IN THE SUPREME COURT OF THE STATE OF NEVADA

Supreme Court Case No.
District Court Case No. A-19-792978

UnitedHealth Group, Inc., United Healthcare Insurance Company, United Health Care Services, Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health and Life Insurance Company, Inc., Sierra Health-Care Options, Inc., Health Plan of Nevada, Inc.,
Petitioners

v.

The Eighth Judicial District Court, State of Nevada, Clark County, and the Honorable Nancy L. Allf, District Court Judge,
Respondent

and

Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada-Mandavia, P.C., Crum Stefanko and Jones, Ltd.,
Real Parties in Interest.

PETITION FOR WRIT OF PROHIBITION, OR, ALTERNATIVELY, MANDAMUS

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NRAP 26.1 DISCLOSURE

The undersigned counsel of record certifies that the following is an entity as described in NRAP 26.1(a) and must be disclosed. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

Petitioner UnitedHealth Group Incorporated is the ultimate parent corporation of Petitioners United Healthcare Insurance Company, United Health Care Services, Inc., UMR, Inc., Oxford Health Plans, LLC (incorrectly named in District Court Complaint as Oxford Health Plans, Inc.), Sierra Health and Life Insurance Company, Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc. UnitedHealth Group Incorporated is a publicly held company and directly and/or indirectly owns 10% or more of these Petitioners' stock. Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC is the only law firm that has appeared on behalf of Petitioners in this case or is expected to appear on behalf of Petitioners in this Court.

Dated: August 21st, 2020

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ROUTING STATEMENT

This matter is assigned to the Nevada Supreme Court because the case originated in business court. *See* NRAP 17(a)(9). In addition, the issues raised herein regarding the application of preemption under the Employee Retirement Income Security Act of 1974 ("ERISA") to a health care provider's state law claims against an insurer/plan administrator constitute questions of first impression on the scope of ERISA preemption of state common law claims arising out of ERISA plans which the Supreme Court may wish to address. *See* NRAP 17(a)(11). And all issues presented raise a question of statewide public importance. *See* NRAP 17(a)(12).

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

Rules

I. ISSUES PRESENTED AND RELIEF SOUGHT

Plaintiffs are for profit, private-equity backed out-of-network medical providers based in Nevada who are affiliated with TeamHealth Holdings, Inc., one of the largest national physician management companies in the United States ("TeamHealth Providers" or "Plaintiffs"). Defendants are affiliates and subsidiaries of UnitedHealth Group Incorporated ("United" or "Defendants"). Defendants administer health plans whose members have received medical treatment from the TeamHealth Providers. Plaintiffs allege that the health plans have underpaid Plaintiffs for medical services rendered to plan members, and seek to compel the controlling plans to pay Plaintiffs at what they suggest is the "usual and customary rate"—without any regard to the explicit terms of the plans. To achieve the goal of forcing all of the plans (which contain varying terms) to pay the same inflated amounts regardless of their terms, the Plaintiffs have brought a host of state law claims. However, all of Plaintiffs' claims are subject to dismissal because they suffer from the same defect—they are preempted by ERISA.

This petition arises out of the district court's June 24, 2020 denial of Defendants' Motion to Dismiss Plaintiffs' First Amended Complaint ("Motion to Dismiss"). By denying Defendants' Motion to Dismiss, the district court erred with respect to three significant issues and is now acting in contravention of both federal law and Nevada law governing the issue of ERISA preemption.

Allowing Plaintiffs' state law claims to proceed would directly undermine the congressional intent behind ERISA—creating a uniform national administrative scheme that guides the processing of claims and disbursement of benefits for employee health plans. ERISA expressly requires that an employee health plan (1) "specify the basis on which payments are made to and from the plan," 29 U.S.C. § 1102(b)(4), and (2) that the fiduciary shall administer the plan "in accordance with the documents and instruments governing the plan," 29 U.S.C. § 1104(a)(1)(D) (emphasis added). The health plans implicated by Plaintiffs' claims contain payment terms—generally selected by plan sponsors—specifying the amount of reimbursement owed to out-of-network providers like Plaintiffs when those providers treat a plan member. By bringing state law claims that ask a court/jury to force the health plans to pay out-of-network providers at a higher rate than their plan terms require, the Plaintiffs are seeking a remedy that directly conflicts with ERISA's requirements and thus their state law claims are preempted.

Defendants have no plain, speedy, and adequate remedy at the conclusion of this action and principles of judicial economy favor entertaining this petition on the merits. This case is more similar to a suit by 1000-plus separate plaintiffs, each with their own multi-faceted claim, than a suit by just three plaintiffs, as the caption would make it appear. Plaintiffs have received assignments of benefits from all of the plan members they treated, which have allowed them to bring

15,210 separate claims of underpayment against the Defendants. With 15,210 claims at issue, Defendants estimate it would take 30,420 hours just to pull the administrative records for each claim. Based on the foregoing, it would take a team of four people working full-time on nothing other than gathering documents for this case over 3 years to pull the applicable administrative records. Moreover, this does not even take into account the substantial discovery from outside the administrative record that Plaintiffs are seeking based on state law claims that are unquestionably preempted.

Now is the appropriate time to remedy these legal errors, which, if allowed to run their natural course, will lead to years of burdensome discovery and extraordinary expense that will be rendered completely unnecessary if, on appeal, this Court finds that Plaintiffs' claims are preempted. Without writ relief, the real parties in interest will be rewarded for artfully pleading state law claims that are, at bottom, claims for additional benefits from ERISA plans and thus subject to ERISA's broad preemption provisions. Writ relief is necessary to avoid such manifest injustice.

In addition, the Nevada Supreme Court has never addressed the scope of ERISA preemption as applied to an out-of-network provider's claims against an insurer/plan administrator. This issue is currently being litigated around the country by TeamHealth-affiliated providers and addressing this issue now (as

opposed to three years from now after an appeal) will provide needed guidance to not only the Parties, but also numerous other Nevada medical providers and insurers who face this issue. Indeed, the United States District Court for the District of Arizona recently dismissed a complaint filed by Plaintiffs' affiliates asserting nearly identical factual allegations against United. *Emergency Group of Arizona Professional Corporation, et al. v. United Healthcare Incorporated, et al.*, No. CV-19-04687-PHX-MTL, Dkt. 85 at 13 (D. Az. filed Mar. 25, 2020). And in a similar action filed by TeamHealth affiliates in Texas, the federal court found that certain of the providers' claims were completely preempted by ERISA. *ACS Primary Care Physicians Southwest, P.A., et al v. UnitedHealthcare Insurance Company, et al.*, No. 4:20-CV-1282, Dkt. 38 (S.D. Tex. filed Aug. 17, 2020).

There are two types of preemption under ERISA—conflict preemption and complete preemption. Under conflict preemption, a state law claim is subject to dismissal if it "relates to" an employee benefit plan governed by ERISA. Under complete preemption, on the other hand, a state law claim is subject to dismissal if the plaintiff (1) could have brought a federal claim under ERISA and (2) no independent legal duty is implicated by the defendant's actions. In their Motion to Dismiss, Defendants argued that both types of preemption apply here and are fatal to Plaintiffs' state law claims.

The district court denied Defendants' Motion to Dismiss because it found that ERISA preemption was only intended to apply to disputes between a plan and its members, and was not intended to cover rate of payment disputes between a medical provider and an insurer. The district court further erroneously found that Plaintiffs' state law claims satisfied NRCP 12(b)(5)'s requirements and adequately alleged the violation of a legal duty independent of ERISA that brought the claims outside the broad scope of ERISA preemption.[1] The district court's decision gives rise to the following three issues:

First Issue: Did the district court err by finding that conflict preemption under ERISA can never apply to an out-of-network medical provider's claims against an insurer/plan administrator for additional reimbursement and, if so, did the district court err by refusing to dismiss Plaintiffs' claims on the basis of conflict preemption?

Second Issue: Did the district court err by finding that a state court can never dismiss state law claims on the basis of complete preemption under ERISA

[1] The District Court's decision to allow Plaintiffs to maintain their fourth cause of action, for Violation of NRS 686A.020 and 686A.310, is exemplary of this clear error. The Nevada Supreme Court has already unequivocally found that claims under the Nevada Unfair Trade Practices Act are preempted by ERISA. *Villescas v. CNA Ins. Companies*, 109 Nev. 1075, 1084, 864 P.2d 288, 294 (1993). ("We add Nevada's voice to the growing body of case law holding state unfair insurance practice claims to be preempted by ERISA and conclude that Chapter 686A of the Nevada Insurance Code is preempted by ERISA when applied to a valid ERISA plan.").

and, if so, did the district court err by refusing to dismiss Plaintiffs' claims on the basis of complete preemption?

Third Issue: Did the district court err by finding that Plaintiffs had adequately alleged claims for relief under NRCP 12(b)(5) for (1) Breach of Implied-in Fact Contract, (2) Tortious Breach of the Implied Covenant of Good Faith and Fair Dealing, (3) Unjust Enrichment, (4) Violation of NRS 686A.020 and NRS 686A.310, (5) Violations of Nevada's Consumer Fraud and Deceptive Trade Practices Acts, and (6) Violation of NRS 207.350, et seq. (Nevada's RICO Act)? If so, did the district court also err by finding that Plaintiffs have adequately alleged the violation of a legal duty independent of ERISA that brings these state law claims outside the broad scope of ERISA preemption?

Based on these issues, *Defendants seek the following relief.* As to the first issue, Defendants seek a writ of prohibition or alternatively a writ of mandamus compelling the district court to vacate its order and hold that Plaintiffs' claims are subject to conflict preemption under ERISA.

As to the second issue, Defendants seek a writ of prohibition or alternatively a writ of mandamus compelling the district court to vacate its order and hold that Plaintiffs' claims are subject to complete preemption under ERISA.

As to the third issue, Defendants seek a writ of prohibition or alternatively a writ of mandamus compelling the district court to vacate its order and hold that

Plaintiffs have failed to state a cognizable claim for relief under NRCP 12(b)(5) and that, based on the allegations in the First Amended Complaint ("FAC"), the only legal duties owed by Defendants to Plaintiffs are those that arise based on the terms of the health plans and the assignments of benefits Plaintiffs received from Defendants' plan members.

This writ petition should be granted and the district court instructed to dismiss Plaintiffs' state law claims with prejudice, except that Plaintiffs should be permitted to amend their Complaint to assert a federal statutory cause of action under 29 U.S.C. § 1132(a)(1)(B) of ERISA, subject to any defenses Defendants may have to such a claim.

II. STATEMENT OF PERTINENT FACTS

A. Background

Plaintiffs allege that the Defendants have underpaid Plaintiffs for out-of-network medical services rendered to Defendants' plan members, and seek to be reimbursed at either the "reasonable rate" or the "usual and customary rate" for the medical services they provided to Defendants' plan members. 2 PA 97 (FAC ¶ 21).[2] Plaintiffs allege that the reasonable rate of reimbursement is 75-90% of their unilaterally set billed charges. 2 PA 101 (FAC ¶ 46). Plaintiffs are challenging the

[2] "PA" refers to the Petitioners' Appendix submitted in conjunction with this writ petition. The number preceding PA indicates the volume number. The number following the PA indicates the bates number.

amount that they received on 15,210 separate health benefit claims they submitted to Defendants for payment after receiving an assignment of benefits from Defendants' plan members. *See* 1 PA 77-84 (showing number of claims at issue); 2-3 PA 172-273 (showing Plaintiffs received assignments). The dispute between the Parties involves medical services that were provided from approximately July 2017 to present. 2 PA 98. Defendants contend that each health plan is an employer sponsored plan governed by ERISA and thus all of Plaintiffs' state law claims are preempted by ERISA. 2 PA 143-145.

B. Relevant Procedural History

1. Plaintiffs File Suit in State Court, Defendants Remove to Federal Court, and the Case is Remanded

Plaintiffs filed their original Complaint on April 15, 2019 in the Eighth Judicial District Court. 1 PA 1-17. Defendants removed this case to Nevada Federal District Court on May 14, 2019. 1 PA 18-76. On February 20, 2020, the Nevada Federal District Court remanded this case back to the Eighth Judicial District Court. 1 PA 85-90.

2. After Remand, Defendants Move to Dismiss the FAC in its Entirety Based on Conflict Preemption and Complete Preemption Under ERISA

On May 15, 2020, by mutual agreement of the Parties, Plaintiffs filed the FAC in the Eighth Judicial District Court. 2 PA 91-139. The FAC asserted the

following eight causes of action: (1) Breach of Implied-in-Fact Contract, (2) Tortious Breach of the Implied Covenant of Good Faith and Fair Dealing, (3) Unjust Enrichment, (4) Violation of NRS 686A.020 and 686A.310, (5) Violation of Nevada's Prompt Pay Statutes and Regulations, (6) Violation of Nevada's Consumer Fraud & Deceptive Trade Practices Acts, (7) Declaratory Judgment and (8) Violation of Nevada's RICO statute (NRS 207.350 *et. seq.*).

Defendants moved to dismiss the FAC on the basis that all eight claims were preempted by ERISA. 2-3 PA 140-285. Defendants' Motion to Dismiss argued that (1) Plaintiffs' claims were conflict preempted (2 PA 145-150), (2) Plaintiffs' claims were completely preempted (2 PA 150-153) and (3) that Plaintiffs had failed to state a claim under NRCP 12(b)(5)[3] and thus, by extension, had not alleged a violation of a duty independent of ERISA that would allow their state law claims to escape preemption. 2 PA 155-169.

[3] This third argument was also important for the less than 10% of Plaintiffs' claims that relate to individual Affordable Care Act plans and were thus not subject to ERISA preemption. Defendants argued that those claims would still have to be dismissed under NRCP 12(b)(5) for failure to state a claim. Thus, if granted, the Motion to Dismiss would have resulted in the dismissal of all eight of Plaintiffs' claims. 2 PA 143.

3. The Clark County District Court Improperly Denies Defendants' Motion to Dismiss and Finds that None of the TeamHealth Providers' Claims Are Preempted by ERISA

The district court heard oral argument on Defendants' Motion to Dismiss on June 5 and June 9. 5 PA 463-497, 500-589, 498-499. On June 9, the Court denied the Motion for the following reasons:

(1) The Court concluded that both conflict preemption and complete preemption under ERISA are only meant to apply to disputes between a plan and its members, not between a provider and an insurer, which is the relationship between Plaintiffs and Defendants. 5 PA 561 (hearing transcript at 62:15-24);

(2) The Court concluded that the *Davila* test for complete preemption did not apply, and that the federal court's remand order finding that complete preemption did not apply was very persuasive. 5 PA 561-562 (hearing transcript at 62:25 – 63:1-8);

(3) The Court concluded that each of Plaintiffs' eight causes of action had been adequately pled and that the claims that needed to be pled with particularity were pled with sufficient particularity. 5 PA 562-563 (hearing transcript at 63:9-22; 64:3-5).

The Court directed the Plaintiffs to prepare an order that was consistent with the Court's June 9 ruling and also with Plaintiffs' Opposition papers. 5 PA 563.

On June 24, 2020, the Court entered a 40 page order submitted by Plaintiffs. 5 PA 587-628. The primary argument adopted by the Court's written order (in addition to those set forth above) is that provider claims involving the "rate of payment" are not preempted by ERISA because such claims do not require a court/jury to consult the plan terms to resolve the dispute and thus do not "relate to" a plan governed by ERISA. *See e.g.*, 5 PA 599-601. The written order also held that a state district court cannot dismiss state law claims on the basis of complete preemption because complete preemption is a jurisdictional doctrine that only applies when a case is in federal court. 5 PA 598-599.

C. Undisputed Facts Outside the First Amended Complaint that Support a Finding of Conflict Preemption and Complete Preemption Under ERISA

When considering a motion to dismiss, the general rule is that a court is limited to reviewing the allegations in the complaint and should not consider outside evidence. However, there is an exception to this rule where the defendant raises a defense of federal preemption. In that circumstance, the court may consider evidence outside the complaint showing that the claims relate to employee benefit plans governed by ERISA.[4] The purpose of this exception to the general rule is to prevent plaintiffs, like the TeamHealth-affiliated provider Plaintiffs here,

[4] *Densmore v. Mission Linen Supply*, 164 F. Supp. 3d 1180, 1188, n. 2 (E.D. Cal. 2016).

from attempting to thwart the congressional intent that ERISA provide the exclusive remedy for these types of claims through artful pleading.

Plaintiffs' FAC fails to identify any of the specific claims at issue, including failing to identify who was treated, on what date, and pursuant to which health plan. Despite this, as demonstrated below, Defendants have determined that nearly all of the at-issue claims relate to ERISA-governed employee benefit plans and are thus both conflict preempted and completely preempted.

During the time frames alleged in the Complaint, Plaintiffs made claims/requests for payment to the following Defendants: UHIC, UHS, UMR, Oxford, SHL, HPN, and SHO. For the tens of thousands of claims that Plaintiffs submitted to UHIC, UHS and UMR, all but one of the claims were made against ERISA-governed plans.[5] For the claims made against Oxford and SHO, all of the claims were made against ERISA governed plans.[6] For the claims made against SHL, approximately 72% of the claims were made against ERISA-governed plans.[7] For the claims made against HPN, approximately 84% of the claims were made against ERISA-governed plans.[8] In sum, over 90% of Plaintiffs' claims in

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[5] 2 PA 172-175 (UHIC, UHS and UMR Declaration ¶ 7).

[6] 2 PA 176-179 (Oxford Declaration ¶ 7); 2 PA 180-183 (SHO Declaration ¶ 7).

[7] 2 PA 184-187 (SHL and HPN Declaration ¶ 7).

[8] *Id.* (SHL and HPN Declaration ¶ 8).

the relevant period were for services provided to members of ERISA-governed plans. Plaintiffs never disputed this factual issue in the Motion to Dismiss briefing. *See generally* 4 PA 301-406.

Furthermore, for all of the claims that Plaintiffs are asserting in this litigation, Plaintiffs represented that they received assignments of benefits from their patients that would allow Plaintiffs to sue under ERISA by standing in the shoes of each patient and asserting claims for benefits seeking additional reimbursement under the terms of the plans.[9] As discussed in more detail below, these assignments of benefits are critical because they render Plaintiffs the type of party, under the *Davila* test discussed in Section III(B)(3), that can assert a claim under ERISA § 502(a)(1)(B), ERISA's civil enforcement statute, causing Plaintiffs' state law claims to be completely preempted. Plaintiffs never disputed the existence or validity of the assignments of benefits from Defendants' plan

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[9] *See* 2 PA 172-175 (UHIC, UHS and UMR Declarations ¶ 7); 2 PA 184-187 (SHL and HPN Declaration ¶¶ 7–8); 2 PA 176-179 (Oxford Declaration ¶ 7); 2 PA 180-183 (SHO Declaration ¶ 7); *see also* 3 PA 188-233 (sample claims forms to UMR during the 2017-2019 time period showing Box 27 "Accept Assignment" checked "YES"); 3 PA 234-273 (sample claim forms to SHO during the same time period). Defendants have reviewed claim forms and related data for the claims that were made under plans issued or administered by the other United entities named as defendants in this lawsuit and confirmed that Plaintiffs also received an assignment of benefits for those claims but have not attached those claim forms to avoid overburdening the Court. Those claim forms can be produced if necessary, however.

members in the Motion to Dismiss briefing. 4 PA 301-406.

III. STATEMENT OF REASONS WHY THE WRIT SHOULD ISSUE

A. This writ petition should be entertained on the merits.

"A writ of mandamus is available to compel the performance of an act that the law requires as a duty resulting from an office, trust, or station or to control an arbitrary or capricious exercise of discretion." *Int'l Game Tech., Inc. v. Second Judicial Dist. Court*, 124 Nev. 193, 197, 179 P.3d 556, 558 (2008) (citing NRS 34.160). Conversely, a writ of prohibition is available to arrest proceedings where a district court has acted in excess of its jurisdiction. NRS 34.320; *Las Vegas Sands v. Eighth Judicial Dist. Court*, 130 Nev. 643, 649, 331 P.3d 905, 909 (2014).

This Court has discretion whether to entertain a writ petition on its merits and issue a writ of mandamus or prohibition. *See Okada v. Eighth Judicial Dist. Court*, 408 P.3d 566, 569 (Nev. 2018). Nevada courts must entertain writ petitions when a plain, speedy, and adequate remedy in the ordinary course of law does not exist. *See* NRS 34.170; NRS 34.330. A right to direct appeal is generally considered a plain, speedy, and adequate remedy in the ordinary course of law. *See Rawson v. Ninth Judicial Dist. Court*, 396 P.3d 842, 847 (Nev. 2017). But, despite the availability of a direct appeal, Nevada courts consider writ petitions under a variety of circumstances. Here, this writ petition should be entertained on the merits for the following reasons.

1. This writ petition features all of the considerations that have previously motivated the Court to entertain writ petitions under similar circumstances despite the availability of a direct appeal.

Despite the availability of a direct appeal, writ petitions are entertained where all or some of the following considerations are present: (i) there are no factual disputes, (ii) the district court acted contrary to clear authority, (iii) an important issue of law needs clarification, (iv) the petition gives the Court an opportunity to define the parameters of a statute, (v) public policy will be served by the Court's invocation of its original jurisdiction, and (vi) sound judicial economy and administration favor entertaining the petition. *See, e.g., Okada*, 408 P.3d at 569; *Nevada Yellow Cab Corp. v. Eighth Judicial Dist. Court*, 383 P.3d 246, 248 (Nev. 2016); *International Game Technology*, 124 Nev. at 197, 179 P.3d at 559.

The Nevada Supreme Court has relied upon these considerations to entertain writ petitions challenging the denial of a motion to dismiss. *See Otak Nevada, LLC v. Eighth Judicial Dist. Court*, 127 Nev. 593, 597, 260 P.3d 408, 410 (2011); *International Game Technology*, 124 Nev. at 198, 179 P.3d at 559; *Smith v. Eighth Judicial Dist. Court*, 113 Nev. 1343, 1345, 950 P.2d 280, 281 (1997). In *Otak*, the Court entertained a writ petition challenging whether a pleading was void because the determination of the issue was "not fact-bound and [involved] an unsettled question of law that [was] likely to recur, and because [the] case [was] in the early

stages of litigation and resolving [the] question now [would] promote[ ] judicial economy." 127 Nev. at 597, 260 P.3d at 410.

Critically, whether ERISA preempts state law has been previously considered to be of such importance that the Nevada Supreme Court will consider a writ petition challenging the denial of a motion to dismiss on the merits. *See W. Cab Co. v. Eighth Judicial Dist. Court of State in & for Cty. of Clark*, 133 Nev. 65, 68, 390 P.3d 662, 667 (2017) ("The instant petition seeks reversal of a denial of a motion to dismiss. Although we typically deny such petitions, considering this petition would serve judicial economy and clarify an important issue of law.") (addressing ERISA preemption of the Minimum Wage Amendment); *see also Tallman v. Eighth Jud. Dist. Ct.*, 131 Nev. 713, 725, 359 P.3d 113, 121 (2015) (addressing petition on the merits dealing with federal preemption under the Federal Arbitration Act and National Labor Relations Act). As shown below, all of the above considerations favor entertaining this writ petition on the merits.

a. This petition concerns ERISA preemption of a medical provider's state law claims which is an important and novel issue in Nevada that is likely to recur

Here, the core issue presented by this writ petition is whether ERISA preempts Plaintiffs' eight state law claims, which this Court has already previously found can constitute an important issue of law. Further, while this Court has addressed ERISA preemption in a past decision involving state law claims brought

by a *plan member* against an insurer/plan administrator,[10] it has never had an opportunity to address ERISA preemption in the context of an out-of-network *medical provider's claims* against an insurer/plan administrator. Disputes over the appropriate rate of reimbursement for medical services between out-of-network providers and plan administrators are bound to continue to arise and thus this factor favors considering this writ petition on the merits.

b. Judicial economy, administration and public policy favor entertaining the petition on the merits

Although this case was filed on April 15, 2019, it remains in its infancy. Defendants' Motion to Dismiss was not decided until June 9, 2020 and Defendants filed their Answer on July 8, 2020. 5 PA 587-628; 5 PA 629-678. Further, very little discovery has taken place to date. Plaintiffs have served only one set of written discovery, relatively few documents have been produced and no depositions have been noticed.

However, discovery is about to begin in earnest and is likely to be extraordinarily expensive. Plaintiffs are asserting 15,210 claims for additional reimbursement for medical services. 1 PA 78 (Way Declaration at 2:10-12). In a burden declaration attached to their responses to Plaintiffs' requests for production, Defendants demonstrated that it would take, on average, 2 hours just to pull the

[10] *See Villescas*, 109 Nev. 1075, 1083, 864 P.2d 288, 293 (1993) (finding that an insured's state law claims against his insurer were preempted by ERISA).

administrative record for a single claim. 1 PA 82 (Way Declaration at 6:3-11). With 15,210 claims at issue, this means that it would take 30,420 hours just to pull the administrative records for each claim. *Id.* Based on the foregoing, it would take a team of four people working full-time on nothing other than gathering documents for this case over 3 years to pull the applicable administrative records. *Id.* Moreover, this does not take into account the additional discovery which will be needed to probe the merits of Plaintiffs' other state law claims, such as their RICO claim. 2 PA 133-135. The Parties should not be forced to incur substantial discovery costs only for the district court to potentially be reversed on appeal because all of the Plaintiffs' state law claims are subject to preemption under ERISA. This is especially so given that the Nevada Supreme Court has never set forth its position on the scope of ERISA preemption as applied to an out-of-network provider's claims against an insurer/plan administrator.

c. The district court acted contrary to clear authority in declining to find ERISA preemption applied.

As will be set forth more fully below, the district court acted contrary to clear legal authority by finding that ERISA preemption only applies to disputes between plan members and insurers. 5 PA 561 (hearing transcript). While Nevada state courts have not yet addressed this issue, federal courts all over the country, including the Ninth Circuit, have expressly held that once a medical provider accepts an assignment of benefits from a plan member and asserts a claim for

reimbursement to the insurer, that provider stands in the shoes of the plan member and its state law claims are just as susceptible to preemption under ERISA as a plan member's state law claims.[11]

Moreover, by accepting Plaintiffs' "rate of payment vs. right to payment" argument, the district court misapprehended the fundamental difference between in-network providers and out-of-network providers. In-network providers have a written contract with the insurer/plan administrator that sets forth the rate of reimbursement. Thus, for in-network provider claims, a court only need look to the parties' contract to determine whether additional reimbursement is owed by the insurer and does not need to look at the terms of the ERISA governed plan.[12] However, for out-of-network providers with no written provider agreement, the only document setting forth the applicable rate of payment is the patient's health plan.[13] Here, since the Plaintiffs admit they are out-of-network providers that lack a written contract with Defendants (FAC ¶ 20, 2 PA 97), the court will have to consult the members' ERISA plans to determine the appropriate rate of payment

[11] *See e.g., Melamed v. Blue Cross of California,* 557 F. App'x 659, 661 (9th Cir. 2014); *In Re Managed Care Litig.*, 298 F. Supp. 2d 1259, 1292 (S.D. Fla. 2003).

[12] *See e.g., Blue Cross of California v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1051 (9th Cir. 1999) (provider's state law claims were not preempted because the provider had a written agreement with the insurer that specified the rate of payment owed for medical services).

[13] *See e.g.*, n. 11, *supra.*

and thus a finding of preemption is required.[14] For these, and the other reasons set forth below, the district court's decision was clear error and the writ should be entertained on the merits.

d. The Court does not need to resolve any factual disputes to decide this writ petition

Since this writ petition challenges a district court's denial of a motion to dismiss, the majority of the analysis involves simply applying the case law to the allegations in the FAC. The only factual issues outside the FAC implicated by this writ are (1) whether the patients treated by Plaintiffs had employer sponsored health plans governed by ERISA and (2) whether Plaintiffs accepted an assignment of benefits from those patients.[15] However, there was no dispute over these factual issues at the district court level. Defendants submitted evidence with their Motion to Dismiss demonstrating (1) that over 90% of Plaintiffs' claims were for services provided to members of ERISA-governed plans and (2) that Plaintiffs received an assignment of benefits from the patients for all of the claims at issue. 2 PA 143-146. Plaintiffs never contested these facts but instead argued they were irrelevant to the district court's analysis. 4 PA 311-312. Thus, deciding this writ petition will not require this Court to resolve any factual disputes between the Parties.

[14] *See* Section III(B)(2), *infra*, for a thorough explanation of why Plaintiffs' rate of payment argument fails.

[15] *See* n. 4, *supra*, for case law showing that facts outside the pleadings may be considered at the motion to dismiss stage if a defense of ERISA preemption is raised.

2. Given the stage and nature of this litigation, appeal does not constitute an adequate and speedy remedy.

Under certain circumstances, the Nevada Supreme Court has held that "the availability of a direct appeal from a final judgment may not always be an adequate and speedy remedy." *Okada*, 408 P.3d at 569. "Whether a future appeal is sufficiently adequate and speedy necessarily turns on the underlying proceedings' status, the types of issues raised in the writ petition, and whether a future appeal will permit this court to meaningfully review the issues presented." *D.R. Horton, Inc. v. Eighth Judicial Dist. Court*, 123 Nev. 468, 475, 168 P.3d 731, 736 (2007). In fact, in *International Game Technology*, the Court, in entertaining a writ petition challenging the denial of a motion to dismiss, noted that "an appeal is not an adequate and speedy remedy, given the early stages of litigation and policies of judicial administration." 124 Nev. at 198, 179 P.3d at 559. *See also G. & M. Properties*, 95 Nev. at 303–04, 594 P.2d at 715–16 (internal citations omitted).

Given the early stage of this litigation, the enormous burden that discovery on 15,210 separate claims for reimbursement will impose on the Defendants, and the important issues presented by this writ petition, the potential availability of a direct appeal on the issues does not, as found in *International Game Technology*, actually constitute "an adequate and speedy remedy."

B. This Court should issue a writ of prohibition, or, of mandamus to correct the district court's improper denial of the Motion to Dismiss

1. Standard of Review

The Nevada Supreme Court has long held that, in the context of a writ petition, questions of law, such as questions of statutory interpretation are reviewed de novo. *See Helfstein v. Eighth Judicial Dist. Court*, 131 Nev. Adv. Op. 91, 362 P.3d 91, 94 (2015). Here, all of the issues raised in this writ petition involve issues of law and should thus be reviewed de novo by this Court.

2. The district court erred by concluding that Plaintiffs' claims were not subject to conflict preemption under ERISA

a. Explanation of the ERISA Preemption Clause, Saving Clause and Deemer Clause

ERISA is a federal legislative scheme that "comprehensively regulates" employee benefit plans that provide medical care for employees. 29 U.S.C. §§ 1001(b), 1002(1); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44 (1987). To ensure that plans and plan administrators would be subject to a uniform body of benefit laws, Congress capped off ERISA with three provisions setting forth the preemptive effect of the federal legislation, which are known as (1) the preemption clause,[16] (2) the saving clause,[17] and (3) the deemer clause.[18] These clauses work

[16] 29 U.S.C. § 1144(a). In cases discussing conflict preemption, this section is also commonly referred to as § 514(a) of ERISA.

[17] 29 U.S.C. § 1144(b)(2)(A).

together as follows: First, if a state law "relates to" an employee benefit plan, it is preempted. Second, even if a state law relates to an employee benefit plan, the ERISA saving clause exempts laws that "regulate insurance" from preemption. Third, even if a state law regulates insurance and is therefore "saved" from preemption, the ERISA deemer clause prohibits a state from deeming a self-insured[19] employee benefit plan to be an insurer and enforcing such a law against it. *Pilot Life Ins. Co.*, 481 U.S. at 45.

b. Plaintiffs' Claims "relate to" ERISA plans because they conflict with the payment terms in the plan documents and would require the Court to essentially rewrite those terms.

The Ninth Circuit has repeatedly stated that ERISA's preemption clause is "one of the broadest preemption clauses ever enacted by Congress." *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1439 (9th Cir. 1990). "[A] state law 'relate[s] to' a benefit plan in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Pilot Life Ins. Co.*, 481 U.S. at 47. In elaborating further on this principle, the U.S. Supreme Court has stated that two categories of state laws[20] are subject to conflict preemption: (1) state laws that have an explicit

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[18] 29 U.S.C. § 1144(b)(2)(B).

[19] A self-funded plan is defined as a plan that does "not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants." Rather, it pays claims out of its own funds. *FMC Corp. v. Holliday*, 498 U.S. 52, 54 (1990).

[20] Under ERISA, the term "state law" is defined as "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." 29 U.S.C.

"reference to" ERISA plans such that the existence of ERISA plans is essential to the law's operation and (2) state laws that "govern a central matter of plan administration or interfere[] with nationally uniform plan administration." *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016) (emphasis added). Here, Plaintiffs' eight state law claims fall into the second category of conflict preemption described in *Gobeille* as they impact a central matter of plan administration—the amount of reimbursement owed for out-of-network services that plan members receive.

ERISA commands that a plan shall "specify the basis on which payments are made to and from the plan," 29 U.S.C. § 1102(b)(4), and that the fiduciary shall administer the plan "in accordance with the documents and instruments governing the plan," 29 U.S.C. § 1104(a)(1)(D) (emphasis added). Thus, any state law claim that would run counter to these ERISA requirements by, for example, requiring a plan administrator to make payments that are different than the payments required to be paid pursuant to the plan documents, is preempted. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147.

Here, that is exactly what Plaintiffs' state law claims attempt to do. Through their first cause of action for Breach of Implied-in-Fact Contract, Plaintiffs are

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§ 1144(c)(1). Thus, ERISA preempts not only state statutes but also the common law of each state.

attempting to compel thousands of different ERISA-governed plans administered by the Defendants to pay Plaintiffs an inflated "usual and customary rate" without regard to the specific benefit rates established by the terms of each controlling health plan, and without any of the plans ever having agreed to pay anything other than what their terms afford. *See e.g.*, 2 PA 125 (FAC ¶ 199). The Ninth Circuit has repeatedly found that plaintiffs cannot plead around ERISA preemption by asserting an implied-in-fact contract claim. *See Aetna Life Ins. Co. v. Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000); *Parlanti v. MGM Mirage*, No. 2:05-CV-1259-ECR-RJJ, 2006 WL 8442532, at *6 (D. Nev. Feb. 15, 2006) (same). Plaintiffs' Implied-in-Fact Contract Claim is conflict preempted.

In regard to Plaintiffs' second cause of action for Tortious Breach of the Covenant of Good Faith and Fair Dealing, the U.S. Supreme Court found in *Pilot Life* that this claim is subject to conflict preemption under ERISA's "relates to" preemption clause. *Pilot Life*, 481 U.S. at 48–49. There is no reason for this Court to deviate from the reasoning in that case.[21]

Plaintiffs' third cause of action for Unjust Enrichment "relates to" employee benefit plans because to determine the appropriate benefit rate, the Court would

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[21] *See also Thrall v. Prudential Insurance Company of America*, 2005 WL 8161321, at *2 (D. Nev. Aug. 11, 2005) (finding claim for breach of duty of good faith and fair dealing preempted under ERISA).

need to refer to the payment terms in the plans at issue. Notably, Plaintiffs' allegations supporting their unjust enrichment claim specifically reference health plans. 2 PA 127 (FAC ¶ 220). Courts regularly find such claims to be preempted. *Hill v. Opus Corp.*, 841 F. Supp. 2d 1070, 1086 (C.D. Cal. 2011); *Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co.*, 2020 WL 4033125, at *16 (3d Cir. July 17, 2020).

Plaintiffs' fourth cause of action is for Violation of NRS 686A.020 and 686A.310 (the Nevada Unfair Trade Practices Act). However, the Nevada Supreme Court has already found that claims under the Nevada Unfair Trade Practices Act are preempted by ERISA. *Villescas v. CNA Ins. Companies*, 109 Nev. 1075, 1084, 864 P.2d 288, 294 (1993). The district court inexplicably ignored the *Villescas* decision and allowed this claim to stand.

Plaintiffs' fifth cause of action alleges that Defendants violated Nevada's Prompt Pay Statutes by failing to adequately reimburse Plaintiffs within 30 days of Plaintiffs' requests for payment. 2 PA 130. This claim is unquestionably preempted as, to determine whether the challenged plan benefit payments violated the statute, the Court would have to reference the ERISA plans at issue to determine whether or not Defendants complied with the rate of payment terms for out-of-network providers. Moreover, state prompt pay claims improperly duplicate the injunction remedy already available under ERISA. *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 272 (3d Cir. 2001) (claims related to delay in

processing claims were preempted, as a plan participant or beneficiary can accelerate the plan's approval of a claim by seeking an injunction under 29 U.S.C. § 1132(a)(1)(B) to enforce the benefits to which they are entitled.). This claim should be dismissed as conflict preempted. *See e.g., N. Jersey Brain & Spine Ctr. v. CIGNA Healthcare of NJ, Inc.*, No. CV 09-2630 (JAG), 2010 WL 11594901, at *6 (D.N.J. Jan. 12, 2010) (out-of-network providers' New Jersey prompt pay statute claims found to be conflict preempted); *Am.'s Health Ins. Plans v. Hudgens*, 915 F. Supp. 2d 1340, 1359–60 (N.D. Ga. 2012) (Georgia prompt pay statute found to be conflict preempted since it "interfere[d] with nationally uniform administration of ERISA plans.").

Plaintiffs' sixth cause of action for violation of the Nevada Deceptive Trade Practices Act seeks to hold Defendants liable for making false representations and engaging in coercion, duress or intimidation in relation to Defendants' processing of claims on employee benefit plans. 2 PA 130-131. As part of this claim, Plaintiffs allege that Defendants are refusing to pay for "covered emergency services." 2 PA 131 (FAC ¶ 246). Therefore, this claim is conflict preempted because the Court would need to reference the ERISA plans at issue to determine whether the services Plaintiffs provided were in fact "covered," as well as whether any misrepresentations were made regarding the plan payment terms. The district court should not have deviated from other courts' decisions on this issue. *Pachuta*

v. Unumprovident Corp., 242 F. Supp. 2d 752, 764 (D. Hawaii, March 19, 2002) (holding that plaintiff's Hawaii Deceptive Trade Practices Act claim "related to" an ERISA plan and did not fall within the ERISA saving clause); *Pilot Life Ins. Co.*, 481 U.S. at 57 (finding fraud claims based on the improper processing of a benefits claim were conflict preempted); *Davidian v. S. Cal. Meat Cutters Union*, 859 F.2d 134, 135 (9th Cir. 1988) (claims against an ERISA plan for bad faith, fraud, deceit and breach of fiduciary duty were conflict preempted).

Plaintiffs' seventh cause of action for Declaratory Judgment seeks a judicial declaration requiring Defendants to cause the plans they administer to pay Plaintiffs amounts of reimbursement set without regard to the terms of the plans. 2 PA 133 (FAC ¶¶ 257-259). But it would be impossible for the district court to determine the correct amount of reimbursement for Plaintiffs' medical services without referring to and interpreting the terms and conditions of the members' ERISA plans. Moreover, this claim directly conflicts with and duplicates the declaratory judgment claim available under ERISA. 29 U.S.C. § 1132(a)(1)(B); *see also Franchise Tax Board of California v. Construction Laborers Vacation Trust for S. California*, 463 U.S. 1, 27 n.31 (1983) ("ERISA has been interpreted as creating a cause of action for a declaratory judgment."). Therefore, Plaintiffs' Declaratory Judgment claim is also preempted. *See, e.g., Brandner v. UNUM Life Ins. Co. of Am.*, 152 F. Supp. 2d 1219, 1225 (D. Nev. 2001) (declaratory relief

claim related to an ERISA plan, did not fall within ERISA saving clause and was preempted); *Bland v. Fiatallis N. Am., Inc.*, No. 02 C 0069, 2003 WL 1895429, at *2 (N.D. Ill. Apr. 15, 2003) (stating "ERISA preempts state claims for declaratory relief that relate to an ERISA benefits plan").

Finally, Plaintiff's eighth cause of action for violation of Nevada's RICO statute cannot survive preemption either. In a highly similar case, a plaintiff tried to escape preemption by arguing that the insurer had engaged in an elaborate fraudulent scheme to avoid paying benefits and that the existence of such a scheme meant that even if plaintiff's other state law claims were preempted, the state law RICO claim was not. The court rejected this argument and found that the RICO claim was conflict preempted because it was intertwined with a dispute over a refusal to pay benefits. *Moorman v. UnumProvident Corp.*, No. CIV.A. 104CV2075BBM, 2007 WL 4984162, at *3 (N.D. Ga. Oct. 30, 2007) ("As the court understands the current state of law, a federal RICO claim is not preempted by ERISA, but a state RICO claim is.") (emphasis added) (internal citation omitted). The result should be the same here. The district court erred by not finding that this claim was conflict preempted.

c. Plaintiffs' State Law Claims Do Not Fall Within ERISA's Saving Clause

Once it is determined that a state law claim "relates to" a benefit plan, which all of Plaintiffs' claims do, the next question is whether the state laws at issue

"regulate insurance." If they do, they are exempted from ERISA preemption under the ERISA saving clause. 29 U.S.C. § 1144(b)(2)(A).

The U.S. Supreme Court has held that two criteria should be considered in determining whether a state law falls within ERISA's saving clause. First, a court should consider whether, as a matter of "common sense," the state law is one that "regulates insurance." *Pilot Life Ins. Co.*, 481 U.S. at 48-49. Second, a court should use the McCarran-Ferguson[22] test to determine whether the state law (1) is limited to the insurance industry, (2) has the effect of transferring or spreading a policyholder's risk, and (3) involves an integral part of the relationship between the insurer and the insured. *Id.* The Nevada Supreme Court has adopted the U.S. Supreme Court's framework for assessing whether the ERISA saving clause applies and held that all three elements of the McCarran-Ferguson test must be met for the ERISA saving clause to apply. *See Villescas*, 109 Nev. at 1082, 864 P.2d at 293.

Here, none of Plaintiffs' state law claims fall within the ERISA saving clause. As to Plaintiffs' common law claims for (1) Breach of Implied-in-Fact Contract, (2) Tortious Breach of the Implied Covenant of Good Faith and Fair Dealing, and (3) Unjust Enrichment, none of these claims can be said to regulate

[22] The McCarran-Ferguson Act generally permits states to regulate the "business of insurance." 15 U.S.C. § 1012(a). In determining what constitutes the "business of insurance," courts have come up with the three part McCarran-Ferguson test.

insurance or to be "limited to the insurance industry." Rather, such claims are applicable to a wide variety of non-insurance related commercial disputes. *See e.g., Pilot Life Ins. Co.*, 481 U.S. at 48–49 (1987) (holding that a claim for tortious breach of contract and the Mississippi law of bad faith did not "regulate insurance" and was thus preempted because "[a]ny breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages.").

With respect to Plaintiffs' statutory claims for (1) Violation of NRS 686A.020 and 686A.310 (Nevada Unfair Trade Practices Act), (2) Violation of Nevada Prompt Pay Statutes, (3) Violation of Consumer Fraud and Deceptive Trade Practices Acts, (4) Declaratory Judgment, and (5) Violation of NRS 207.350, *et. seq.* (Nevada's RICO statute), all of these claims fail the McCarran-Ferguson test. While the Nevada Unfair Trade Practices Act is specifically aimed at insurance companies, the Nevada Supreme Court has found that the law does not have the effect of spreading a policyholder's risk and thus does not fall within ERISA's saving clause. *Villescas*, 109 Nev. at 1083, 864 P.2d at 293.

The Nevada Prompt Pay Act does not fall under the saving clause for the same reason. "Riskspreading . . . is the pooling or averaging of policyholder's risks." *Id.* at 1082, 864 P.2d at 293; *see also* BLACK'S LAW DICTIONARY (11th ed. 2019) (defining "Risk" in the insurance context as "[t]he chance or degree of probability of loss to the subject matter of an insurance policy."). The Prompt Pay

Act simply subjects an insurer to fines by the Nevada Insurance Commissioner if the insurer does not process/pay claims within a specified time frame. NRS 683A.0879(8). This does nothing to pool or average a policyholder's risks.

Finally, Nevada's Deceptive Trade Practices Act, Uniform Declaratory Judgments Act, and RICO statute are laws of general applicability and not limited to the insurance industry. *See* NRS 598.0915 (stating that any "person" with a "business or occupation" can be liable under the Deceptive Trade Practices Act); NRS 30.040 (allowing a declaratory judgment claim to be brought for any "deed, written contract or other writings constituting a contract."); NRS 207.380 (stating that a criminal "Enterprise" may consist of "any natural person, sole proprietorship, partnership, corporation, business trust or other legal entity."). Thus, these claims also do not fall under the ERISA saving clause and, as a result, are conflict preempted.

d. In the Alternative, ERISA's Deemer Clause also Bars Plaintiffs' State Law Claims

Even if this Court were to find that some of Plaintiffs' claims fall within ERISA's saving clause, *which they do not*, the claims would still be preempted by ERISA's "deemer clause." 29 U.S.C. § 1144(b)(2)(B). This clause bars enforcement of any state insurance law against self-funded ERISA plans by mandating that these plans be "deemed" to not be insurance companies for

purposes of state insurance laws and regulations. *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990). Here, the only state laws at issue that even purport to regulate insurance are Plaintiffs' claims for violation of (1) the Nevada Unfair Trade Practices Act and (2) the Nevada Prompt Pay Statutes. However, even assuming, *arguendo*, that these laws would otherwise fall within ERISA's saving clause, the deemer clause prohibits them being enforced against any ERISA plans that are self-funded, which must be deemed to not be in the business of insurance. In sum, ERISA conflict preemption presents an insurmountable barrier to Plaintiffs' state law claims and the district court erred by finding conflict preemption to be inapplicable.

e. The district court erred when it found that ERISA preemption can never apply to an out-of-network medical provider's claims

The district court accepted the flawed argument that, while ERISA regularly preempts a *plan member's* state law claims against the plan administrator, it does not preempt a *medical provider's* identical state law claims. 5 PA 561. This finding was an error of law as there is no distinction between a plan member's state law claims and a medical provider's state law claims if there has been an assignment of benefits from the plan member to the medical provider. Here, it is undisputed that Plaintiffs accepted a written assignment of benefits from Defendants' plan members for all of the claims they are asserting in this suit. 2-3

PA 172-273. Thus, Plaintiffs stand in exactly the same position as a plan member making a claim for benefits against their insurer.

The *In Re Managed Care* case shows the crucial importance of an assignment of benefits in determining whether ERISA preemption applies. There, the court found that the state law claims of out-of-network providers who *had* received an assignment of benefits were preempted. Conversely, the state law claims of the out-of-network providers who *had not* received an assignment of benefits were not preempted. *In Re Managed Care Litig.*, 298 F. Supp. 2d 1259, 1292 (S.D. Fla. 2003); *see also Torrent & Ramos, M.D., P.A. v. Neighborhood Health Partnerships, Inc.*, No. 04-20858-CIV, 2004 WL 7320735, at *4 (S.D. Fla. July 1, 2004) (out-of-network provider's acceptance of assignment of benefits from patients it treated meant that its state law claims were preempted by ERISA since it now stood in the shoes of the plan members); *Misic v. Bldg. Serv. Employees Health & Welfare Tr.*, 789 F.2d 1374, 1379 (9th Cir. 1986) (same). Since Plaintiffs do not dispute that they accepted an assignment of benefits for all claims asserted in this action, those claims are subject to ERISA preemption.

f. The district court erred by adopting Plaintiffs' flawed "rate of payment vs. right to payment" argument

Plaintiffs also argued that, even if out-of-network providers' claims can,

under certain circumstances, be subject to ERISA conflict preemption,[23] Plaintiffs' claims may escape preemption because they involve a dispute over the *rate* of payment, not the *right* to payment. Not so. As a threshold matter, Plaintiffs' "rate of payment" argument arises from a superficial and erroneous analysis of the case law. Courts have held that the "rate" versus "right" distinction does not apply where the plaintiff-provider is out-of-network (like Plaintiffs here), and further does not apply in conflict preemption cases. *See North Cypress Med. Ctr. Operating Co. v. Cigna Healthcare*, 781 F.3d 182, 201 (5th Cir. 2015) (finding rate versus right distinction inapposite in out-of-network provider context); *Emergency Group of Ariz. Prof. Corp. v. United Healthcare Inc.*, 2020 WL 1451464, at *5 (D. Az. Mar. 25, 2020) (same); *Surgery Ctr. of Viera, LLC v. UnitedHealthcare Ins. Co., et al.*, Case No. 6:20-cv-668-Orl-37DCI, Doc. 44 at 7 (M.D. Fla. July 28, 2020) ("[T]he rate/right distinction only applies in complete preemption cases when jurisdiction is at issue . . . . [Conflict] preemption is a separate and distinct issue") (internal citations omitted).

Furthermore, in all of the so-called "rate of payment" cases cited in the district court's order,[24] preemption did not apply because the payment terms of a

[23] Defendants address Plaintiffs' "rate of payment" argument here in the context of whether it defeats conflict preemption. However, Plaintiffs' rate of payment argument fails to defeat complete preemption for the same reasons.

[24] 5 PA 599-600 (order denying motion to dismiss).

written provider agreement, an oral promise to pay, or a state statute requiring insurers to pay out-of-network providers at a particular rate governed the appropriate rate of payment such that the terms of the ERISA plans did not come into play.

For example, if the provider has a written in-network provider agreement that sets forth the applicable rate of payment, this saves its claims from preemption because the contract governs whether additional reimbursement is due, not the terms of the ERISA plan. *See e.g.*, *Blue Cross of California v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1052 (9th Cir. 1999) (express written provider agreement with the insurer created duties independent of the employee benefit plan and thus state law claims were not preempted); *Windisch v. Hometown Health Plan, Inc.*, No. 308-CV-00664-RJC-RAM, 2010 WL 786518, at *1 (D. Nev. Mar. 5, 2010) (same).

In other cases, an oral rate of payment promise by the insurer will save the out-of-network provider's claims from preemption. In *California Spine*, a federal district court found that preemption did not apply because the provider alleged that the insurer promised during a pre-surgery phone call that it would pay 100% of the usual, customary and reasonable charges for the service. *California Spine & Neurosurgery Inst. v. Bos. Sci. Corp.*, No. 18-CV-07610-LHK, 2019 WL 1974901, at *4 (N.D. Cal. May 3, 2019). Thus, the terms of the ERISA plan did not come

into play. *Id.* Rather, the court only needed to look to the independent oral promise by the insurer to determine the appropriate rate of payment and therefore preemption did not apply. *Id.*; *See also Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 950–51 (9th Cir. 2009) (no ERISA preemption because provider alleged that the insurer orally promised to pay 90% of the billed medical expenses).

Finally, a provider's state law claims may also escape preemption if a duty to pay an out-of-network provider at a particular rate is created by a state rate of payment statute. *See e.g., Med. & Chirurgical Faculty of State of Maryland v. Aetna U.S. Healthcare, Inc.*, 221 F. Supp. 2d 618, 619, 621 (D. Md. 2002) (citing "Maryland statutes that require HMOs to pay non-contracting physicians according to certain formulas" to find that provider-plaintiff's claims were not preempted by ERISA).

Here, Plaintiffs admit in the FAC that they are out-of-network providers that lack a written agreement with the Defendants that would govern the rate of payment. 2 PA 97 (FAC ¶ 20). Moreover, Plaintiffs' FAC does not allege that Defendants orally promised to pay Plaintiffs at a particular rate. Finally, unlike some other states, Nevada does not have a rate of payment statute requiring

insurers to pay out-of-network providers at any particular rate.[25] *Cf.* Fla. Stat. §§ 641.513(5), 627.64194(4). Thus, the only documents setting forth the required rate of payment to out-of-network providers like Plaintiffs are the ERISA governed health plans. Indeed, but for the existence of the health plans, Defendants would have no duty to pay Plaintiffs *anything*.

Plaintiffs try to get around this issue with vague allegations that an implied-in-fact contract was created by Defendants' payments for past services rendered to their plan members. 2 PA 123-126. However, as set forth more fully in Section III(B)(4)(a), *infra*, Nevada law is clear that such past payments do not create an implied-in-fact contract.

Moreover, in cases similar to this one where providers (1) received an assignment of benefits from the patient, (2) lacked a written contract, (3) lacked an oral promise to pay and (4) lacked a state rate of payment statute, courts have found that ERISA preemption applies because the only document governing the rate of payment to the out-of-network providers is the ERISA plan. *See e.g.*, *Torrent & Ramos, M.D., P.A.*, 2004 WL 7320735, at *4; *Melamed,* 557 F. App'x at 661; *In Re Managed Care Litig.*, 298 F. Supp. 2d at 1292. In short, where a dispute

[25] A special statutory rate of payment scheme did pass in the 2019 Nevada Legislative Session, but the scheme did not go into effect until January 1, 2020 and is not retroactively applicable to this case. *See* AB 469 at § 29(2) (2019 Nevada Legislative Session) (stating that law does not go into effect until January 1, 2020).

relates to the amount owed under the terms of a plan—as this dispute plainly does—the claim is preempted and must be pursued under ERISA's exclusive remedial scheme.

g. The Nevada federal district court's remand order has no bearing on whether Plaintiffs' claims are conflict preempted and is an outlier decision whose reasoning has been rejected by other federal courts

Plaintiffs and the district court placed great weight on the reasoning in the federal court's February 20, 2020 remand order. 5 PA 561-562 (hearing transcript). However, the remand order should be given little weight by this Court. First, the remand order only analyzed whether Plaintiffs' implied-in-fact contract claim was completely preempted. The federal court did not perform a complete preemption analysis for Plaintiffs' seven other claims as it should have done, *cf. Gaming Corp. of Am. v. Dorsey & Whitney*, 88 F.3d 536, 543 (8th Cir. 1996); *Emergency Grp. of Arizona Prof'l Corp.*, 2020 WL 1451464, at *7, nor did the federal court analyze whether conflict preemption applied to any of Plaintiffs' claims. The defense of conflict preemption under § 514(a) of ERISA is "much broader" than complete preemption and thus even more likely to apply to Plaintiffs' state law claims. *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1492 (7th Cir. 1996). Therefore, at the outset, the remand order has no persuasive value in the context of determining whether conflict preemption applies.

Second, the remand order is an outlier decision that adopted Plaintiffs' flawed "rate of payment" argument. In two recent cases brought by TeamHealth affiliates against United with nearly identical state law claims, two federal district courts expressly rejected the same rate of payment argument that the Nevada Federal District Court accepted and found that the providers' state law claims were preempted by ERISA. *See Emergency Grp. of Arizona Prof'l Corp.*, 2020 WL 1451464, at *7;[26] *Hill Country Emergency Medical Associates, P.A., et al. v. United HealthCare Insurance Company, et al.*, Civil Action No. 19-cv-00548-RP, Dkt. No. 18 (W.D. Tex. Dec. 10, 2019).[27]

Third, courts have repeatedly held that a federal district court's ruling on complete preemption is not entitled to deference once the matter is remanded to state court because the federal court's ruling is not subject to appellate review. *See Whitman v. Raley's Inc.*, 886 F.2d 1177, 1181 (9th Cir. 1989); *AT&T Commc'ns, Inc. v. Superior Court*, 21 Cal. App. 4th 1673, 1680, 26 Cal. Rptr. 2d 802, 806 (1994) (holding that federal district court's finding that ERISA complete preemption did not apply in a remand order was "not persuasive," did not dictate the result in state court, and electing to dismiss the complaint on grounds of complete preemption).

[26] The TeamHealth affiliates in the Arizona case where also represented by the same counsel that represents Plaintiffs in this case.

[27] A copy of the *Hill Country* order is attached hereto at 3 PA 274-285.

For all the above reasons, this Court should not defer to the complete preemption analysis in the federal court's remand order and should assess the Parties' competing preemption arguments *de novo* and on the merits.

3. The district court erred by concluding that Plaintiffs' claims were not subject to complete preemption under ERISA

a. The district court erred by finding that complete preemption can never be used to obtain dismissal of state law claims

The district court found that complete preemption under § 502 of ERISA is a jurisdictional doctrine that cannot be used to obtain dismissal of a state law claim. Order at 12:16-28 – 13:1-6, 5 PA 597-598. This finding was clear error as the Nevada Supreme Court has already rejected this argument. In *Marcoz*, the district court dismissed a state law wrongful discharge claim not only on the basis of conflict preemption under 29 U.S.C. § 1144, but also on the basis of complete preemption pursuant to 29 U.S.C. § 1132. *Marcoz v. Summa Corp.*, 106 Nev. 737, 742, 801 P.2d 1346, 1350 (1990) ("Here, the district court primarily based its decision on its interpretation of 29 U.S.C. §§ 1144(a), 1140, **and 1132.**") (emphasis added). In affirming the district court's dismissal, the Nevada Supreme Court stated as follows:

> Marcoz attempts to avoid **complete preemption** of some of his claims by alleging compensable losses of non-ERISA benefits. Under the narrow confines of *K Mart*, Marcoz has not stated a viable cause of action for other employment benefits after the ERISA preemption of the retirement benefits issues. Our ruling

> in *K Mart* has no application to claims involving ERISA benefits. **The reasoning of the court below is sound and we perceive no error in its decision on this aspect of the case**.

Id. at 749, 801 P.2d at 1354 (emphasis added). The district court's decision directly contravenes *Marcoz* and therefore writ relief is warranted.

b. Plaintiffs' state law claims are completely preempted

i. The doctrine of complete preemption and the consequences of a finding of complete preemption

The doctrine of complete preemption applies when a federal statute so completely dominates a particular area that any state law claims are converted into an action arising under federal law. *See Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63–64 (1987). This doctrine applies in the context of claims for reimbursement made against employee benefit plans. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004).

As part of ERISA's comprehensive scheme, Congress created a special civil enforcement mechanism to deal with all claims that relate to employee benefit plans. That mechanism is set forth in 29 U.S.C. § 1132(a)[28] and permits a "participant or beneficiary" to bring a statutory claim for benefits owed pursuant to the terms of the plan under ERISA. The U.S. Supreme Court has found that this statute evidences congressional intent to completely preempt state law claims that relate to ERISA plans.

[28] This section is also commonly referred to as § 502(a) of ERISA.

A finding of complete preemption means that a plaintiff's state law claims are barred and subject to dismissal, as the plaintiff will only be permitted to assert a statutory cause of action under 29 U.S.C. § 1132(a)(1)(B). *See Davila*, 542 U.S. at 209.

ii. Pursuant to the *Davila* Test, Plaintiffs' state law claims are completely preempted

Davila sets forth a two-prong test for determining whether a state law claim is completely preempted by ERISA's civil enforcement provision. A state law cause of action is completely preempted if (1) the plaintiff, "at some point in time, could have brought [the] claim under ERISA § 502(a)(1)(B)," and (2) "there is no other independent legal duty that is implicated by [the] defendant's actions." *Davila*, 542 U.S. at 210.

Both prongs of the *Davila* test are met. The first element is met because Plaintiffs obtained assignments that gave them standing to bring a statutory ERISA claim. *Misic*, 789 F.2d at 1377-79 (finding that provider's acceptance of an assignment of benefits from patient gave him the right to assert a statutory ERISA claim against the plan administrator because he now stood in the shoes of the plan member.); *In Re Managed Care Litig.*, 298 F. Supp. 2d at 1292 (same). The fact that Plaintiffs now self-servingly disclaim that they are suing as the assignee of Defendants' plan members is not relevant to a *Davila* analysis. Indeed, a driving

force behind the creation of the doctrine of complete preemption was to defeat attempts by plaintiffs to subvert ERISA's comprehensive national scheme through artfully pled state law claims.[29] The only question is whether Plaintiffs "*could*" have brought an ERISA claim, and Plaintiffs clearly could have done so.

Prong two of the *Davila* test is met because Plaintiffs are out-of-network providers who lack a written contract with Defendants that sets forth negotiated payment terms. 2 PA 97 (FAC ¶ 20). Thus, the only legal duties owed to Plaintiffs flow from the terms of the applicable ERISA plans and all of Plaintiffs' claims are completely preempted and should have been dismissed.

4. The district court erred by concluding that Plaintiffs had stated a claim under NRCP 12(b)(5)

Whether the Plaintiffs have stated any claim for relief under NRCP 12(b)(5) is partially intertwined with the issue of whether Plaintiffs' claims are subject to conflict preemption and complete preemption under ERISA given that sufficiently alleging the violation of a legal duty independent of ERISA can defeat preemption.[30] And, as explained previously, whether ERISA preemption applies is an issue this Court has previously found to be of sufficient importance to warrant

[29] *Cleghorn v. Blue Shield of California*, 408 F.3d 1222, 1226 (9th Cir. 2005) ("Artful pleading does not alter the potential for this suit to frustrate the objectives of ERISA.").

[30] *See e.g.*, *Davila*, 542 U.S. at 210-214 (discussing the importance of examining each state law claim to determine whether a "violation of a legal duty independent of ERISA" has been adequately alleged such that the state law claim can escape preemption).

entertaining a writ petition on the merits. Therefore, it is appropriate for this Court to review not only the district court's ERISA preemption analysis de novo, but also its finding that the Plaintiffs have adequately alleged state law claims upon which relief can be granted. For the reasons set forth below, Plaintiffs have failed to state cognizable claims for relief under Nevada law[31] and thus, by extension, have failed to allege a violation of a legal duty independent of ERISA.

a. Plaintiffs failed to state an implied-in-fact contract claim

An implied-in-fact contract exists where the conduct of the parties demonstrates that they (1) intended to contract, (2) exchanged bargained-for promises, and (3) the terms of the bargain are sufficiently clear. *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 379–80, 283 P.3d 250, 256 (2012).

Plaintiffs have not sufficiently alleged any of the above three elements. Nowhere in the FAC is there an allegation that the Defendants "intended to contract" with Plaintiffs. On the contrary, Plaintiffs allege that contract negotiations failed because the parties *could not agree on rates*, thus foreclosing any argument that an implied-in-fact contract was created. 2 PA 107-109. Nor is there any explanation of what "promises" were exchanged between the Parties and what the terms of those promises were. Reading the FAC in the light most

[31] In regard to Plaintiffs' fifth and seventh causes of action for Violation of Nevada's Prompt Pay Act and Declaratory Judgment, an NRCP 12(b)(5) analysis would be superfluous as both claims clearly duplicate relief permitted under ERISA and are thus preempted. *See* Section III(B)(2)(b), *supra*.

favorable to Plaintiffs, there is instead an allegation that (1) Plaintiffs provided medical services to members of Defendants' health plans, (2) Plaintiffs requested full reimbursement for these services from Defendants and (3) on some occasions Defendants obliged, and on other occasions Defendants did not. 2 PA 123-125. In essence, Plaintiffs argue that payments for some past services constitute a promise by Defendants to pay for all future services at the same rate. *Id.*

The Nevada Supreme Court's decision in *Recrion Corp.* forecloses such a theory. There the Court refused to find an implied-in-fact contract where an employee provided unsolicited services to a hotel prior to having a discussion about compensation. The Court noted that its ruling would have been the same even if, after the services were provided, the hotel had promised the employee compensation. The Court held that "[p]ast consideration is the legal equivalent to no consideration" and that services cannot be subject to an implied-in-fact contract unless the contract was created "before" the services were provided." *Smith v. Recrion Corp.*, 91 Nev. 666, 669, 541 P.2d 663, 665 (1975) (emphasis added).

Here, just like in *Recrion Corp*, Plaintiffs are attempting to force the Defendants to compensate them for unsolicited[32] services that were provided without any contract in place. Further, Plaintiffs rely only on the past consideration of prior payments to create the alleged implied-in-fact contract—a

[32] The FAC does not allege that the Defendants did anything to solicit or induce Plaintiffs to provide emergency medical services to their plan members.

theory that *Recrion Corp* expressly disapproved. Thus, Plaintiffs have failed to state a claim for implied-in-fact contract and this claim should be dismissed.

b. Plaintiffs failed to state a tortious breach of the implied covenant of good faith and fair dealing claim

Nevada has only recognized this cause of action in two discrete circumstances—(1) a suit by an insured against its insurer where an insurer acts in bad faith in denying coverage and (2) bad faith wrongful discharge by an employer where the employee has a special relationship of trust, reliance and dependency with the employer. *U.S. Fid. & Guar. Co. v. Peterson*, 91 Nev. 617, 620, 540 P.2d 1070, 1071 (1975) (recognizing bad faith tort in insurance context); *D'Angelo v. Gardner*, 107 Nev. 704, 717, 819 P.2d 206, 215 (1991) (recognizing bad faith tort in employment context).

Critically, the Nevada Supreme Court has refused to expand this tort to contracts between sophisticated parties in the commercial realm. *Aluevich v. Harrah's*, 99 Nev. 215, 216, 660 P.2d 986, 986 (1983) (holding that claim for tortious breach of the implied covenant of good faith and fair dealing does not extend to commercial leases between two sophisticated parties). The tort is only meant for situations where there is a "special relationship" between the parties, such as in the insured-insurer or employer-employee context. *Id.* Here, this litigation involves a dispute between two sophisticated parties (a national physician practice and a large insurer/plan administrator) who do not even have an express

written contractual relationship and therefore this claim fails.

c. Plaintiffs failed to state an unjust enrichment claim

"Unjust enrichment exists when the plaintiff [1] confers a benefit on the defendant, [2] the defendant appreciates such benefit, and there is [3] acceptance and retention by the defendant of such benefit under circumstances such that it would be inequitable for him to retain the benefit without payment of the value thereof." *Certified Fire Prot. Inc.*, 128 Nev. at 381, 283 P.3d at 257.

Here, while the Nevada Supreme Court has not yet weighed in on this issue, Plaintiffs' claim fails as courts around the country routinely hold that providing medical services to a plan member does not benefit the insurer/administrator. Rather, courts have found that the medical provider is providing a benefit only to the patient (i.e. the insured/plan member). *See e.g., Peacock Med. Lab, LLC v. UnitedHealth Grp., Inc.*, No. 14-81271-CV, 2015 WL 2198470, at *5 (S.D. Fla. May 11, 2015) ("a healthcare provider who provides services to an insured does not benefit the insurer."); *Encompass Office Solutions, Inc. v. Ingenix, Inc.*, 775 F.Supp.2d 938, 966 n. 11 (E.D. Tex. 2011) (same); *Travelers Indem. Co. of Connecticut v. Losco Grp., Inc.*, 150 F. Supp. 2d 556, 563 (S.D.N.Y. 2001) (same); *Joseph M. Still Burn Ctrs., Inc. v. AmFed Nat'l Ins. Co.*, 702 F.Supp.2d 1371, 1377 (S.D. Ga. 2010) (same); *Sinai Med. Ctr. v. Mid–West Nat. Life Ins. Co. of Tenn.*, 118 F.Supp.2d 1002, 1013 (C.D.Cal. 2000) (same).

The district court found the above case law inapplicable because Nevada law permits recovery for unjust enrichment even if the benefit provided is "indirect." 5 PA 611-612 (order). The district court erred because Plaintiffs' treatment of Defendants' plan members was neither a "direct" nor an "indirect" benefit to Defendants—it was no benefit at all, as the above case law makes clear. This claim fails as a matter of law and should be dismissed.

d. Plaintiffs' failed to state a claim for violation of NRS 686A.020 and 686A.310

Plaintiffs assert that the Defendants violated the Nevada Unfair Insurance Practices Act by not paying more on Plaintiffs' claims. 2 PA 128-129. Plaintiffs' claim fails as a matter of law because the Act only gives a private right of action to "insureds," not to third party claimants like Plaintiffs. NRS 686A.310(2) ("In addition to any rights or remedies available to the Commissioner, an insurer is liable to its insured for any damages sustained by the insured as a result of the commission of any act set forth in subsection 1 as an unfair practice.") (emphasis added). Indeed, the Nevada Supreme Court has specifically held on multiple occasions that the Act does not create a private right of action against insurers in favor of third party claimants like Plaintiffs. *Gunny v. Allstate Ins. Co.*, 108 Nev. 344, 346, 830 P.2d 1335, 1336 (1992) ("we conclude that [plaintiff] has no private right of action as a third-party claimant under NRS 686A.310.").

Case law out of the Nevada federal district court is in accord. *See Tweet v.*

Webster, 614 F. Supp. 1190, 1195 (D. Nev. 1985) ("we do not find any facts or evidence presented by plaintiffs to persuade us that a Nevada court would grant a third party claimant a cause of action directly against an insurer for bad faith refusal to settle a reasonably clear claim, based on statute, implied contract, or common law tort, under Nevada law as it stands today."); *Crystal Bay Gen. Imp. Dist. v. Aetna Cas. & Sur. Co.*, 713 F. Supp. 1371, 1376 (D. Nev. 1989) (same).

Here, Plaintiffs are not "insureds" but rather third party medical providers with no contractual relationship with Defendants. 2 PA 96-97. Therefore, this claim should be dismissed, as Plaintiffs lack standing to bring it.

e. Plaintiffs failed to state a claim for violations of Nevada's Consumer Fraud and Deceptive Trade Practices Acts

An action under the Nevada Deceptive Trade Practices Act may be brought by any person who is a "victim" of consumer fraud. NRS 41.600(1). The term "victim" in NRS 41.600 is not defined, and the Nevada Supreme Court has not yet offered a definition. Nonetheless, the Nevada Supreme Court has defined "victim" as that term is used in NRS 176.033(c), which authorizes restitution for a crime victim. The court addressed the issue in *Igbinovia v. State*, 111 Nev. 699, 895 P.2d 1304 (1995) and found that "the word 'victim' has commonly-understood notions of passivity, where the harm or loss suffered is generally unexpected and occurs without the voluntary participation of the person suffering the harm or loss." *Id.* at 706, 895 P.2d at 1308.

At least two Nevada federal district court decisions have found that it is appropriate to use the definition of "victim" proposed by the *Igbinovia* decision when determining whether a claimant has standing to bring a claim under the Nevada Deceptive Trade Practices Act. *Winnemucca Farms, Inc. v. Eckersell*, No. 3:05-CV-385-RAM, 2010 WL 1416881, at *7 (D. Nev. Mar. 31, 2010); *Weaver v. Aetna Life Ins. Co.*, No. 308-CV-00037-LRH-VPC, 2008 WL 4833035, at *5 (D. Nev. Nov. 4, 2008). Further, in a pre-*Igbinovia* decision, a Nevada federal district court found that business competitors are not "victims" within the meaning of NRS 41.600 and thus lack standing to sue under the Act (i.e. again accepting the distinction between passive and active involvement in a scheme). *Rebel Oil Co. v. Atl. Richfield Co.*, 828 F. Supp. 794, 797 (D. Nev. 1991). Thus, significant persuasive authority exists indicating that, if forced to address the issue, the Nevada Supreme Court would adopt the definition of "victim" set forth in *Igbinovia* and only confer standing on individuals who were "passive" victims of a deceptive trade practice and did not "voluntarily" participate in the scheme that caused them harm.

Here, Plaintiffs' claim fails as they admit in the FAC that they are not passive victims of Defendants' alleged scheme, but rather were active and knowing participants in the events in dispute. Plaintiffs admit that they entered into contract negotiations with Defendants beginning in 2017, that Defendants fully informed

Plaintiffs during those negotiations of the rates they should expect to be paid for all future services rendered, and that Plaintiffs nonetheless thereafter willingly provided medical services to the Defendants' members. 2 PA 97-98, 107, 131 (FAC at ¶¶ 22, 25–26, 90–109, 246). As such, Plaintiffs do not qualify as passive "victims" under NRS 41.600 and lack standing to bring this claim.

f. Plaintiffs failed to state a Nevada RICO claim

To state a RICO claim, Plaintiffs must adequately plead, among other things, that Defendants engaged in at least two of the thirty-seven predicate RICO crimes listed in NRS 207.360. The FAC purports to identify three predicate RICO crimes:

- "[O]btaining possession of money or property valued at $650 or more," NRS 207.390, 207.360(28);
- "[M]ultiple transactions involving fraud or deceit in [the] course of [an] enterprise or occupation," NRS 205.377, NRS 207.360(35); and
- "[I]nvoluntary servitude," NRS 207.360(36).

2 PA 110, 112, 134.

i. Plaintiffs have failed to plead "but for" cause and proximate cause as required by RICO.

In addition to alleging at least two predicate RICO acts, a plaintiff must allege that those RICO acts were both the "but for" cause and the proximate cause of its injuries. *Holmes v. Sec. Inv'r Prot. Corp.*, 503 U.S. 258, 268 (1992); *Allum v. Valley Bank of Nevada*, 109 Nev. 280, 282, 849 P.2d 297, 299 (1993) ("[F]or a

plaintiff to recover under Nevada RICO . . . the plaintiff's injury must flow from the defendant's violation of a predicate Nevada RICO act . . . .").

In the FAC, Plaintiffs contend that the Defendants violated RICO by using websites and other communications to make false representations to providers concerning the transparency and objectivity of the Data iSight claim pricing service that Defendants used to assist them in determining plan payment rates. 2 PA 121 (FAC ¶¶ 177–78). The FAC specifically identifies Plaintiffs' asserted injury as the alleged underpayment of various health claims that they submitted to Defendants for payment. 2 PA 134-135. Plaintiffs' inescapable problem, however, is that the FAC makes clear that the alleged misrepresentations played no role in causing Plaintiffs' asserted underpayment injuries; Plaintiffs would have rendered the same services, and received the same alleged underpayments, if the asserted misrepresentations on Data iSight's website had never been made. This is a textbook case of lack of causation.

The FAC states that "federal and state law requires that emergency services be provided to individuals by the Health Care Providers." 2 PA 97. It further acknowledges that Plaintiffs accordingly are legally obligated to—and do—provide services to patients "without regard to insurance status or ability to pay." *Id.* These admissions make plain that no representation that Defendants or Data iSight may have made concerning their payment rates or methodologies could have

had any effect on Plaintiffs' provision of services, because Plaintiffs were legally obligated to provide those services without regard to any understandings they may have had about what the associated payment rates would be. Even if the health claims at issue were underpaid under the terms of the relevant plans, that alleged underpayment injury would bear no causal connection to any of the alleged misrepresentations identified in the FAC.

Plaintiffs also cannot establish the required causation for the separate reason that the FAC admits Defendants provided advance notice to Plaintiffs that their out-of-network payment rates were expected to drop. 2 PA 107-108. This frank disclosure—assertedly made by Defendants on at least three separate occasions—breaks any conceivable causal chain connecting Plaintiffs' purported underpayment injuries to the asserted misrepresentations on Data iSight's website.

In the district court briefing, Plaintiffs offered no coherent legal argument supporting RICO causation. The district court then side-stepped this issue and held that, based on *Yamaha Motor*, proximate cause is a factual issue that may not be addressed in a motion to dismiss. 5 PA 620 (order at 34:21–22); *Yamaha Motor Co., U.S.A. v. Arnoult*, 114 Nev. 233, 238, 955 P.2d 661, 665 (1998). However, *Yamaha Motor* is inapplicable, as it was a personal injury case dealing with negligence and strict liability claims. *Id.* The Nevada Supreme Court has expressly held that a district court *can* and *should* dismiss a Nevada RICO claim at

the pleading stage for failure to adequately plead causation. *See Allum v. Valley Bank of Nevada*, 109 Nev. 280, 286, 849 P.2d 297, 301 (1993) (affirming the district court's granting of a motion to dismiss a Nevada RICO claim because the plaintiff had failed to plead proximate cause). Thus, contrary to the district court's conclusion, a court is required to dismiss a Nevada RICO claim at the pleading stage, if the plaintiff has failed to adequately plead causation like Plaintiffs here. Because Plaintiffs have not alleged a direct causal connection between the injury asserted and the injurious conduct alleged, Plaintiffs' RICO claim fails as a matter of law and must be dismissed.

ii. Plaintiffs have failed to allege reliance and intent to deceive for the two fraud based RICO predicate crimes

The first two crimes, NRS 207.360(28) (obtaining money by false pretenses) and NRS 207.360(35) (transaction involving fraud or deceit), are fraud-based,[33] and therefore must meet the heightened pleading standard of NRCP 9(b). *See Hale v. Burkhardt,* 104 Nev. 632, 637, 764 P.2d 866, 869 (1988). Both crimes require that a plaintiff allege (1) reliance on a false representation and (2) intent to deceive. *Barron*, 783 P.2d at 449 (discussing elements of an NRS 207.360(28) violation); *Mendoza v. Amalgamated Transit Union Int'l*, 2019 WL 4221078, at *6 (D. Nev. Sept. 5, 2019) (discussing the elements of an NRS 206.360(35) violation and

[33] Nevada false pretenses law requires, among other things, an "intent to defraud," and that "the victim be defrauded." *Barron v. State*, 783 P.2d 444, 449 (Nev. 1989).

dismissing the RICO claim based on plaintiff's failure to allege detrimental reliance).

Plaintiffs have failed to plead the elements of reliance and intent to deceive for either of these crimes for the same reason they have failed to plead causation. Namely, Plaintiffs admit that they were required by state and federal law to provide the medical services in question without regard to the rates Defendants would pay. 2 PA 97. Plaintiffs further expressly admit that they do in fact provide medical services "to all patients, regardless of insurance coverage or ability to pay, including to Patients with insurance coverage issued, administered and/or underwritten by Defendants." 2 PA 96. These admissions definitively establish that Plaintiffs never relied on any representations concerning Defendants' payment rates in deciding whether to render services to patients. Nor can Plaintiffs establish intent to deceive: Plaintiffs admit that Defendants expressly notified them well in advance of the very reimbursement reductions about which they now complain, 2 PA 107-108, 109, defeating any suggestion of deception. Therefore, Plaintiffs have failed to adequately plead at least two RICO predicate crimes and the RICO claim must be dismissed.

iii. Plaintiffs do not properly plead a predicate crime of involuntary servitude.

Plaintiffs' attempt to invoke involuntary servitude under NRS 207.360(36) is novel and entirely specious. The Nevada statutes describe involuntary servitude as

"knowingly subject[ing], or attempt[ing] to subject, another person to *forced labor or services*" by certain enumerated means, and "[a]ssuming rights of ownership over another person; purchase or sale of person." *See* NRS 200.463, 200.464, and 200.465. Unsurprisingly, the few Nevada cases that have addressed involuntary servitude have understood it to deal with crimes involving physical harm, forced labor, or abuse. *See e.g., Bonanza Beverage Co. v. MillerCoors, LLC*, 2018 WL 6729776, at *8 n.87 (D. Nev. Dec. 21, 2018) (dismissing as "hyperbolic" a claim that plaintiff would "suffer irreparable harm akin to involuntary servitude" if it was "forced to sell and work for" defendant); *see generally Zavala v. Wal Mart Stores Inc.*, 691 F.3d 527, 540–41 (3d Cir. 2012) (affirming dismissal of RICO claim predicated on involuntary servitude and stating, "[T]he phrase 'involuntary servitude' was intended . . . 'to cover those forms of compulsory labor akin to African slavery'" and noting that "[m]odern day examples of involuntary servitude have been limited to labor camps, isolated religious sects, or forced confinement.") (citations omitted). Plaintiffs do not allege any such conduct here. Indeed, to the extent anything was responsible for "forcing" Plaintiffs to provide the services at issue, the FAC makes clear that federal and state law did so, not Defendants. *See* 2 PA 97. What is more, Plaintiffs acknowledge that the relevant plans paid each and every one of the claims at issue; they simply contend that the plans should have

paid more. *See e.g.*, 2 PA 98, 100. This does not come close to meeting the standard for alleging involuntary servitude under Nevada law.

IV. CONCLUSION

Based on the foregoing, this Court should entertain this petition on the merits and issue the relief requested herein. The district court's erroneous denial of Defendants' Motion to Dismiss should be corrected. The district court is acting in contravention of both federal and Nevada law governing ERISA preemption of state law claims. Now is the appropriate time to remedy these errors. Writ relief is warranted.

Dated: August 21, 2020

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VERIFICATION

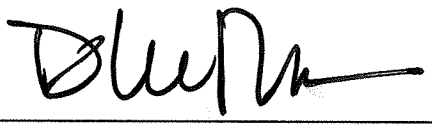
1. I, the undersigned, declare as follows:

2. I am a lawyer duly admitted to practice before the courts of this State and I represent Petitioners in this proceeding.

3. I verify that I have read the foregoing Petition for Writ of Prohibition, or, Alternatively, of Mandamus and that the same is true to my own knowledge, except for those matters stated on information and belief, and as to those matters, I believe them to be true.

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

Dated: August 21, 2020



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CERTIFICATE OF COMPLIANCE

1. Pursuant to NRAP 21(e), I hereby certify that this petition complies with the formatting requirements of NRAP 21(d), including the fact that this brief has been prepared in a proportionally spaced typeface using Microsoft Word in 14 point Times New Roman type style.

2. I further certify that Petitioners' brief exceeds the type-volume limitations of NRAP 21(d) because it contains 13,993 words and a petition may not exceed 7,000 words unless the Court grants leave to file a longer petition.

3. Petitioner is filing a motion to exceed word length contemporaneously with this petition.

4. I further certify that I have read this brief, 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 brief complies with all applicable Nevada Rules of Appellate Procedure, and I understand that I may be subject to sanctions in the event that the accompanying petition is not in conformity with the requirements of the Nevada Rules of Appellate Procedure.

DATED: August 21, 2020

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CERTIFICATE OF SERVICE

Pursuant to NRAP 25, I hereby certify that I am an employee of Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC and that on August 21, 2020, I filed a Petition for Writ of Prohibition, or, Alternatively, Mandamus with the Clerk of the Nevada Supreme Court and served a copy of the Writ to the addresses shown below (in the manner indicated below). The accompanying Five Volume Appendix will be electronically filed in the court under NRAP 30(f)(2).

VIA U.S. MAIL:

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