefits be cut-rate supplemental-style health care products, or must they provide employees with the opportunity to enroll in meaningful health insurance as described under Nevada law? This Court has already signaled that it understands that the "health insurance" indicated in the Amendment must *be something*, it must meet some standard. In *Diaz I*, the Court repeated several times that employers are required to offer "qualifying health benefit plan." *Diaz I*, 383 P.3d at 264, 265 n. 2, 266-68. This writ petition will determine what benefit plans qualify.

IV. STATEMENT OF FACTS

For brevity, Real Parties adopt and incorporate the Statement of Facts included with the motion for partial summary judgment this writ petition seeks to challenge. *See* 1 App. 66-67.

V. THE DISTRICT COURT DETERMINED THAT PETITIONERS' HEALTH BENEFITS PLANS ARE LEGALLY INSUFFICIENT TO MEET THE REQUIREMENTS OF "HEALTH INSURANCE" UNDER THE MINIMUM WAGE AMENDMENT

The district court ruled that the Amendment mandates that health benefits must be "health insurance," and that Nevada had very clear and long-standing statutory requirements for the Individual Health Insurance (N.R.S. Chapter 689A), and for Group and Blanket Health Insurance (N.R.S. Chapter 689B). Petitioners' plans were group plans, "that form of health insurance covering groups of two or more persons, formed for a purpose other than obtaining insurance." N.R.S. 689B.020(1).

Considering, additionally, N.R.S. 608.1555, which states that "[a]ny 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," the district court determined that, at a minimum, Petitioners' health insurance plans must meet the basic mandates of those statutory chapters in order to qualify to pay employees lower-tier constitutional minimum wage rate. N.R.S. 608.1555; 6 App. 1244.

There has never been any argument from Petitioners that their plans actually meet the basic requirements for health insurance found in N.R.S. Chapters 689A, 689B, or 608.[2] Their plans offer bare minimal coverage for highly restricted health events, with limitations upon insurer liability that place the vast proportion of risk for health care costs upon the employee. Health plans that limit coverage to a few thousand dollars, or that only indemnify a few particular health care events are not meaningful health insurance under law.

A. Petitioners' Health Benefits Plans

All of Petitioners' plans between 2012 and 2015 were some form of *limited-benefit plans*. The 2012-2013 plans were plain vanilla limited-benefit plans. *See* 1 App. 165-199. The 2014 plan represented a subset—a significantly more limited variety—of limited-benefit plans known as *fixed-indemnity plans*, or *hospital indemnity plans*. *See* 1 App. 201-2 App. 274; *see also* 2 App. 321 ("Supplemental

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[2] It is also undisputed that Petitioners' plans do not meet the minimum requirements for health insurance under the Affordable Care Act, and the plans in question carry disclaimers on their faces saying exactly that. *See* 1 App. 176; *see also* 1 App. 201. Due to this, none of Petitioners' employees who enroll in the plans are freed from the necessity of either purchasing real health insurance or paying the federal tax penalty for not having done so. In other words, having these plans at work would cost an employee a dollar for every hour worked, a further 10% of those reduced wages for premium costs, and she would still have to go buy real insurance or pay a tax penalty under the ACA's individual mandate because Petitioners' plans fall short of minimum legal standards.

or limited health plans include those plans commonly referred to as hospital indemnity or other fixed indemnity policies[.]"). The 2015 plan—instituted after Petitioners were sued for failing to provide qualifying health insurance to their sub-minimum wage employees—barely qualifies as either of these types of plans, and represented a deep plunge in benefits and coverage for Petitioners' minimum wage employees. *See* 2 App. 276-283. In other words, Petitioners' offered plans steadily got worse over the years.

Limited-Benefits Plans: Also known as "mini-meds," limited-benefits plans are products that cap payouts to beneficiaries at very low annual limits, usually between $1,000 and $5,000. These plans also contain internal caps under which, for example, inpatient or outpatient services or prescription drugs are subject to even lower payouts or reimbursements.[3] Compare these types of plans to traditional comprehensive or major medical insurance policies, which have neither annual nor lifetime caps on coverage, and instead feature annual out-of-pocket

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[3] These kinds of "insurance" products have long been a source of concern for policymakers. As far back as 2007, then-Connecticut Attorney General, now-United States Senator, Richard Blumenthal investigated Aetna's limited benefits plans, stating, "We found that a particular policy set forth by Aetna had benefits so small as to be virtually worthless. We were also concerned that people were led to believe they had significantly more coverage than they actually had. While we are currently investigating this particular plan to determine whether it violates existing law, we want to leave no doubt that sham policies are not permitted in Connecticut." *See* Center for American Progress, *Limited Benefits: Insurers Peddle 'Limited Health Care' to America's Working Poor*, https://www.americanprogress.org/issues/healthcare/news/2007/05/07/3076/limited-benefits-insurers-peddle-limited-health-care-to-americas-working-poor/ (May 7, 2007) (accessed Dec. 28, 2016).

In 2009, still well before the enactment of the ACA, ranking member of the Senate Committee on Finance U.S. Senator Charles Grassley was sounding the oversight alarm, worried that these plans "had been marketed in a misleading way" and pressing Congress to "make limited benefit indemnity plans obsolete by making meaningful insurance coverage available and affordable." *See* U.S. Senate Comm. on Finance, *Press Release*, http://www.finance.senate.gov/newsroom/ranking/release /?id=2f7af1bb-78f8-41d2-8813-7d6ae06b5705 (Apr. 22, 2009) (accessed Dec. 28, 2016).

maximums pursuant to which insured persons can be secure in the knowledge that health care expenses beyond deductibles and co-pays will be paid by the insurer.

Severe benefit limitations are important in an industry where a single day in a Nevada hospital, in 2013, according to the Kaiser Family Foundation, cost an average of **$1,913**. *See* Kaiser Family Foundation, *Hospital Adjusted Expenses per Inpatient Day, Nevada*, http://kff.org/other/state-indicator/expenses-per-inpatient-day/ (accessed Dec. 28, 2016). Knee replacement surgery: **$32,000**; ACL repair: **$12,000**; childbirth through caesarean procedure: **$13,000**; basic carpal tunnel surgery: **$4,000**. *See* Guroo, *All Conditions, Care Bundles, and Tests*, http://www.guroo.com/#!a-to-z-list (accessed Dec. 28, 2016). These figures do not even begin to approach the costs of serious or chronic illnesses, such as cancer or diabetes, which by their terms limited-benefits plans are not designed, intended, or equipped to cover. Minimum wage workers with real health issues would face bankruptcy if they relied upon these kinds of plans as their primary health insurance.

Fixed-Indemnity, or Hospital Indemnity Plans: Fixed-indemnity benefits plans are health care products that pay a fixed amount per visit or service, given directly to the beneficiary. They do not "cover" any expense at all; they provide low flat-cash payments on the happening of an event: doctor visits, missed days of work, etc. These plans pay the small specific amount regardless of the seriousness of the care needed or the health condition at issue.

The Center on Health Insurance Reforms, housed in Georgetown University's Health Policy Institute, notes that "federal law (and most states) do not consider fixed indemnity insurance to be traditional medical insurance." *See* Center on Health Ins. Reform, *Update on Fixed Indemnity Insurance: No Longer an ACA Loophole?*, http://chirblog.org/update-on-fixed-indemnity-insurance-no-longer-an-aca-loophole/ (Mar. 19, 2014) (accessed Dec. 28, 2016). Instead, such

products "have been considered **income replacement policies**, to help compensate people for time out of work." *Id.* (emphasis supplied). Furthermore, "both state federal and state regulators have expressed concerns that insurance companies could attempt to market these policies **in such a way that they appear to consumers to be health insurance**." *Id.* (emphasis supplied). This concern arose out of the prospect of consumers "being duped into buying a fixed indemnity policy as their sole source of health coverage." *Id*.

In 2015, in fact, the Nevada Division of Insurance issued Bulletin No. 15-001, wherein the Insurance Commissioner directs that fixed-indemnity policies may no longer be sold to individuals in Nevada unless the purchaser is made to attest that he or she already has "major medical health insurance that meets the requirements of minimum essential coverage as defined by the Affordable Care Act." *See* 2 App. 323-325. Stating that more clearly, the plan that Petitioners offered to their subminimum wage employees in 2014 today cannot be sold to an individual in Nevada if that person does not swear, under penalty of perjury, to having acquired other, actual health insurance.

In general, all limited-benefits plans are designed to be supplemental to real, comprehensive, major medical insurance. Neither limited-benefit plans nor fixed-indemnity plans function as reliable or useful health benefits policies on their own. This is not fairly debatable. The question is whether these kinds of health care products qualify as "health insurance" under the Minimum Wage Amendment.

1. Petitioners' 2012-2013 limited-benefits plans

Between 2010 and 2013, Petitioners offered their Nevada minimum wage hourly employees CIGNA Starbridge Limited Benefits Plans. *See* 1 App. 165-199. The 2013 version of the plan underwent minor downward modifications in coverage and benefits levels from the 2010-2012 levels.

The plans carry an express warning on their faces:

> Starbridge is a sickness & accident plan that covers everyday medical expenses. It is not a major medical plan and is not designed to cover major health problems like heart disease or cancer.

See 2 App. 328.

Once the annual maximums are met for a particular service, the 2012 and 2013 plans make no further payment, and the employee is responsible for 100% of the cost of that service for the rest of the year. These plans had no out-of-pocket maximums for policyholders which, of course, is the definition of a limited-benefit plan, and why they are dangerous health benefits products, if marketed or purchased as comprehensive coverage.

The 2012 plan contains an annual maximum of $1,250/year for outpatient care paid by the Plan, and an annual maximum of $3,000/year for inpatient care. *See* 1 App. 168. This plan pays a maximum of $1,500 toward each surgery, and will only pay $1,500 toward costs incurred in a pregnancy. *Id*. The 2010-12 Plan only contains benefits for inpatient surgery. *Id.* There is no annual limit for maternity benefits, but the 2012 Plan will only pay $1,500 toward costs incurred in each pregnancy. *Id*. The 2013 version of the Starbridge limited-benefits Plan was similar in structure to the 2012 version, with one general exception: It got worse. The annual inpatient maximum for the 2013 plan was reduced to only $2,000. *Id*.

The plans provide no coverage for chiropractic care, treatment of mental or nervous disorders, treatment of substance abuse, home health services (except when in lieu of hospital confinement), and skilled nursing facility charges. *See* 1 App. 169-171.

These plans purport to include prescription drug programs, but these are virtually useless, as the plans specifically state such programs "are not insured benefits." *See* 2 App. 333. In other words, the Plans provide no specific insurance coverage for prescription drugs. *See also* 1 App. 176 ("Prescription Coverage:

Discount Only program, limits do not apply."). Let that be repeated: the plans do not provide insurance for prescription drugs.

The 2012 and 2013 plans contained exclusions for pre-existing conditions, lasting up to a full year. *See* 2 App. 334. For a year-long policy, this would effectively mean that a pre-existing condition would go uncovered entirely by the plan. For employees in a high-turnover industry such as fast food, this means, in practical terms, that pre-existing conditions are excluded from coverage.

Referencing specific Nevada statutory requirements, N.R.S. 608.156 requires an employer to provide treatment for abuse of alcohol and drugs with an outpatient maximum of $1,500/year and an inpatient benefit of $9,000/year. *See* N.R.S. 608.156. The 2012 and 2013 plans exclude treatment for abuse of drugs and alcohol. The plans do not contain any provision for benefits from expenses arising from home health care, as required by N.R.S. 689B.030(4), but instead only provide home health services in lieu of hospital confinement. *See* N.R.S. 689B.030(4). There is no provision for benefits for the expenses of hospice care, as required by N.R.S. 689B.030(5). *See* N.R.S. 689B.030(5). In fact, the plans do not include hospices within the definition of hospitals, and do not otherwise provide for hospice care at all. The 2012 and 2013 plans cannot comply with further coverage requirements of Chapter 689B, including a $36,000 annual maximum for Autism Spectrum Disorders (*see* N.R.S. 689B.0335) and $2,500/year in coverage for food products related to metabolic diseases (*see* N.R.S. 689B.0353). The low benefit limitations of the plans ensure there is no way for these plans to comply with state law on these matters. The 2012-2013 plans are noncompliant as a basic matter of state law.

2. Petitioners' 2014 fixed-indemnity plan

In 2014, Petitioners switched to offering their subminimum wage workers the TransChoice Hospital Indemnity Plan. Right off the bat, the 2014 plan alerts

prospective enrollees that it is "NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE." *See* 1 App. 201; 2 App. 209.

Unlike the 2012-2013 limited-benefits plan, which at least tried to look like coverage for actual health events and expenses, the 2014 Plan provides only payments in connection with events, not actual health care costs. It provides, for example, fixed payments of $100/day for up to 31 days a year, with no connection to the actual cost of that health care service. *See* 2 App. 219-220. This $100/day payment obviously would not be sufficient to cover the average daily cost of a hospital stay in Nevada. Furthermore, nursing homes, extended care facilities, skilled nursing facilities, institutions for the treatment of mental disorders, rest homes, rehabilitation centers, or centers for the treatment of alcohol or drugs are excluded from the definition of "hospital" under the 2014 plan, and care in those contexts would not be covered. *See* 2 App. 226.

Petitioners' 2014 Plan also offers limited fixed payments for certain outpatient services including a maximum payment of $200/year for advanced diagnostic tests (such as an MRI or CT Scan), $50/year for other diagnostic tests (such as an x-ray or ultrasound), $20/year for laboratory tests, and $300/year for doctor office visits. It offers limited payments for certain surgical services including a maximum payment of $500/year for an inpatient surgery (plus $100 for anesthesia), $250/year for outpatient surgery (plus $50 for anesthesia), and $50/year for "minor" outpatient surgery (plus $10 for anesthesia). *See* 2 App. 219-224.

The function of any of these "payments" is not that of insurance in any event—at best, they may be considered supplemental income-replacement, and not very good income-replacement at that: The employee remains responsible for payment of all health care costs over and above the fixed payment. Any costs for a

1 day hospital stay in excess of $100 would be paid by the employee, as would any costs for an outpatient surgery in excess of $250 for the surgery and $50 for the anesthesia. *Id.* Clearly the costs to an enrolled employee for any of these health events would be very significant.

The 2014 plan also expressly excludes some of the most necessary and common healthcare expenses, providing no benefits for care in the emergency room of a hospital, ambulance services, rehabilitative care and treatments, immunization shots, or routine examinations such as mammograms or pap smears. *See* 2 App. 227; 2 App. 231. This is not health insurance.

Again, N.R.S. 608.156 requires an employer to provide treatment for abuse of alcohol and drugs with an outpatient maximum of $1,500/year and an inpatient benefit of $9,000/year. *See* N.R.S. 608.156. The 2014 plan contains no outpatient benefit for treatment for abuse of alcohol and drugs and a maximum overall inpatient benefit of $3,100.

N.R.S. 689B.030(4) requires a provision for benefits for expenses arising from home health care, but the 2014 plan does not provide any benefit for home health services. *See* N.R.S. 689B.030(4); *see also* 2 App. 219-220.

N.R.S. 689B.030(5) mandates a provision for benefits for the expenses of hospice care, but the 2014 plan does not include hospice within the definition of hospital and excludes all rest care from its coverage provisions. *See* N.R.S. 689B.030(5); *see also* 2 App. 226; 2 App. 231.

N.R.S. 689B.0313 requires a provision providing coverage for the human papillomavirus vaccine, but the 2014 plan does not provide benefits for vaccinations. *See* N.R.S. 689B.0313; *see also* 2 App. 231.

N.R.S. 689B.0335 mandates $36,000 in annual maximum for Autism Spectrum Disorders, while N.R.S. 689B.0353 prescribes $2,500/year in coverage for food products related to metabolic diseases. *See* N.R.S. 689B.0335. None of

these are covered by the 2014 plan. *See* 2 App. 219-220.

N.R.S. 689B.0357 requires a provision covering costs related to self-management of diabetes, but the 2014 plan does not provide an indemnity benefit for this condition. *See* N.R.S. 689B.0357; *see also* 2 App. 219-220.

These are not optional requirements under law. Petitioners do not get to pick and choose which aspects of Nevada health insurance law they deem necessary or unnecessary, or what conditions or services mandated by the Legislature for coverage their employees will or will not receive. The plans, demonstrably and concretely, fall short of many, many statutory requirements for employee health insurance.

3. The 2015 MVP plan

In 2015—after having been sued for maintaining substandard benefits plans to their subminimum wage employees—Petitioners made the choice to switch from the 2014 TransChoice Plan to what it called the "MVP Plan." *See* 2 App. 276-283.

At first glance Petitioners' 2015 plan appears to be a parody of health insurance. This plan excludes just about everything a consumer would expect health insurance to provide, as a matter of the basic expectations of society, it also attempts to conceal its insufficiency through its marketing, by appropriating a term form the Affordable Care Act to mislead consumers. "MVP" stands for "minimum value plan," and administrator Key Benefits actually calls this policy its "ACA Minimum Value Plan." *See* 2 App. 278. In truth, however, the 2015 plan is far from constituting real health insurance, on any level.

The 2015 plan excludes surgery—all surgery, to the point where it will not cover stitches, or the setting of broken bones. *See* 2 App. 279. It also fails to cover just about the entire range of any other useful healthcare services: It provides no coverage whatsoever for inpatient hospital stays, surgery, ambulatory surgery center charges, mental health, substance abuse treatment, rehabilitative services,

ambulance services, chiropractic care, infusion, chemotherapy, injections, skilled nursing facility charges, or any facility charges of any kind. *See* 2 App. 278-281. This, again, is not health insurance.

Further, the 2015 plan contains a perverse "benefit" regarding emergency room services. It will pay for emergency room visits, after a $400 co-pay by the insured, but that benefit is rescinded if the person going to the emergency room actually needs to be admitted to the hospital. Additionally, the ambulance to the emergency room would not be covered at all. *See* 2 App. 280.

As for childbirth, "delivery and inpatient charges … are not covered." *See* 2 App. 279. Neither are "all medical supplies, durable medical equipment [or] prosthetics." *Id.* "Ambulance services are not covered." *Id.* Neither are injections. *Id.* Do not even think about "infusion, chemotherapy, or radiation," or "mental health and substance abuse services"—"not covered." *Id.* Prescription drug "coverage" is "limited to a 34-day supply." *See* 2 App. 282. Not 34 necessary fills, or 34 separate prescription needs: 34 days' worth of supply of any needed drug. *Id.* The 2015 plan's schedule regarding Chronic Disease Management is itself astonishing. *See* 2 App. 282. An epileptic will be covered for "1 office exam per plan year," although a sufferer of congestive heart failure or multiple sclerosis will be generously covered for two. *Id.*

It goes without saying that the 2015 plan does not and cannot meet the specific statutory requirements under N.R.S. 608 or N.R.S. 689A or 689B, as described above in relation to the other plans.

* * *

In sum, none of Petitioners' plans provide the benefits required by Nevada law and cannot properly be considered "group health insurance," or "benefits for health care," or even simply "health insurance" at all. Because the plans do not meet basic legal mandates for employer-provided health insurance under state law,

they certainly cannot meet the requirements of the Minimum Wage Amendment as qualifying health insurance permitting payment of the subminimum wage to Real Parties.

The district court noted all the legal deficiencies of Petitioners' plans in its findings of fact and conclusions of law. *See* 6 App. 1241-1248. The court found that "the Nevada Legislature has determined that these coverage requirements are essential to lawful health insurance," and that under the Amendment "health insurance provided by employers … must meet the substantive requirements" found in state law. *See* 6 App. 1245.

The district court also found that "limited benefits plans" or "hospital indemnity plans" could likely never meet the requirements for health insurance under the Minimum Wage Amendment, "because the nature of these plans is to limit total benefits to a few thousand dollars per year for all coverage." *See* 6 App. 1246. "It is essentially impossible," the court wrote, "for such a plan to provide coverage for all things required under the statutes should an employee experience more than a single medical issue during a particular year." *Id*. In practical terms, what the district court was positing was that given the low limits on benefits, an employee who breaks an ankle at the company softball game in April would have no benefits remaining should they be diagnosed a metabolic disease—say, diabetes mellitus—in September.[4]

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[4] The district court also noted that the carrier of Petitioners' 2014 plan, TransAmerica, stated in response to a subpoena duces tecum in this action that its hospital indemnity plan "was not to be considered health insurance at all." *See* 6 App. 1247. Petitioners, therefore, demand this Court recognize this plan as "health insurance," while the insurer who sold them the policy unequivocally states the policy is anything but.

B. Expert Testimony Before The District Court

The poor quality of Petitioners' plans made the decision of the district court easy, but the court did not rule on this matter reflexively or without deliberation. It had voluminous briefing at hand, and also was the beneficiary of extensive expert testimony. Real Parties submitted an expert report, and Petitioners provided reports from not one but two rebuttal experts, and all experts were deposed. The difference between the approaches of each side's experts, however, was palpable: Real Parties' expert demonstrated that the offered health plans did not comply with the statutory provisions set out in Nevada law, while both of Petitioners' experts sought, above all else, to define "health insurance" for the district court in ways that stripped the term of any substantive requirements for coverage.

Both Petitioners' experts maintained that because the Minimum Wage Amendment only uses the term "health insurance," Nevada employers need only provide anything that the industry might plausibly define as health insurance—with no regard for what state law may have to say about coverage requirements. Both experts reduced their analyses to very simple definitions of what they believe "health insurance" is, in the most general sense:

For Mr. Arrigo, Petitioners' Expert #1: Health insurance includes "marketing to make health insurance available, publishing a medical coverage determination policy ('benefits') for medical care, enrollment of those who wish to have these benefits, collecting premiums from insured members, and redistributing funds collected to those members with medical claims …" *See* 2 App. 383.

For Mr. Mulliner, Petitioners' Expert #2: Health insurance is "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 someone to administer the plan through the payment of claims submitted by [employees] under the plan. *See* 3 App. 528.

That was the heart of these experts' opinions. As long as Petitioners' plans met these mechanistic definitions, both experts confirmed at deposition they believed the Amendment imposed absolutely no coverage or quality requirements whatsoever. This position led both experts into absurdities, in which both admitted that if the only requirement is that there is *some* kind of benefit, administered by *somebody*, in exchange for paid premiums, then the product was *health insurance*—even if it only covered broken toes, or were mere teeth-cleaning plans standing alone. *See* 3 App. 516-518. The "industry" considers these benefits to be "health insurance," according to Petitioners' experts, and therefore so does the Minimum Wage Amendment.

For a number of reasons, Petitioners have essentially abandoned their two experts in subsequent briefing and argument. That may be, in part, because one of them argued that minimum wage employees are so poor that they should qualify for Medicaid and that, therefore, employers were under no obligation to offer them any health insurance at all under the Amendment. *See* 2 App. 383. But is instructive that Petitioners have been casting about for a legal argument that can relieve them of liability for the low-quality health benefits plans they chose to offer their employees, and that little of the specific argumentation made in this writ petition was ever put to the district court.

VI. ARGUMENT

A. The District Court's Jurisdiction Is Unquestionable

Petitioners expend a lot of time and energy trying to convince this Court that Real Parties' claims should be brought, in the first instance, before the Labor Commissioner, or at least a "hearing officer" from the Labor Commissioner's office. The Minimum Wage Amendment, however, contains within its terms an

express private right of action:

> 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.

Nev. Const. art. XV, § 16(B).

That is a pretty expansive right of action, in which access to Nevada courts is established in order to remedy claims of violation. That right cannot even be waived under the terms of the Amendment. *See id*. Petitioners cannot contest, for example, that employees could file lawsuits in Nevada courts claiming violation of the Minimum Wage Amendment if:

- Their employer charged them premiums exceeding ten percent of their gross wage from the employer (Nev. Const. art. XV, § 16(A));
- The mechanisms for setting the annual minimum wage under the Amendment were not followed by the Governor or the Labor Commissioner (*Id*.);
- Their employer failed to provide written notification of the rate adjustments to each of its employees and make the necessary payroll adjustments by July 1 of every year (*Id*.);
- Their employer took a tip or gratuities credit or offset against the wage rates required by the Minimum Wage Amendment (*Id*.);
- Their employer contended that individual employees had waived any of their rights under the Minimum Wage Amendment in an agreement between themselves and the employer (*See* Nev. Const. art. XV, § 16(B));
- Their employer discharged, reduced the compensation of, or otherwise discriminated against them for using any civil remedies to enforce the

Minimum Wage Amendment, or otherwise asserting their rights under it (*Id.*);

- Their employer attempted to exclude them from the Amendment's protections even though they were not under eighteen 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 days (*See* Nev. Const. art. XV, § 16(C)).

All the claims listed above could be brought directly in state court on behalf of an employee-claimant, and no issue of the Labor Commissioner's authority or administrative exhaustion could possibly be entertained as a counterargument, because they would obviously be alleged as violations of the Amendment. But Petitioners claim here that, alone among provisions in the text, one of the keystones to the entire constitutional scheme—the health insurance benefits which form the basic bargain of the Amendment—vests authority in the Labor Commissioner for enforcement. That is not a plausible argument.

Perhaps that is not even a proper characterization of Petitioners' argument in full—perhaps they are saying that *every* alleged violation of the Amendment should first be brought before the Labor Commissioner; it is a bit difficult to tell. Their argument is that "all means all," and the Commissioner has been vested with authority to enforce all of Nevada's labor laws. *See* N.R.S. 607.170(1)(a). This would be difficult to mesh with, for example, N.R.S. 608.260, Nevada's minimum wage statute predating the Amendment, which also states that an aggrieved employee "may, at any time within 2 years, bring a civil action to recover the difference between the amount paid to the employee and the amount of the minimum wage." *See* N.R.S. 608.260. In Petitioners' logic, that express private right of action would yield, as well, to the Labor Commissioner's primary jurisdiction. And what, exactly, are the aspects of the Labor Commissioner's

historic expertise in health insurance regulation that would persuade this Court to read out of the Amendment an express right of action in the Courts of Nevada? This is never explained in the writ petition, probably for obvious reasons: there is no such expertise and no one believes it exists in any event.

It does not really matter. The only question necessary to dispel Petitioners' administrative remedies argument is this: Have Real Parties alleged a violation of the Minimum Wage Amendment? If so, they brought their claims in the right place, district court. Their rights to do so not need to be inferred, and they are not difficult to locate; they are in the very text of the Nevada Constitution, in black and white.

B. The Labor Commissioner's Standard For Qualified Health Insurance In N.A.C. 608.102 Cannot Control The District Court's—Or This Court's—Interpretation Of The Nevada Constitution

Decoupled from the possibility of the Labor Commissioner's primary jurisdiction, the standard for the Amendment's required "health insurance" found in the Commissioner's N.A.C. 608.102 loses any real usefulness. In order to apply the regulation as its standard, this Court would have to find it persuasive, and approve it as its own construction of the Constitution. This would have to be due to its own merits as a constitutional interpretation, or through some other jurisprudential mechanism. Unfortunately, N.A.C. 608.102 is not persuasive as an interpretation of the Minimum Wage Amendment on its own, and Petitioner's argument regarding some form of mandatory construction stemming from legislative enactment of wholly-separate tax statutes is too attenuated to convince this Court to adopt the standard despite its failings.

1. N.A.C. 608.102 is an unworkable standard

N.A.C. 608.102 states that, in order to pay the sub-minimum wage under the Amendment, an "employer must offer a health insurance plan which … 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[.]" N.A.C. 608.102. For something as important as health insurance for which Nevada employees are giving up a dollar of wages every hour they work, this is not a good or workable interpretation of the Minimum Wage Amendment.

Petitioners point to at least half the problem with this standard. They malign Real Parties for reading "those categories" to mean *all* categories, i.e. that if *any* particular health care service or product can be deducted from an employee's federal taxes if he or she pays for it themselves, it must be covered by Petitioners' insurance. They do not appear to realize, however, that their reading of the regulation leads them into a *cul-de-sac* as well. If N.A.C. 608.102 can be read to require all things be covered, it can also be read to require almost nothing be covered. If "those categories" does not mean all categories, how many categories does it mean? One? Five? Is the health insurance requirement like a power-train warranty: brain, heart, lungs, guts, kidneys? And who decides how many and which categories? Petitioners' reading of N.A.C. 608.102 would lead the court away from bright and practical standards for health benefits plans under the Amendment, and towards endless case-by-case litigation over whether some particular plan carries just enough coverage, or falls just shy of requirements, etc.[5]

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[5] This argument is also what led both defense experts to conclude at their depositions that Petitioners could offer literally anything—a bare dental plan by itself, a plan that covered only broken toes—as long as the plans covered something, and they would meet the requirements of the Amendment for paying employees all the way down to $7.25 per hour worked. Both agreed that they believed there were no substantive requirements for coverage under the Amendment.

N.A.C. 608.102 is either an incredibly easy and burden-free bar to clear, or it is a very difficult and rigorous standard to meet. It can be read as a mandate to cover everything, or a demand to cover next to nothing.

26 U.S.C. § 213 establishes the federal individual tax deductions for expenses paid for medical care generally, which is defined at § 213(d) as "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." 26 U.S.C. § 213. It is difficult to imagine a more expansive definition of "medical care."

There are dozens of categories of health care expenses that are deductible. The Internal Revenue Service goes to the trouble of providing a near-comprehensive list of those categories of health care services that are deductible on an individual's federal tax return. The 2016 list, for example, is found in I.R.S. Publication No. 502 for Tax Year 2016. *See* https://www.irs.gov/pub/irs-pdf/p502.pdf (last accessed Dec. 29, 2016). Expenses paid for any of the expenses listed by the I.R.S. are tax deductible, above a certain minimum threshold, on an individual's federal tax return.

On Real Parties' side of the ledger, the Labor Commissioner, in promulgating N.A.C. 608.102, did not state that "some," or a "few," or a "small proportion" of those health care expenses that would be deductible need only be covered; the regulation states "**those** categories of health care expenses[.]" N.A.C. 608.102(1) (emphasis supplied). Petitioners' 2012 and 2013 plans do not cover chiropractic care, hearing aids, infertility treatments, treatment of mental or nervous disorders, treatment of substance abuse, home health services (except when in lieu of hospital confinement), and skilled nursing facility charges—all of which are examples of services generally deductible by an employee on his individual federal income tax return pursuant to 26 U.S.C. § 213. The 2014 plan does not cover emergency room care at a hospital, ambulance services,

rehabilitative care and treatments, immunization shots, or routine examinations such as mammograms or pap smears, again all of which are generally deductible by an employee on his individual federal income tax return pursuant to 26 U.S.C. § 213. *See* 2 App. 227, 231. The coverage gaps in the 2015 plan are even more glaring.

For Petitioners' part, they expressly argue that there are no coverage requirements under the Amendment, only technical requirements to provide something that can be defined, if held up to the right light, as health insurance. They also argue that it would be unlikely—or at least prohibitively expensive—to garner insurance policies that cover all possible deductible medical care categories. Real Parties do not doubt that that is true; they also note that Petitioners never went to the Labor Commissioner for clarification, or to district court for a declaratory ruling, saying that they believed the standard was confusing or expensive or in need of revision. Why would they, the regulation operated to their benefit for a decade, over which they retained the difference in wages Real Parties now seek.

The logic of Petitioners' position is that as long as the plan in question provides some benefit—*any* benefit—that touches *any* category of health expense that would be tax deductible, N.A.C. 608.102 allows the employer to pay below the upper-tier minimum wage. In their reading they, and they alone, get to select how many or how few of the categories of potential health care expenses their plans will cover, and they also get to determine the meaning and level of "coverage," whether that be a suitable amount to provide the kind of shifting of risk that health insurance is meant to supply or a mere few hundred dollars in the event of the need for an emergency kidney transplant. This is what Petitioners refer to as a "discretionary, market-oriented standard." Petition at 71. It is hard to see, however, how this "market" ever benefits minimum wage employees, who have no

role in selecting these health care products and no hand in negotiating either prices or coverage.

In short, the Labor Commissioner's N.A.C. 608.102 standard is unworkable because, given the impossibility of its clear application to actual health benefits plans, this Court would end up interpreting not the Nevada Constitution itself, but rather the N.A.C. 608.10 language instead. The Court would be interpreting not what the Constitution means when it says "health insurance," but what the Labor Commissioner meant when he said that plans "must … cover those categories of health care expenses that are generally deductible by an employee on his individual federal income tax return." That is not the role of the Court, nor is it the place of the Labor Commissioner to put the Court in that position. What strange rabbit hole is this?

The bottom line is that this Court would never adopt N.A.C. 608.102 as its standard for interpreting the Minimum Wage Amendment, for the very reason that it is no standard at all. "Health insurance" has fundamental, substantial, and identifiable qualities in Nevada law, and Defendants' limited-benefit and fixed-benefit Plans cannot satisfy these requirements. The Labor Commissioner has no authority to alter the statutory meaning of "health insurance." She cannot require less than what is mandated by law for health insurance provided by an employer in Nevada. Under law, any health insurance benefits plan, provided by a Nevada employer (including purposes of qualifying to pay a subminimum wage), must follow the provisions of N.R.S. Chapters 608, 689A and 689B.

2. Petitioners' "contemporaneous construction" argument simply does not add up

Petitioners attempt to breathe life into the Labor Commissioner's N.A.C. 608.102 standard by mounting a convoluted argument that either the Legislature or the Labor Commissioner—it is not entirely clear which—engaged in a

"contemporaneous construction" of the Minimum Wage Amendment that should hold great weight with this Court.

As Real Parties understands Petitioners' analysis, the chain proceeds like this: After drafting but before the first vote of the people on the Amendment in 2006, the Fiscal Division of the Legislative Counsel Bureau ("LCB") indicated in its fiscal note to then-Question 6 that one of the potential fiscal impacts of the measure would be that if wages increased after passage of the Amendment, then so too would revenues to the State from the Modified Business Tax ("MBT"). Then, during a 2005 Special Session—after the first passage of the Minimum Wage Amendment but prior to the second vote—the Legislature enacted statutes creating a deduction to Nevada's Modified Business Tax that included a definition of "health benefit plan" for purposes of taking that deduction that a health benefit plan is one that "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. § 213 and any federal regulations relating thereto, if those expenses had been borne directly by those employees." N.R.S. 363B.115(4)(e). Thereafter, in 2007, the Labor Commissioner enacted N.A.C. 608.102, importing the legislative language drafted to allow a particular tax deduction into, now, the Commissioner's interpretation of the meaning of the Nevada Constitution. This sequence of events—the mentioning of the MBT in LCB's fiscal note, the enactment of the tax deduction, the closeness in time to the first and then final approval of Question 6—functions, in Petitioners' minds, as if the Legislature had pronounced directly upon, and the people had ratified by an overwhelming majority, the Labor Commissioner's N.A.C. 608.102 standard for "health insurance" as the most appropriate interpretation of the text of the Amendment. Hence, the argument concludes, the Court should not just be

persuaded but very nearly compelled to adopt the Labor Commissioner's standard as its own.

This approach does not reflect Real Parties' understanding of the doctrine of contemporaneous construction. That doctrine, actually, is a number of different interpretative approaches sometimes given that label. Primarily, it functions as a check upon arbitrary and politicized changes in regulatory policies and interpretations by administrative agencies. The doctrine is a shield used *against* agencies:

> Interpretation of a statute made by an administrative agency, once made and applied over a long period of time, cannot be unilaterally revoked by the agency … The doctrine of contemporaneous construction means that where an administrative agency has the responsibility of interpreting a statute that is in some manner ambiguous, the agency is restricted to any long-standing construction of the provisions of the statute it has made previously.

Revenue Cabinet v. Humana, Inc., 998 S.W.2d 494, 495 (Ky. Ct. App. 1998). The doctrine has a policy rationale "similar to the reasoning used to prohibit *ex post facto* laws," in that it prohibits an administrative agency "from revoking its long-held interpretation of a statute, while applying its new interpretation retrospectively." *Pate v. Department of Corrections*, 466 S.W.3d 480, 489 (Ky. 2015). That does not seem to fit Petitioner's theory very well, as no one is seeking to hold the labor Commissioner to some version of a statutory interpretation she is now seeking to jettison. This aspect of the contemporaneous construction doctrine would not appear to have much to do with the weight to be given by this Court to the Commissioner's interpretation of the Minimum Wage Amendment.

Even in the instances in which other iterations of the contemporaneous construction doctrine are employed in order to weigh statutory or constitutional interpretations urged upon a court, it remains clear that an agency interpretation of a statute or constitutional provision is merely suggestive to courts of one potential,

avenue of understanding and applying the law.[6] *See Shasta Linen Supply, Inc. v. Applied Underwriters, Inc.*, 2016 WL 6094446, at *4 (E.D. Cal. Oct. 17, 2016).

The California Supreme Court, for example, has held that while "an agency['s] interpretation of the meaning and legal effect of a statute is entitled to consideration and respect by the courts," the "courts are the ultimate arbiters of the construction of a statute." *Yamaha Corp. of Am. v. State Bd. of Equalization*, 19 Cal. 4th 1, 7, 17, 960 P.2d 1031 (1998) ("*Yamaha I*"); *Dyna-Med, Inc. v. Fair Employment & Hous. Com.*, 43 Cal. 3d 1379, 1389, 743 P.2d 1323 (1987) ("The final meaning of a statute … rests with the courts.").

In keeping with that principle, courts "independently judge the text of the statute," even where an agency has interpreted its meaning. *Yamaha I*, 19 Cal. 4th at 7. An agency's interpretation is only "one among several tools available to the court" in construing a statute. *Id.* "Depending on the context, [an agency's interpretation] may be helpful, enlightening, even convincing." *Id.* at 7-8. It is not controlling, however. *Dyna-Med, Inc.*, 43 Cal. 3d at 1388 (holding that while agency interpretation of statutes may be "entitled to great weight," they are "not controlling").

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[6] And, of course, it is only in instances of an ambiguous provision that contemporaneous construction can be resorted to as an extrinsic interpretive aid at all. *See Chicaksaw Nation v. Dept. of Interior*, 161 F. Supp. 3d 1094, 1099 n. 8 (W.D. Okla. 2015) (quoting *Houghton v. Payne*, 194 U.S. 88, 99, 24 S. Ct. 590 (1904)) (only where statute is ambiguous that weight is given to doctrine of contemporaneous construction). The Minimum Wage Amendment, in this case, is not ambiguous; the Labor Commissioner's N.A.C. 608.102 may be susceptible of multiple constructions, but not the Amendment's use of the term "health insurance."

This is particularly true in the context of administrative interpretations, which, unlike quasi-legislative rules, "do[ ] not implicate the exercise of a delegated lawmaking power," but merely "represents the agency's view of the statute's legal meaning and effect, questions lying within the constitutional domain of the courts." *Yamaha I*, 19 Cal. 4th at 11. Indeed, "however 'expert'" they may be, agency interpretations "command a commensurably lesser degree of judicial deference" than quasi-legislative rules, which are themselves not controlling either. *See Dyna-Med, Inc.*, 43 Cal. 3d at 1388 ("The **contemporaneous construction** of a new enactment by the administrative agency charged with its enforcement [is] not controlling …") (emphasis supplied).

An agency interpretation of the meaning and legal effect of a statute is entitled to consideration and respect by the courts, but the binding power of an agency's interpretation is always contextual. *Yamaha I*, 19 Cal. 4th at 7. Any power agency interpretations may have to persuade a court is circumstantial and dependent on the merit of the interpretation itself. *Id*. Real Parties have offered above a substantive and detailed critique of the deficiencies of the Labor Commissioner's N.A.C. 608.102 as an interpretation and application of the Minimum Wage Amendment's requirements for "health insurance," such that it is unlikely this Court can look at that standard and feel comfortable it is appropriate on its merits.

Now, it is true that one of the factors a court takes into account when it considers the value of an agency interpretation is the expertise of the agency in the subject area. *Yamaha Corp. of Am. v. State Bd. of Equalization*, 73 Cal. App. 4th 338, 353, 86 Cal. Rptr. 2d 362 (1999) ("*Yamaha II*"). Petitioners do their best to establish the expertise necessary to regulate health insurance on the part of the Labor Commissioner, but the effort is undone by a few readily-available facts. First, it is objectively true that the Labor Commissioner *qua* Labor Commissioner

has no obviously inherent expertise in the complex field of health insurance or its regulation. Second, in the decade since promulgating N.A.C. 608.102, the number of times the Labor Commissioner has examined, passed upon, or otherwise considered particular health benefits plans for purposes of determining their compliance with the regulation or the Amendment is precisely zero. *See* Real Parties in Interest Appendix ("RA") 1-4, Public Records Request to Nevada Labor Commissioner, filed as an exhibit in *Landry's Inc. et al v. Sandoval*, D. Nev. Case No. 2:15-cv-01160-GMN-PAL, ECF No. 16-1. Third, the Labor Commissioner herself expressly disclaimed the expertise necessary to win any deference from the Court on this issue. Produced as part of the records request made to her office, and available here at RA 1-4, is a document in which the Labor Commissioner addresses questions regarding the meaning of "qualified health insurance" in the Amendment, she states:

> [I]t must be determined whether [a] plan is an actual health insurance plan. The Office of the Labor Commissioner relies on the Nevada Division of Insurance to make that determination. Once that determination has been made, the Office of the Labor Commissioner can determine whether the plan meets other requirements.

RA 3. There is no evidence that the Labor Commissioner ever actually sought or relied upon any determination by the Division of Insurance in regard to any particular health benefits plan, either from Petitioners or any other Nevada employer, but the salient point is that the Commissioner herself recognizes that her office is not equipped with the expertise to make substantive determinations about health insurance plans. Why, then, would the Commissioner's N.A.C. 608.102 gain any deference from this Court in interpreting the Nevada constitution?

Lastly, Petitioners try to make the Legislature's enactment of N.R.S. 363A.135 and 363B.115, the deductions available to employers under the MBT, and the timing of the 2005 Regular Session followed by the 2006 second vote on Question 6, into some sort of quasi-referendum in which the Legislature settled

upon a standard for "health insurance" that should be applied to the Minimum Wage Amendment and the people—apparently somehow alerted to and informed of this maneuver—approved it by a wide margin. This is whole-cloth invention and post-hoc fantasy. The Legislature enacted those statutes with the purpose of those bills in mind, not the Amendment. Encouraging employers to provide certain benefits in exchange for a tax break for the costs associated with doing so is very different from a scheme in which the working poor are offered health insurance in exchange for more than 12% of their hourly wages.

In any event, the Legislature cannot direct this Court's interpretation of the Constitution. "The constitution may not be construed according to a statute enacted pursuant thereto; rather, statutes must be construed consistent with the constitution," and rejected if inconsistent therewith." *Strickland v. Waymire,* 126 Nev. 230, 241, 235 P.3d 605, 613 (2010) (internal quotations omitted). Accepting Petitioners' theory of construction "would require the untenable ruling that constitutional provisions are to be interpreted so as to be in harmony with the statutes enacted pursuant thereto; or that the constitution is presumed to be legal and will be upheld unless in conflict with the provisions of a statute." *Id*. (internal quotations omitted).

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In summary, the Labor Commissioner's N.A.C. 608.102 is just not a very good or usable standard to apply in these circumstances, and there exists no compelling reason for the Court to adopt it or give deference to the interpretation in its own deliberations.

C. The District Court Was Correct To Apply Nevada's Existing Health Insurance Statutes To Petitioners' Plans

The order of the district court in this matter was cleanly reasoned. The court understood that "health insurance" in the Amendment had to mean something. It

understood that for purposes of effecting the actual aims of the Amendment, any standard for "health insurance" needed to make real, substantive health insurance available to Nevada employees making the sub-minimum wage. It understood that Petitioners' plans were obviously group plans within the definition of that term. Finally, it understood that over many years, the Nevada Legislature had made policy decisions regarding what characteristics and coverages group health insurance plans or employer-provided health benefits plans had to feature in order to be lawful.

Given all that, the objectively poor quality of Petitioners' plans, and other evidence before the court which did not create an impression that Petitioners were focused on any aspect of the Minimum Wage Amendment except the dollar per hour they could prise from their employees, the district court's decision was not a difficult one. It did not take much to demonstrate that Petitioners' plans could not meet statutory requirements once the court determined those requirements applied.[7]

The district court was correct in its analysis because Nevada's existing health insurance statutes 1) furnish a clear set of standards for employers and employees alike to understand; 2) are of longstanding nature, and therefore employers and insurers are familiar with their provisions; 3) ensure that the health insurance minimum wage employees are being offered in exchange for a portion of their hard-earned wages is real and substantial, rather than cheap or practically unusable to the insured.

Furthermore, the district court was correct to determine that limited-benefits plans or hospital indemnity plans likely could never meet statutory requirements of

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[7] Petitioners refer to N.R.S. Chapters 689A and 689B, and those provisions of Chapter 608 that deal with health insurance requirements as "legacy statutes." Petition at 61. This appears to be a made-up term, with no meaning.

N.R.S. Chapters 608, 689A, of 689B, and therefore could never qualify an employer to pay less than the upper-tier constitutional wage. Severely limited or supplemental benefits cannot be health insurance in Nevada, and certainly cannot be justified as qualifying employers to pay less in wages to the lowest-paid employees in the state.

The easiest, clearest, and most appropriate way of resolving the question here is to presume that when the drafters of the Amendment required "health insurance" be provided to employees to whom the employer desired to pay the lower-tier minimum hourly wage rate, the drafters knew 1) that "health insurance" was and remains a highly-regulated insurance product under a vast array of state and federal laws, especially including the Nevada Revised Code; 2) that the "insurance" being required as part of the Amendment was being provided by an employer to employees, thus bringing it within the ambit of N.R.S. Chapters 689A and 689B; 3) that because the Amendment is remedial and proposes certain benefits flow to minimum wage employees in Nevada, the insurance so offered would be substantive, usable, worthwhile insurance of the kind required by those code chapters; and 4) employers would have a choice to provide this kind of health insurance or simply go ahead and pay at the upper tier. This is the only principled way to treat the requirements of the Amendment for health insurance for minimum wage employees.

D. Amici Curiae

1. The Briad Amici

The Briad Amici argue ERISA preemption to invalidate entire sections of the Nevada Revised Statutes regarding health insurance. This is a bit of a non-sequitor, because Petitioners make no ERISA arguments in their writ petition.

Addressing this issue anyway, however, it is fair to say that Amici do not appear to understand ERISA or ERISA preemption. None of the Nevada state laws

referenced—not N.R.S. 608.1555, nor N.R.S. 608.156-1577, nor any portion of N.R.S. Chapter 689B—are preempted by ERISA. First, not even the Nevada Attorney General's opinion cited by Amici agrees with their position. The Attorney General, in A.G.O. 84-17, expressly assumed that "for the purposes of this opinion … we shall … assume that it is self-insured, or more properly self-funded, employee benefit plans which, not being subject to the Insurance Code, believe they are exempt from the Labor Code statutes at issue." 84 Nev. Att'y Gen Op. 17 (Nov. 2, 2984). Other types of non-self-insured group health plans are governed by the *Insurance Code* and those statutes are not preempted by ERISA. This is a key distinction escaping Amici. Petitioners' plans are not self-insured plans, or self-funded plans; they contracted with CIGNA (2012-2013), TransAmerica (2014), and whatever fly-by-night outfit concocted the 2015 plan, to allow those companies access to their employees. ERISA is not at issue here, nor could it be. Insofar as N.R.S. 608.1555, and through it N.R.S. Chapter 689B, regulates the offerings of insurers to which employers seeking to provide group health insurance to their workers must resort (which it clearly does—*see* N.R.S. 689B.015 *et seq.*), rather than only employers who self-insure their own employee benefits plans (which Petitioners do not), there can be no argument regarding ERISA preemption.

Second, there is no claim made in this case for an ERISA benefit, so preemption of a particular claim—the normal context for ERISA preemption—cannot apply. The claim here is for unpaid wages and damages associated therewith. In other words, ERISA preemption does not apply in a vacuum, and Real Parties have made no demand under state law that ought, properly, to have been made pursuant to ERISA.

Next, to the prospect of a potentially broader preemption, in Amici's rush to seize upon the ERISA language that Section 514(a) "preempts all state laws that

'relate to' any employee benefit plan," they miss the import of that section entirely, and its lengthy history of interpretation by courts. Only a little bit of research reveals that "ERISA was passed by Congress in 1974 to safeguard employees from the abuse and mismanagement of funds that had been accumulated to finance various types of employee benefits." *Massachusetts v. Morash*, 490 U.S. 107, 112, 109 S. Ct. 1668, 1671 (1989). "In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employee benefits from accumulated funds." *Id.* ERISA is, primarily, a pension-and-benefits protection statute, and its primary concern is not with health insurance made available by an employer through a private third-party insurer under state law—that is an area left, appropriately, to the states—but with self-funded or self-insured benefits plans that may include health benefits, so that those promised benefits are administered and paid out to qualified employees in a uniform manner overseen by federal courts.

As this Court has stated, "We cannot believe that [ERISA] regulates bare purchases of health insurance where, as here, the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits." *See Turnbow v. Pacific Mutual Life Ins. Co.*, 104 Nev. 676, 678, 765 P.2d 1160, 1161 (1988) (citing *Taggart Corp. v. Life and Health Benefits Administration*, 617 F.2d 1208, 1211 (5th Cir. 1980)). Here, Petitioners never "purchased" the Plans in question; they merely arranged for their subminimum wage employees to be solicited by the insurer entities.

Amici read the basic application of ERISA preemption far too broadly. This Court has stated, in the ERISA context, that "absent a clear and manifest intent of Congress, there is a presumption that federal laws do not preempt the application of state or local laws regulating matters that fall within the traditional police powers of the state, including health and safety matters." *Cervantes v. Health Plan*

of Nevada, Inc., 127 Nev. 789, 794, 263 P.3d 261, 265 (2011). While the text of ERISA states that it "preempts all state laws that 'relate to' any employee benefit plan," such "sweeping 'relate[d] to' language cannot be read with uncritical literalism," and that "United States Supreme Court noted that if the statute's 'relate[d] to' language is taken to extend to the furthest reaches imaginable, Congress's words of limitation would hold no meaning." *Id.*

This Court has also stated that

> State laws that 'relate to any employee benefit plan' are preempted by ERISA. In the context of ERISA, "[t]he words 'relate to' must be interpreted broadly to effectuate Congress' purpose of 'establish[ing] pension plan regulation as exclusively a federal concern. While there is no concrete rule to determine whether a state law is preempted by ERISA, the United States Court of Appeals for the Second Circuit provided some guidance in *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146 (2d Cir. 1989), when it stated that
>
> > [W]e find that laws that have been ruled preempted are those that provide an alternative cause of action to employees to collect benefits protected by ERISA, refer specifically to ERISA plans and apply solely to them, or interfere with the calculation of benefits owed to an employee. Those that have not been preempted are laws of general application—often traditional exercises of state power or regulatory authority—whose effect on ERISA plans is incidental.

Mack v. Estate of Mack, 125 Nev. 80, 98, 206 P.3d 98, 110 (2009) (certain internal quotations omitted). The application of N.R.S. 608.1555 *et seq.*, or any of the pertinent portions of N.R.S. Chapter 689B, do not "provide an alternative cause of action to employees to collect benefits protected by ERISA, refer specifically to ERISA plans and apply solely to them, or interfere with the calculation of benefits owed to an employee." Further, there is no pension plan at issue here. There is no ERISA conflict, and no ERISA preemption.

Furthermore, if more were needed, Amici's ERISA preemption argument is defeated by the simple fact that paying less than $8.25 per hour to employees and providing health insurance in order to do so is optional under the Minimum Wage

Amendment. No one forces them to submit themselves to the Nevada statutory regime governing health insurance in this context. Petitioners chose to submit themselves to those statutes, in their desire to pay the sub-minimum wage. ERISA is in place to avoid "bind[ing] ERISA plan administrators to a particular choice of rules" per state law, in derogation of federal regulation. *See Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 147, 121 S. Ct. 1322, 1327 (2001). But where a statutory "scheme does not force employers to provide any particular employee benefits or plans, to alter their existing plans, or even to provide ERISA plans or employee benefits at all," ERISA can have no preemptive effect on the state law in question. *SeWSB Elec., Inc. v. Curry*, 88 F.3d 788, 793 (9th Cir. 1996). *See also Keystone Chapter, Associated Builders & Contractors, Inc. v. Foley*, 37 F.3d 945, 960 (3d Cir. 1994) ("Where a legal requirement may be easily satisfied through means unconnected to ERISA plans, and only relates to ERISA plans at the election of the employer, it affects employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan.").

Even the Hawaii case which Amici cite does not support their preemption position. In *Standard Oil Co. of California v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), the Court of Appeals found preemption of a statute "because it required employers to have health plans, and it dictated the specific benefits employers were to provide in those plans." *Golden Gate Rest. Ass'n v. City & Cty. of San Francisco*, 546 F.3d 639, 655 (9th Cir. 2008) (citing *Standard Oil Co. of California*, 633 F.2d at 766)). And the benefits plan at issue in *Agsalud* was a "self-funded health care plan, governed by ERISA." *Standard Oil Co. of California*, 633 F.3d at 763. Petitioners' plans are not self-funded plans, and the Minimum Wage Amendment does not require Petitioners to have any plan at all.

The overall effect of the Briad Amici's intervention here is to underscore that Petitioners could have avoided any entanglement with questions of "qualifying

health benefits plans" merely by paying their employees the full constitutional minimum wage.

2. The Landry's Amicus Group

The Landry's Amici take a different tack, but the problem with their approach is that it gets us no further down the path towards determining what "health insurance" means in the Amendment.

The argument is that the district court should have undertaken some sort of massive survey to determine the available health insurance products in 2006, or between 2006 and 2013, to show that Petitioners could have complied with the dictates of Nevada statutory law. Putting aside the practical issues with such a demand, this argument concedes that Petitioners' plans since 2014 are not qualified plans.

On a more fundamental level, this approach—focusing primarily as it does upon the 10% premium cost cap issue—rests upon a misreading of the Amendment. Amici read the cost cap provision to mean that the total cost of the health benefits plan cannot exceed 10% of the employee's wages. That is not how the Amendment functions. The 10% provision mandates a cap on the cost of qualified health insurance *to the employee*. The insurance itself can cost five times that amount, as long as the charge to the employee is no more than 10% of wages, the employer can choose to subsidize any cost overrun. Many Nevada employers—*amici* Wendy's of Las Vegas, Inc. and Cedar Enterprises, Inc. among them—do exactly that: they ensure compliance with the 10% cost cap by charging themselves with any premium amounts over 10% of an employee's wages. This is the normal functioning of the Amendment, in which employers calculate whether it is more advantageous to withhold the dollar per hour when figuring the potential liability for premium subsidies, or whether it is simply better to pay the $8.25 in hourly wages.

Thus Amici's suggested survey of available plans would tell us nothing useful, because any employer could, were it magnanimous enough, to subsidize even the most expensive health insurance plans for its minimum wage employees That employers would resist those subsidies is not material; theoretically, any employer could comply with both coverage and cost requirements for any insurance plan, even employing the standards found in N.R.S. Chapters 608, 689A, and 689B, anytime they chose to. The predicate of Amici's position is that employers would prefer the costs of these health insurance plans be borne entirely by the employee.

The Landry's Amici also include a paternalistic section touting the benefits of limited-benefits health plans, or "mini-meds." This is rich, coming from a defendant in a companion case to this one in which discovery has shown that less than 4% of Amici's thousands of employees enrolled in their offered limited-benefits plans. The shame is not that Amici's employees may be denied access to such plans, it is that such plans may be allowed to stand as "health insurance" and provide Amici with the windfall of retention of these employees' wages under the Amendment. The concern by public health advocates regarding limited-benefits plans has been sustained and incisive. *See* Consumer Reports, *Junk health insurance: Stingy plans may be worse than none at all*, http://www.consumerreports.org/cro/magazine/2012/03/junk-health-insurance/index.htm (Mar. 2012) (last accessed on Dec**.** 29, 2016); Consumer Reports, *Hazardous health plans: Coverage gaps can leave you in big trouble*, http://www.consumerreports.org/cro/2012/05/hazardous-health-plans/index.htm (May 2009) (last accessed on Dec**.** 29, 2016).

One last point: The overarching narrative of the Landry's Amici's brief is that this Court should interpret the Minimum Wage Amendment in a manner that gives it real meaning. In general, of course, we agree with that sentiment and point

out that, in combination with the Court's decision in *Diaz I* that employers need only offer plans to employees, a ruling here that the offered plans may be as hollow and useless as Petitioners' will leave Real Parties—ten years after enactment of the Minimum Wage Amendment—with no raise in wages above the federal minimum and no functional health insurance.

VII. CONCLUSION

Based upon the foregoing, Real Parties ask this Court to deny the writ petition, with instructions that the district court's decision be given effect as the correct interpretation of the meaning of "health insurance" as employed by the Minimum Wage Amendment.

Dated this 30th day of December 2016.

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CERTIFICATE OF COMPLIANCE

1. I certify that this Answer complies with the formatting requirements of N.R.A.P. 32(a)(4), the typeface requirements of N.R.A.P. 32(a)(5) and the type style requirements of N.R.A.P. 32(a)(6) because it has been prepared in a proportionally spaced typeface, size 14, Times New Roman.

2. I further certify that this Answer complies with the type-volume limitations of N.R.A.P. 32(a)(7) because, excluding the parts of the Answer exempted by N.R.A.P. 32(a)(7)(C), it contains 13,561 words.

3. Finally, I hereby certify that I have read this Answer, and to the best of my knowledge, information and belief, it is not frivolous or interposed for any improper purpose. I further certify that this Answer complies with all applicable Nevada Rules of Appellate Procedure, in particular N.R.A.P. 28(e)(1), which requires every assertion in the Answer regarding matters in the record to be supported by a reference to the page and volume number, if any, of the transcript or appendix where the matter relied on is to be found. I understand that I may be subject to sanctions in the event that the accompanying Answer is not in conformity with the requirements of the Nevada Rules of Appellate Procedure.

Dated this 30th day of December 2016.

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CERTIFICATE OF SERVICE

I hereby certify that on this 30th day of December, 2016, a true and correct copy of the **REAL PARTIES IN INTEREST'S ANSWER TO PETITION FOR WRIT OF MANDAMUS** was served upon all counsel of record by electronically filing the document using the Nevada Supreme Court's electronic filing system.

By: */s/ Dannielle Fresquez*
Dannielle Fresquez, an Employee of
WOLF, RIFKIN, SHAPIRO, SCHULMAN & RABKIN, LLP