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 Healthcare 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.

PETITIONER'S APPENDIX – VOLUME 2

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DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: A-19-792978-B Dept. No.: XXVII **FIRST AMENDED COMPLAINT** **Jury Trial Demanded**

Pursuant to the Court's May 15, 2020 Order, Plaintiffs' First Amended Complaint follows.

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

Case No.: 2:19-cv-00832-JAD-VCF

FIRST AMENDED COMPLAINT

Jury Trial Demanded

Plaintiffs Fremont Emergency Services (Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest" and collectively the "Health Care Providers") as and

for their First Amended Complaint against defendants UnitedHealth Group, Inc. ("UHG"), and its subsidiaries and/or affiliates United Healthcare Insurance Company ("UHCIC") United Health Care Services Inc. dba UnitedHealthcare ("UHC Services"); UMR, Inc. dba United Medical Resources ("UMR"); Oxford Benefit Management, Inc. ("Oxford" together with UHG, UHC Services and UMR, the "UHC Affiliates" and with UHCIC, the "UH Parties"); Sierra Health and Life Insurance Company, Inc. ("Sierra Health"); Sierra Health-Care Options, Inc. ("Sierra Options" and together with Sierra Health, the "Sierra Affiliates"); Health Plan of Nevada, Inc. ("HPN") (collectively "Defendants") hereby complain and allege as follows:

NATURE OF THIS ACTION

1. This action arises out of a dispute concerning the rate at which Defendants reimburse the Health Care Providers for the emergency medicine services they have already provided, and continue to provide, to patients covered under the health plans underwritten, operated, and/or administered by Defendants (the "Health Plans") (Health Plan beneficiaries for whom the Health Care Providers performed covered services that were not reimbursed correctly shall be referred to as "Patients" or "Members").[1] Collectively, Defendants have manipulated, are continuing to manipulate, and have conspired to manipulate their third party payment rates to defraud the Health Care Providers, to deny them reasonable payment for their services which the law requires, and to coerce or extort the Health Care Providers into contracts that only provide for manipulated rates. Defendants have reaped millions of dollars from their illegal, coercive, unfair, fraudulent conduct and will reap millions more if their conduct is not stopped.

2. Defendants have manipulated, are continuing to manipulate, and have conspired to manipulate their payment rates to defraud the Health Care Providers and deny them reasonable payment for services, which the law requires.

[1] The Health Care Providers do not assert any causes of action with respect to any Patient whose health insurance was issued under Medicare Part C (Medicare Advantage) or is provided under the Federal Employee Health Benefits Act (FEHBA). The Health Care Providers also do not assert any claims relating to Defendants' managed Medicaid business or with respect to the right to payment under any ERISA plan. Finally, the Health Care Providers do not assert claims that are dependent on the existence of an assignment of benefits ("AOB") from any of Defendants' Members. Thus, there is – and was – no basis to remove this lawsuit to federal court under federal question jurisdiction.

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PARTIES

3. Plaintiff Fremont Emergency Services (Mandavia), Ltd. ("Fremont") is a professional emergency medicine services group practice that staffs the emergency departments at ER at Aliante; ER at The Lakes; Mountainview Hospital; Dignity Health – St. Rose Dominican Hospitals, Rose de Lima Campus; Dignity Health – St. Rose Dominican Hospitals, San Martin Campus; Dignity Health – St. Rose Dominican Hospitals, Siena Campus; Southern Hills Hospital and Medical Center; and Sunrise Hospital and Medical Center located throughout Clark County, Nevada. Fremont is part of the TeamHealth Holdings, Inc. ("TeamHealth") organization.

4. Plaintiff Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians") is a professional emergency medicine services group practice that staffs the emergency department at Banner Churchill Community Hospital in Fallon, Nevada.

5. Plaintiff Crum, Stefanko And Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest") is a professional emergency medicine services group practice that staffs the emergency department at Northeastern Nevada Regional Hospital in Elko, Nevada.

6. Defendant UnitedHealth Group, Inc. ("UHG") is the largest single health carrier in the United States and is a Delaware corporation with its principal place of business in Minnesota. UHG is a publicly-traded holding company that is dependent upon monies (including dividends and administrative expense reimbursements) from its subsidiaries and affiliates which include all of the other Defendant entities named herein.

7. Defendant United HealthCare Insurance Company ("UHCIC") is a Connecticut corporation with its principal place of business in Connecticut. UHCIC is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, United HealthCare Insurance Company is a licensed Nevada health and life insurance company.

8. Defendant United HealthCare Services, Inc. dba UnitedHealthcare ("UHC Services") is a Minnesota corporation with its principal place of business in Connecticut and affiliate of UHCIC. UHC Services is responsible for administering and/or paying for certain

emergency medical services at issue in the litigation. On information and belief, United HealthCare Services, Inc. is a licensed Nevada health insurance company.

9. Defendant UMR, Inc. dba United Medical Resources ("UMR") is a Delaware corporation with its principal place of business in Connecticut and affiliate of UHCIC. UMR is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, UMR is a licensed Nevada health insurance company.

10. Defendant Oxford Health Plans, Inc. ("Oxford") is a Delaware corporation with its principal place of business in Connecticut and affiliate of UHCIC. Oxford is responsible for administering and/or paying for certain emergency medical services at issue in the litigation.

11. Defendant Sierra Health and Life Insurance Company, Inc. is a Nevada corporation and affiliate of UHCIC. Sierra Health is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, Sierra Health is a licensed Nevada health insurance company.

12. Defendant Sierra Health-Care Options, Inc. ("Sierra Options") is a Nevada corporation and affiliate of UHCIC. Sierra Options is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, Sierra Options is a licensed Nevada health insurance company.

13. Defendant Health Plan of Nevada, Inc. ("HPN") is a Nevada corporation and affiliate of UHCIC. HPN is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, HPN is a licensed Nevada Health Maintenance Organization ("HMO").

14. There may be other persons or entities, whether individuals, corporations, associations, or otherwise, who are or may be legally responsible for the acts, omissions, circumstances, happenings, and/or the damages or other relief requested by this Complaint. The true names and capacities of Does 1-10 and Roes Entities 11-20 are unknown to the Health Care Providers, who sues those defendants by such fictitious names. The Health Care Providers will seek leave of this Court to amend this Complaint to insert the proper names of the defendant

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Doe and Roe Entities when such names and capacities become known to the Health Care Providers.

JURISDICTION AND VENUE

15. The amount in controversy exceeds the sum of fifteen thousand dollars ($15,000.00), exclusive of interest, attorneys' fees and costs.

16. The Eighth Judicial District Court, Clark County, has subject matter jurisdiction over the matters alleged herein since only state law claims have been asserted and no diversity of citizenship exists. The Health Care Providers contest this Court's subject matter jurisdiction over the matters alleged herein and have moved to remand. *See* Motion to Remand (ECF No. 5). The Health Care Providers do not waive their continued objection to Defendants' removal based on alleged preemption under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1132(a)(1)(B). Venue is proper in Clark County, Nevada.

FACTS COMMON TO ALL CAUSES OF ACTION

The Health Care Providers Provide Necessary Emergency Care to Patients

17. The Health Care Providers are professional practice groups of emergency medicine physicians and healthcare providers that provides emergency medicine services 24 hours per day, 7 days per week to patients presenting to the emergency departments at hospitals and other facilities in Nevada staffed by the Health Care Providers. The Health Care Providers provide emergency department services throughout the State of Nevada.

18. The Health Care Providers and the hospitals whose emergency departments they staff are obligated by both federal and Nevada law to examine any individual visiting the emergency department and to provide stabilizing treatment to any such individual with an emergency medical condition, regardless of the individual's insurance coverage or ability to pay. *See* Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd; NRS 439B.410. The Health Care Providers fulfill this obligation for the hospitals which they staff. In this role, the Health Care Providers' physicians provide emergency medicine 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.

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19. Upon information and belief, Defendants operate as an HMO under NRS Chapter 695C, and is an insurer under NRS Chapters 679A, 689A (Individual Health Insurance), 689B (Group and Blanket Health Insurance), 689C (Health Insurance for Small Employers) and 695G (Managed Care Organization). Defendants provide, either directly or through arrangements with providers such as hospitals and the Health Care Providers, healthcare benefits to its members.

20. There is no written agreement between Defendants and the Health Care Providers for the healthcare claims at issue in this litigation; the Health Care Providers are therefore designated as a "non-participating" or "out-of-network" provider for all of the claims at issue. An implied-in-fact agreement exists between the Health Care Providers and Defendants, however.

21. Because federal and state law requires that emergency services be provided to individuals by the Health Care Providers without regard to insurance status or ability to pay, the law protects emergency service providers -- like Fremont here -- from predatory conduct by payors, including the kind of conduct in which Defendants have engaged leading to this dispute. If the law did not do so, emergency service providers would be at the mercy of such payors. the Health Care Providers would be forced to accept payment at any rate or no rate at all dictated by insurers under threat of receiving no payment, and then the Health Care Providers would be forced to transfer the financial burden of care in whole or in part onto Patients. The Health Care Providers are protected by law, which requires that for the claims at issue, the insurer must reimburse the Health Care Providers at a reasonable rate or the usual and customary rate for services they provide.

22. The Health Care Providers regularly provide emergency services to Defendants' Patients.

23. Defendants are contractually and legally responsible for ensuring that Patients receive emergency services without obtaining prior approval and without regard to the "in network" or "out-of-network" status of the emergency services provider.

24. The uhc.com website state:

> There are no prior authorization requirements for emergency services in a true emergency, even if the emergency services are

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> provided by an out-of-network provider. Payment for the emergency service will follow the plan rules for network emergency coverage. This provision applies to all non-grandfathered fully insured and self-funded group health plans [Fully Funded plans], as well as group and individual health insurance issuers [Employer Funded plans].

25. Relevant to this action:

a. From July 1, 2017 through the present, Fremont has provided emergency medicine services to Defendants' Members as an out-of-network provider of emergency services as follows: ER at Aliante (approximately July 2017-present); ER at The Lakes (approximately July 2017-present); Mountainview Hospital (approximately July 2017-present); Dignity Health – St. Rose Dominican Hospitals, Rose de Lima Campus (approximately July 2017-October 2018); Dignity Health – St. Rose Dominican Hospitals, San Martin Campus approximately (July 2017-October 2018); Dignity Health – St. Rose Dominican Hospitals, Siena Campus (approximately July 2017-October 2018); Southern Hills Hospital and Medical Center (approximately July 2017-present); and Sunrise Hospital and Medical Center (approximately July 2017-present).

b. At all times relevant hereto, Team Physicians and Ruby Crest have provided emergency medicine services to Defendants' Members as out-of-network providers of emergency services at Banner Churchill Community Hospital in Fallon, Nevada and Northeastern Nevada Regional Hospital in Elko, Nevada, respectively.

26. Defendants have generally adjudicated and paid claims with dates of service through July 31, 2019. As the claims continue to accrue, so do the Health Care Providers' damages. For each of the claims for which the Health Care Providers seek damages, Defendants have already determined the claim was covered and payable.

The Relationship Between the Health Care Providers and Defendants

27. Defendants provide health insurance to their members (*i.e.*, their insureds).

28. In exchange for premiums, fees, and/or other compensation, Defendants are responsible for paying for health care services rendered to members covered by their health plans.

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29. In addition, Defendants provide services to their Members, such as building participating provider networks and negotiating rates with providers who join their networks.

30. Defendants offer a range of health insurance plans. Plans generally fall into one of two categories.

31. "Fully Funded" plans are plans in which Defendants collect premiums directly from their members (or from third parties on behalf of their members) and pay claims directly from the pool of funds created by those premiums.

32. "Employer Funded" plans are plans in which Defendants provide administrative services to their employer clients, including processing, analysis, approval, and payment of health care claims, using the funds of the claimant's employer.

33. Defendants provide coverage for emergency medical services under both types of plans.

34. Defendants are contractually and legally responsible for ensuring that their members can receive such services (a) without obtaining prior approval and (b) without regard to the "in network" or "out-of-network" status of the emergency services provider.

35. Defendants highlight such coverage in marketing their insurance products.

36. For example, on the "patient protections" section of Defendants' website, uhc.com, Defendants state:

> There are no prior authorization requirements for emergency services in a true emergency, even if the emergency services are provided by an out-of-network provider. Payment for the emergency service will follow the plan rules for network emergency coverage. This provision applies to all non-grandfathered fully insured and self-funded group health plans [Fully Funded plans], as well as group and individual health insurance issuers [Employer Funded plans].

37. Payors typically demand a lower payment rate from contracted participating providers.

38. In return, payors offer participating providers certainty and timeliness of payment, access to the payor's formal appeals and dispute resolution processes, and other benefits.

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39. For all claims at issue in this lawsuit, the Health Care Providers were non-participating providers, meaning they did not have an express contract with Defendants to accept or be bound by Defendants' reimbursement policies or in-network rates.

40. Specifically, the reimbursement claims within the scope of this action are (a) non-participating commercial claims (including for patients covered by Affordable Care Act Exchange products), (b) that were adjudicated as covered, and allowed as payable by Defendants, (c) at rates below the billed charges and a reasonable payment for the services rendered, (d) as measured by the community where they were performed and by the person who provided them. These claims are collectively referred to herein as the "Non-Participating Claims."

41. The Non-Participating Claims involve only commercial and Exchange Products operated, insured, or administered by the insurance company Defendants. They do not involve Medicare Advantage or Medicaid products.

42. Further, the Non-Participating Claims at issue do not involve coverage determinations under any health plan that may be subject to the federal Employee Retirement Income Security Act of 1974, or claims for benefits based on assignment of benefits.[2]

43. Those counts concern the *rate* of payment to which the Health Care Providers are entitled, not whether a *right* to receive payment exists.

44. Defendants bear responsibility for paying for emergency medical care provided to their members regardless of whether the treating physician is an in-network or out-of-network provider.

45. Defendants understand and expressly acknowledge that their members will seek emergency treatment from non-participating providers and that Defendants are obligated to pay for those services.

…

…

[2] The Health Care Providers understand, in any event, that Defendants do not require or rely upon assignments from their members in order to pay claims for services provided by the Health Care Providers to their members.

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The Reasonable Rate for Non-Participating Emergency Services is Well-Established

46. Defendants have traditionally allowed payment at 75-90% of billed charges for the Health Care Providers' emergency services.

47. Defendants have done so largely through the use of rental networks, which establish a reasonable rate for out-of-network provider services through arms-length negotiations between the rental network and providers on the one hand, and the rental network and health insurance companies on the other.

48. Rental networks act as "brokers" between non-participating providers and health insurance companies.

49. A rental network will secure a contract with a provider to discount its out-of-network charges.

50. The rental network then contracts with (or "rents" its network to) health insurance companies to allow the insurer access to the rental network and to the providers' agreed-upon discounted rates.

51. As such, rental networks' negotiated rates act as a proxy for a reasonable rate of reimbursement for out-of-network emergency services, both in the industry as a whole and for particular payors.

52. For many years, the Health Care Providers' respective contracts with a range of rental networks, including MultiPlan, have contemplated a modest discount from the Health Care Providers' billed charges for claims adjudicated through the rental network agreement.

53. In practice, nearly all of the Health Care Providers' non-participating provider claims submitted under Employer Funded plans from 2008 to 2017 were paid at between 75-90% of billed charges, including the Non-Participating Claims submitted to Defendants.

54. This longstanding history establishes that a reasonable reimbursement rate for the Health Care Providers' Non-Participating Claims for emergency services is 75-90% of the Health Care Providers' billed charge.

55. Beginning in approximately January 2019, Defendants have further slashed their reimbursement rate for Non-Participating Claims to less than 60%, and to as low as 12% of the

charges billed for professional services, rates that are well-below reasonable reimbursement rates.

56. Defendants' drastic payment cuts are entirely inconsistent with the established rate and history between the parties.

Defendants Paid the Health Care Providers Unreasonable Rates

57. Defendants arbitrarily began manipulating the rate of payment for claims submitted by the Health Care Providers. Defendants drastically reduced the rates at which they paid the Health Care Providers for emergency services for some claims, but not others. Instead of paying a usual and customary rate of the charges billed by the Health Care Providers, Defendants paid some of the claims for emergency services rendered by the Health Care Providers at far below the usual and customary rates. Yet, Defendants paid other substantially identical claims (e.g. claims billed with the same Current Procedural Terminology (CPT) Code, as maintained by American Medical Association) submitted by the Health Care Providers at higher rates and in some instances at 100% of the billed charge.

a. For example, on October 10, 2017, Defendants' Member #1, presented to the emergency department at Southern Hills Hospital and was treated by Fremont's providers. The professional services were billed with CPT Code 99285 in the amount $1,295.00; Defendants allowed and paid $223.00, which is just 17% of the charges billed. By contrast, on October 9, 2017, Defendants' Member #2 presented to the emergency department at St. Rose Dominican Hospitals, Siena Campus. The professional services were billed with CPT Code 99285 in the amount $1,295.00; Defendants paid $1,295.00, 100% of the charges billed.

b. By way of further example, between January 9 and 31, 2019, Defendants' Members #3, #4, #5 all presented to emergency departments staffed by Fremont's providers. In each instance the professional services were billed with CPT Code 99285 and Defendants paid nearly all or 100% of the billed charges. By contrast, on February 26, 2019, Defendants' Members #6, #7 and #8 all presented to emergency departments staffed by Fremont. In each instance the professional services were billed with CPT Code 99285 in the amount of $1,360.00 and Defendants only paid $185.00, a mere 13.6% of the billed charges in each instance.

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c. Further, Fremont's providers treated Member #9 on March 3, 2019. The professional services were billed at $971.00 (CPT 99284) and Defendants allowed $217.53, which is 22% of billed charges.

d. The Health Care Providers do not assert any of the foregoing claims pursuant to, or in reliance on, any assignment of benefit by Defendants' Members. Upon information and belief, Defendants do not require or rely upon assignment of benefits from their Members in order to pay claims for services provided by the Health Care Providers.

58. Defendants generally paid lower reimbursement rates for services provided to Members of their fully insured plans and authorize payment at higher reimbursement rates for services provided to Members of employer funded plans or those plans under which they provide administrator services only.

59. The Health Care Providers have continued to provide emergency medicine treatment, as required by law, to Patients covered by Defendants' plans who seek care at the emergency departments where they provide coverage.

60. Defendants bear responsibility for paying for emergency medical care provided to their Members regardless of whether the treating physician is an in-network or out-of-network provider.

61. Defendants expressly acknowledge that their Members will seek emergency treatment from non-participating providers and that they are obligated to pay for those services.

62. In emergency situations, individuals go to the nearest hospital for care, particularly if they are transported by ambulance. Patients facing an emergency situation are unlikely to have the opportunity to determine in advance which hospitals and physicians are in-network under their health plan. Defendants are obligated to reimburse the Health Care Providers at the usual and customary rate for emergency services the Health Care Providers provided to their Patients, or alternatively for the reasonable value of the services provided.

63. Defendants' Members received a wide variety of emergency services (in some instances, life-saving services) from the Health Care Providers' physicians: treatment of

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conditions ranging from cardiac arrest, to broken limbs, to burns, to diabetic ketoacidosis and shock, to gastric and/or obstetrical distress.

64. As alleged herein, the Health Care Providers provided treatment on an out-of-network basis for emergency services to thousands of Patients who were Members in Defendants' Health Plans. The total underpayment amount for these related claims is in excess of $15,000.00 and continues to grow. Defendants have likewise failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of these claims.

65. Defendants paid some claims at an appropriate rate and others at a significantly reduced rate which is demonstrative of an arbitrary and selective program and motive or intent to unjustifiably reduce the overall amount Defendants pay to the Health Care Providers. Defendants implemented this program to coerce, influence and leverage business discussions with the Health Care Providers to become a participating provider at significantly reduced rates, as well as to unfairly and illegally profit from a manipulation of payment rates.

66. Defendants failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of the subject claims as legally required.

67. The Health Care Providers contested the unsatisfactory rate of payment received from Defendants in connection with the claims that are the subject of this action.

68. All conditions precedent to the institution and maintenance of this action have been performed, waived, or otherwise satisfied.

69. The Health Care Providers bring this action to compel Defendants to pay it the usual and customary rate or alternatively for the reasonable value of the professional emergency medical services for the emergency services that it provided and will continue to provide Patients and to stop Defendants from profiting from their manipulation of payment rate data.

Defendants' Prior Manipulation of Reimbursement Rates

70. Defendants have a history of manipulating their reimbursement rates for non-participating providers to maximize their own profits at the expense of others, including their own Members.

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71. In 2009, defendant UnitedHealth Group, Inc. was investigated by the New York Attorney General for allegedly using its wholly-owned subsidiary, Ingenix, to illegally manipulate reimbursements to non-participating providers.

72. The investigation revealed that Ingenix maintained a database of health care billing information that intentionally skewed reimbursement rates downward through faulty data collection, poor pooling procedures, and lack of audits.

73. Defendant UnitedHealth Group, Inc. ultimately paid a $50 million settlement to fund an independent nonprofit organization known as FAIR Health to operate a new database to serve as a transparent reimbursement benchmark.

74. In a press release announcing the settlement, the New York Attorney General noted that: "For the past ten years, American patients have suffered from unfair reimbursements for critical medical services due to a conflict-ridden system that has been owned, operated, and manipulated by the health insurance industry."

75. Also in 2009, for the same conduct, defendants UnitedHealth Group, Inc., United HealthCare Insurance Co., and United HealthCare Services, Inc. paid $350 million to settle class action claims alleging that they underpaid non-participating providers for services in *The American Medical Association, et al. v. United Healthcare Corp., et al.*, Civil Action No. 00-2800 (S.D.N.Y.).

76. Since its inception, FAIR Health's benchmark databases have been used by state government agencies, medical societies, and other organizations to set reimbursement for non-participating providers.

77. For example, the State of Connecticut uses FAIR Health's database to determine reimbursement for non-participating providers' emergency services under the state's consumer protection law.

78. Defendants tout the use of FAIR Health and its benchmark databases to determine non-participating, out-of-network payment amounts on its website.

79. As stated on Defendants' website (https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits) for non-participating provider claims, the relevant United

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Health Group affiliate will "in many cases" pay the lower of a provider's actual billed charge or "the reasonable and customary amount," "the usual customary and reasonable amount," "the prevailing rate," or other similar terms that base payment on what health care providers in the geographic area are charging.

80. While Defendants give the appearance of remitting reimbursement to non-participating providers that meet usual and customary rates and/or the reasonable value of services based on geography that is measured from independent benchmark services such as the FAIR Health database, Defendants have found other ways to manipulate the reimbursement rate downward from a usual and customary or reasonable rate in order to maximize profits at the expense of the Health Care Providers.

81. During the relevant time, Defendants imposed significant cuts to the Health Care Providers' reimbursement rate for out-of-network claims under Defendants' fully funded plans, without rationale or justification.

82. Defendants pay claims under fully funded plans out of their own pool of funds, so every dollar that is not paid to the Health Care Providers is a dollar retained by Defendants for their own use.

83. Defendants' detrimental approach to payments for members in fully funded plans continues today, Defendants have made payments to the Health Care Providers at rates as low as 20% of billed charges.

84. Team Physicians' providers treated Member #10 on March 15, 2019 and the professional services (CPT 99285) were billed in the amount of $1,138.00, but Defendants allowed $435.20 which is just 38% of the billed charges.

85. In another example, Team Physicians' providers treated Member #11 on February 9, 2019 and the professional services (CPT 99285) were billed in the amount of $1,084.00, but Defendants allowed $609.28 which is just 56% of the billed charges.

86. Further, Fremont's providers treated Member #12 on April 17, 2019 and the professional services were billed in the amount of $1,428.00 (CPT 99285), but defendants allowed $435.20 which is 30% of the billed charges.

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87. Fremont also treated Member #13 on March 25, 2019 and the professional services were billed in the amount of $973.00, but defendants allowed $214.51 which is 22% of the billed charges.

88. As a result of these deep cuts in payments for services provided to Members of fully funded plans, Defendants have not paid the Health Care Providers a reasonable rate for those services since early 2019.

89. In so doing, Defendants have illegally retained those funds.

Defendants' Current Schemes

90. In 2017, Defendants also attempted to pay less than a reasonable rate on their employer funded plans, further exacerbating the financial damages to the Health Care Providers.

91. From late 2017 to 2018, over the course of multiple meetings in person, by phone, and by email correspondence, the Health Care Providers' representatives tried to negotiate with Defendants to become participating, in-network providers.

92. As part of these negotiations, the Health Care Providers' representatives met with Dan Rosenthal, President of Defendant UnitedHealth Networks, Inc., John Haben, Vice President of Defendant UnitedHealth Networks, Inc., and Greg Dosedel, Vice President of National Ancillary Contracting & Strategy at Defendant UnitedHealthCare Services, Inc.

93. Around December 2017, Mr. Rosenthal told the Health Care Providers' representatives that Defendants intended to implement a new benchmark pricing program specifically for their employer funded plans to decrease the rate at which such claims were to be paid.

94. Defendants then proposed a contractual rate for their employer funded plans that was roughly half the average reasonable rate at which Defendants have historically reimbursed providers – a drastic and unjustified discount from what Defendants have been paying the Health Care Providers on their non-participating claims in these plans, and an amount materially less than what Defendants were paying other contracted providers in the same market.

95. Defendants' proposed rate was neither reasonable nor fair.

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96. In May 2018, Mr. Rosenthal escalated his threats, making clear during a meeting that, if the Health Care Providers did not agree to contract for the drastically reduced rates, Defendants would implement benchmark pricing that would reduce the Health Care Providers' non-participating reimbursement by 33%.

97. Dan Schumacher, the President and Chief Operating Officer of UnitedHealthcare Inc. and part of the Office of the Chief Executive of Defendant UnitedHealth Group, Inc., said that, by April 2019, Defendants would cut the Health Care Providers' non-participating reimbursement by 50%.

98. Asked why Defendants were forcing such dramatic cuts on the Health Care Providers' reimbursement, Mr. Schumacher said simply "because we can."

99. Defendants made good on their threats and knowingly engaged in a fraudulent scheme to slash reimbursement rates paid to the Health Care Providers for non-participating claims submitted under their employer funded plans to levels at, or even below, what they had threatened in 2018.

100. Defendants falsely claim that their new rates comply with the law because they contracted with a purportedly objective and transparent third party, Data iSight, to process the Health Care Providers' claims and to determine reasonable reimbursement rates.

101. Data iSight is the trademark of an analytics service used by health plans to set payment for claims for services provided to Defendants' Members by non-participating providers. Data iSight is owned by National Care Network, LLC, a Delaware limited liability company with its principal place of business in Irving, Texas. Data iSight and National Care Network, LLC will be collectively referred to as "Data iSight." Data iSight is a wholly-owned subsidiary of MultiPlan, Inc., a New York corporation with its principal place of business in New York, NY. MultiPlan acts as a Rental Network "broker" and, in this capacity, has contracted since as early as June 1, 2016 with some of the Health Care Providers to secure reasonable rates from payors for the Health Care Providers' non-participating emergency services. The Health Care Providers have no contract with Data iSight, and the Non-

Participating Claims identified in this action are not adjudicated pursuant to the MultiPlan agreement.

102. Since January 2019, Defendants have engaged in a scheme and conspired with Data iSight to impose arbitrary and unreasonable payment rates on the Health Care Providers under the guise of utilizing an independent, objective database purportedly created by Data iSight to dictate the rates imposed by Defendants.

103. Defendants also continued to advance this scheme on the negotiation front.

104. On July 7, 2019, Mr. Schumacher advised, in a phone call, that Defendants planned to cut the Health Care Providers' rates over three years to just 42% of the average and reasonable rate of reimbursement that the Health Care Providers had received in 2018 if the Health Care Providers did not formally contract with them at the rate dictated by Defendants.

105. Mr. Schumacher additionally advised that leadership across the Defendant entities were aware and supportive of the drastic cuts and provided no objective basis for them.

106. The next day, Angie Nierman, a Vice President of Networks at UnitedHealth Group, Inc., sent a written proposal reflecting Mr. Schumacher's stated cuts.

107. In addition to denying the Health Care Providers what is owed to them for the Non-Participating Claims, Defendants' scheme is an attempt to use their market power to reset the rate of reimbursement to unreasonably low levels.

108. As further evidence of Defendants' scheme to use their market power to the detriment of the Health Care Providers and other emergency provider groups that are part of the TeamHealth organization, in August 2019, UHG advised at least one Florida medical surgical facility (the "Florida Facility") that Defendants will not continue negotiating an in-network agreement unless the Florida Facility identifies an in-network anesthesia provider. The current out-of-network anesthesia provider is part of the TeamHealth organization. Defendants' threats to discontinue contract negotiations prompted the Florida Facility's Chief Operating Officer to send TeamHealth a "Letter of Concern" on August 14, 2019. Defendants' threats and leverage are aimed at intentionally interfering with existing contracts and with a goal of reducing TeamHealth's market participation.

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109. Additionally, Defendants first threatened, and then, on or about July 9, 2019, globally terminated all existing in-network contracts with medical providers that are part of the TeamHealth organization, including the Health Care Providers, in an effort to widen the scale of the scheme to deprive the Health Care Providers of reasonable reimbursement rates through its manipulation of reimbursement rate data.

Defendants' Fraudulent Schemes to Deprive the Health Care Providers of Reasonable Reimbursement Violates Nevada's Civil Racketeering Statute

110. Each Defendant, UnitedHealth Group, Inc., United Healthcare Insurance Company, United Health Care Services Inc., UMR, Inc., Oxford Benefit Management, Inc., Sierra Health and Life Insurance Company, Inc., Sierra Health-Care Options, Inc., Health Plan of Nevada, Inc. (collectively "Defendants") violated NRS 207.350 *et seq.* by committing the following crimes related to racketeering activity: NRS 207.360(28) (obtaining possession of money or property valued at $650 or more), NRS 207.360(35) (any violation of NRS 205.377), and NRS 207.360(36) (involuntary servitude) and that the Defendants devised, conducted, and participated in with unnamed third parties, including, but not limited to, Data iSight.

111. The Enterprise, as defined in NRS 207.380 consists of the Defendants, non-parties Data iSight and other entities that develop software used in reimbursement determinations used by the Defendants (the "Enterprise"). The participants of the Enterprise are associated, upon information and belief, by virtue of contractual agreement(s) and/or other arrangement(s) wherein they have agreed to undertake a common goal of reducing payments to the Health Care Providers for the benefit of the Enterprise. The Enterprise participants communicate routinely through telephonic and electronic means as they unilaterally impose reimbursement rates based on their manipulated "data" but which is nothing more than a transparent attempt to impose artificially reduced reimbursement rates that the Defendants threatened during business-to-business negotiations.

112. The Defendants illegally conduct the affairs of the Enterprise, and/or control the Enterprise, that includes Data iSight, through a pattern of unlawful activity.

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113. As part of this scheme, the Defendants prepared to, and did knowingly and unlawfully, reduce the Health Care Providers' reimbursement rates for the non-participating claims to amounts significantly below the reasonable rate for services rendered to Defendants' Members, to the detriment of the Health Care Providers and to the benefit and financial gain of Defendants and Data iSight.

114. To carry out the scheme and in furtherance of the conspiracy, Defendants and Data iSight engaged in conduct violative of NRS 207.400.

115. Since January 2019, the Enterprise worked together to manipulate and artificially lower non-participating provider reimbursement data that coincides and matches the earlier threats made by UHG in an effort to avoid paying the Health Care Providers for the usual and customary fee or rate and/or for the reasonable value of the services provided to Defendants' Members for emergency medicine services. The unilateral reduction in reimbursement rates is not founded on actual statistically sound data, and is not in line with reimbursement rates that can be found through sites such as the FAIR Health database, a recognized source for such reimbursement rates. Each time the Defendants direct payment using manipulated reimbursement rates and issue the Health Care Providers a remittance, the Defendants further their scheme or artifice to defraud Fremont because the Defendants retain the difference between the amount paid based on the artificially reduced reimbursement rate and the amount paid that should be paid based on the usual and customary fee or rate and/or the reasonable value of services provided, to the detriment of the Health Care Providers who have already performed the services being billed. Further, the Health Care Providers' representatives have contacted Data iSight and have been informed that acceptable reimbursement rates are actually influenced and/or determined by Defendants, not Data iSight.

116. As a result of the scheme, Defendants have injured the Health Care Providers in their business or property by a pattern of unlawful activity by reason of their violation of NRS 207.400(1)(a)- (d), (1)(f), (1)(i)-(j). *See* NRS 207.470.

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Defendants' and Data iSight's Activities Constitute Racketeering Activity

117. Defendants and Data iSight committed, and continue to commit, crimes related to racketeering pursuant to NRS 207.360 that have the same or similar pattern, intents, results, accomplices, victims or methods of commission or are otherwise interrelated by distinguishing characteristics and are not isolated incidents in violation of NRS 207.360(28) (obtaining possession of money or property valued at $650 or more), NRS 207.360(35) (any violation of NRS 205.377), and NRS 207.360(36) (involuntary servitude) such that they have engaged in racketeering activity as defined by NRS 207.400 and which poses a continued threat of unlawful activity such that they constitute a criminal syndicate under NRS 207.370.

118. Defendants and Data iSight have knowingly, wrongfully, and unlawfully reduced payment to the Health Care Providers for the emergency services that the Health Care Providers provided to Defendants' Members, for the financial gain of the Defendants and Data iSight.

119. The racketeering activity has happened on more than two occasions that have happened within five years of each other. In fact, the Defendants have processed and submitted a substantial number of artificially reduced payments to the Health Care Providers since January 2019 in furtherance of Defendants' unlawful conduct.

120. As a direct and proximate result of those activities, the Health Care Providers have suffered millions of dollars in discrete and direct financial loss that stem from the Defendants' knowing retention of payment that is founded on a scheme to manipulate payment rates and payment data to their benefit.

The Enterprise and Scheme

121. The Enterprise is comprised of Defendants and third-party entities, to include Data iSight, that developed software used in reimbursement determinations by Defendants.

122. Defendants and Data iSight agreed to, and do, manipulate reimbursement rates and control allowed payments to the Health Care Providers through acts of the Enterprise.

123. The Defendants and Data iSight conceal their scheme by hiding behind written agreements and/or other arrangements, and false statements.

124. Since at least January 1, 2019, the Defendants, by virtue of their engagement and use of Data iSight, have falsely claimed to provide transparent, objective, and geographically-adjusted determinations of reimbursement rates.

125. In reality, Data iSight is used as a cover for Defendants to justify paying reimbursement to the Health Care Providers at rates that are far less than the reasonable payment rate that the Health Care Providers have historically received and are entitled to under the law. The reimbursement rates purportedly collected and employed by Data iSight are nothing more than an instrumentality for the Defendants' unilateral decision to stop paying the Health Care Providers the usual and customary fee and/or the reasonable value of the services provided.

126. This scheme is concealed through the use of false statements on Data iSight's website and in Defendants' and Data iSight's communications with providers, including the Health Care Providers' representatives.

127. The Enterprise's scheme, as described below, was, and continues to be, accomplished through written agreements, association, and sharing of information between Defendants and Data iSight.

The Enterprise's False Statements: Transparency

128. By the end of June 2019, an increasingly significant amount of non-participating claims submitted to Defendants were being processed for payment by Data iSight.

129. The Data iSight website claims to offer "Transparency for You, the Provider," and that the "website makes the process for determining appropriate payment transparent to [providers]. . . so all parties involved in the billing and payment process have a clear understanding of how the reduction was calculated."

130. Contrary to these claims, however, the Enterprise, through Data iSight, uses layers of obfuscation to hide and avoid providing the basis or method it uses to derive its purportedly "appropriate" rates.

131. This concealment was designed by the Enterprise to, and does, prevent the Health Care Providers from receiving a reasonable payment for the services it provides.

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132. For claims whose reimbursement is determined by Data iSight, non-participating providers receive a Provider Remittance Advice form ("Remittance") from Defendants with "IS" or "1J" in the "Remark/Notes" column.

133. Over the past six months, an ever-increasing number of non-participating claims have been processed by Data iSight with drastically reduced payment amounts.

134. Yet Defendants and Data iSight do not state, on the face of the Remittance, or anywhere else, any reason for the dramatic cut.

135. Instead, the Remittances contain a note to call a toll-free number if there are questions about the claim.

136. In July 2019, a representative of Team Physicians contacted Data iSight via that number to discuss three separate claims with CPT Code 99285 (emergency department visit, problem of highest severity) which had been billed at $1,084.00, but for which Data iSight had allowed two claims at $435.20 (40% of billed charges) and one at $609.28 (56% of billed charges). After Team Physicians' representative spoke with Data iSight's intake representative, a Data iSight representative, Kimberly (Last Name Unknown) ("LNU") ("Kimberly"), called back and she asked if Team Physicians wanted a proposal for one of the inquired-upon claims. Team Physicians' representative indicated that he was interested in learning more and asked what reimbursement rate would be offered. Kimberly stated, "I have to look at a couple of things and decide." Thereafter, Kimberly sent the Team Physicians' representative a proposed Letter of Agreement (prepared July 31, 2019) (ICN: 48218522) offering to increase the allowed amount from $609.28 to $758.80 – increasing the amount to 70% of billed charges instead of 56% – as payment in full and an agreement not to balance bill Defendants' Member or Member's family. All it took was one call and a request for a more reasonable payment and almost immediately Defendant United Healthcare Services increased the amount it would pay, although still not to the level that the Health Care Providers consider to be reasonable.

137. Medical providers that are part of the TeamHealth organization have experienced this same trend across the country with Data iSight. In one instance, in July 2019, a representative of another provider, Emergency Group of Arizona Professional Corporation (the

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"AZ Provider"), contacted Data iSight via that number to discuss a claim with CPT Code 99284 (emergency department visit, problem of high severity) which had been billed at $1,190.00, but for which Data iSight had allowed and paid $295.28, just 24.8% of billed charges.

138. After the AZ Provider's representative spoke with Data iSight's intake representative, a Data iSight representative, Michele Ware ("Ware"), called back and claimed the billed charges were paid based on a percentage of the Medicare fee schedule. The AZ Provider's representative challenged the reasonableness of the $295.28 payment. After learning that the AZ Provider had not yet billed Defendants' Member for the difference, Ware stated "ok – so you're willing negotiate" and offered to pay 80% of billed charges. In response, the AZ Provider's representative asked for payment of 85% of billed charges – $1,011.50 – to which Ware promptly agreed. Immediately thereafter, Ware sent a written agreement for the AZ Provider's representative to review and sign, confirming payment of $1,011.50 as payment in full and an agreement not to balance bill Defendants Services' Member or Member's family.

139. In another instance, when asked to provide the basis for the dramatic cut in payment for the claims, a Data iSight representative by the name of Phina LNU, did not and could not explain how the amount was derived or how it was determined that a cut was appropriate at all. The representative could only say that the payments on the claims represented a certain percentage of the Medicare fee schedule; she could not explain how Data iSight had arrived at that payment for either of the two claims, or why it allowed a different amount for each claim.

140. Instead, the representative simply stated that the rates were developed by Data iSight and Defendants. When the Health Care Providers' representative continued to pursue the issue and spoke with a Data iSight supervisor, James LNU, to inquire as to the basis for these determinations, James LNU responded that "it is just an amount that is recommended and sent over to United [HealthCare]." When James LNU was expressly challenged on Data iSight's false claim that it is transparent with providers, he responded with silence.

141. Further attempts to understand Data iSight and obtain information about the basis for its reimbursement rate-setting from Data iSight executives have also been futile.

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142. Data iSight and the Defendants know that the rates that Data iSight have allowed for the Health Care Providers' claims in 2019 are unreasonable and are not, in fact, based on objective, reliable data designed to arrive at a reasonable reimbursement rate.

143. Defendants know this because when a provider challenges the payment, Data iSight and Defendants are authorized to revise the allowed amount back up to a reasonable rate, but only if the Health Care Providers persist long enough in the process.

144. This process to contest the unreasonable payment takes weeks to conclude for the Health Care Providers and is impracticable to follow for every claim – a fact that Defendants and Data iSight understand.

145. For example, as evidence of this fraudulent practice, the Health Care Providers' representatives contested the allowed amounts on the claim discussed above in paragraph 136.

146. Eventually, Data iSight, offered to allow payment of at least one claim at 70% of the billed charges.

147. Absent providers taking the time to chase every claim, Data iSight and Defendants are able to get away with paying a rate that they know is not based on objective data and is far below the reasonable one.

148. Moreover, the Enterprise's scheme of refusing to reimburse at reasonable rates unless and until the Health Care Providers challenge its determinations continually harms the Health Care Providers, in that, even if they eventually receive reasonable reimbursement upon contesting the rate, this scheme burdens them with excessive administrative time and expense and deprives the Health Care Providers of their right to prompt payment.

The Enterprise's False Statements: Representations that Payment Rates Are "Defensible and Market Tested"

149. The Enterprise's claim to "transparency" is not its only fraudulent representation.

150. The Enterprise, through Data iSight, also falsely represents, on Data iSight's website, to set reimbursement rates in a "defensible, market tested" way.

151. Claims processed by Data iSight contain the following note:

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> MEMBER: THIS SERVICE WAS RENDERED BY AN OUT-OF-NETWORK PROVIDER AND PROCESSED USING YOUR NETWORK BENEFITS. IF YOU'RE ASKED TO PAY MORE THAN THE DEDUCTIBLE, COPAY AND COINSURANCE AMOUNTS SHOWN, PLEASE CALL DATA ISIGHT AT 866-835- 4022 OR VISIT DATAISIGHT.COM. THEY WILL WORK WITH THE PROVIDER ON YOUR BEHALF. **PROVIDER: THIS SERVICE HAS BEEN REIMBURSED USING DATA ISIGHT WHICH UTILIZES COST DATA IF AVAILABLE (FACILITIES) OR PAID DATA (PROFESSIONALS).** PLEASE DO NOT BILL THE PATIENT ABOVE THE AMOUNT OF DEDUCTIBLE, COPAY AND COINSURANCE APPLIED TO THIS SERVICE. IF YOU HAVE QUESTIONS ABOUT THE REIMBURSEMENT CONTACT DATA ISIGHT.

(emphasis added).

152. This note is intended to, and does, mislead the Health Care Providers to believe that the reimbursement calculations are tied to external, objective data.

153. Further, in its provider portal, Data iSight describes its "methodology" for reimbursement determinations as "calculated using paid claims data from millions of claims . . . . The Data iSight reimbursement calculation is based upon standard relative value units where applicable for each CPT/HCPCS code, multiplied by a conversion factor."

154. Data iSight's parent company, MultiPlan, similarly describes Data iSight's process as using "cost- and reimbursement-based methodologies" and notes that it has been "[v]alidated by statisticians as effective and fair."

155. These statements are false.

156. Data iSight's rates are not data-driven: they match the rate threatened by Defendants in 2018 and are whatever Defendants want, and direct Data iSight, to allow.

157. For example, the Health Care Providers submitted claims for Members but received reimbursement in very different allowed amounts:

a. Member #14 was treated on May 9, 2019. Fremont billed Defendants $973.00 for procedure code 99284, and Defendants allowed $875.70 through MultiPlan, which is approximately 90% of billed charges – a reasonable rate, in line with the reasonable rate paid by Defendants to Fremont for non-participating provider services.

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b. But, for Member #15, who was treated on May 24, 2019, Defendants, through Data iSight, allowed only $295.28 for billed charges of $1,019.00, which is only 29% of the billed charges.

c. Further, at just one site, Defendants allowed and paid Team Physicians at varying amounts for the same procedure code (99285) (Members ##16a-16e):

i. Date of Service ("DOS"): January 4, 2019; Charge $1084.00; Allowed $609.28 (56% of Charge and reimbursed using Data iSight);

ii. DOS: January 15, 2019; Charge $1084.00; Allowed $294.60 (27% of Charge);

iii. DOS: January 24, 2019; Charge $1084.00; Allowed $435.20 (40% of Charge and reimbursed using Data iSight);

iv. DOS: January 29, 2019; Charge $1084.00; Allowed $328.39 (30% of Charge); and

v. DOS: February 7, 2019; Charge $1084.00; Allowed $435.20 (40% of Charge and reimbursed using Data iSight).

158. This lock-step reduction, consistent with Defendants' 2018 threats to drastically reduce rates even further if the Health Care Providers failed to agree to their proposed contractual rates, spans a significant number of the Health Care Providers' claims for payment for services to Defendants' Members.

159. From the above examples, it is clear that Data iSight is not using any externally-validated methodology to establish a reasonable reimbursement rate, as its rates are not consistent, defensible, or reasonable.

160. Rather, Defendants, in complicity with Data iSight, increasingly reimburse the Health Care Providers at entirely unreasonable rates, in retaliation for the Health Care Providers' objections to their reimbursement scheme, and completely contrary to their false assertions designed to mislead the Health Care Providers and similar providers into believing that they will receive payment at reasonable rates.

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161. This reimbursement is dictated by Defendants, to the financial detriment of the Health Care Providers.

The Enterprise's False Statements: Geographic Adjustment

162. In addition to false statements regarding transparency and its methodologies, the Enterprise furthered the scheme by using false statements promising geographic adjustments to allowed rates.

163. Indeed, on its provider portal, Data iSight falsely claims that "[a]ll reimbursements are adjusted based on your geographic location and the prevailing labor costs for your area."

164. Data iSight's parent company, MultiPlan, further falsely states on its website that:

> For professional claims where actual costs aren't readily available, Data iSight determines a fair price using amounts generally accepted by providers as full payment for services. Claims are first edited, and then priced using widely-recognized, AMA created Relative Value Units (RVU), to take the value and work effort into account [and] CMS Geographic Practice Cost Index, to adjust for regional differences . . . [then] Data iSight multiplies the geographically-adjusted RVU for each procedure by a median based conversion factor to determine the reimbursement amount. This factor is specific to the service provided and derived from a publicly-available database of paid claims.

165. Contrary to those statements, however, claims from providers in different geographic locations show that Data iSight does not adjust for geographic differences but instead, works with Defendants to cut uniformly out-of-network provider payments across geographic locations.

166. For example, Member WY was treated in Wyoming on January 21, 2019. The provider billed Defendants $779 for procedure code 99284, and Defendants, via Data iSight, allowed $413.39.

167. Four days later, on January 25, 2019, Member AZ in Arizona and billed Defendants $1,212.00 for CPT Code 99284 and Defendants, via Data iSight, allowed exactly $413.39.

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168. On the same date, Member NH was treated on the other side of the country in New Hampshire. The provider billed Defendants $1,047 for procedure 99284, and Defendants, via Data iSight, again allowed $413.39.

169. On February 8, 2019, Member OK was treated in Oklahoma. The provider billed Defendants $990 for procedure code 99284, and Defendants, via Data iSight, allowed $413.39.

170. Two days later, Members KS and NM were treated in Kansas and New Mexico, respectively. The providers billed Defendants $778.00 and $895.00, respectively, for procedure code 99284, but for both of these claims, Defendants, via Data iSight, allowed exactly $413.39.

171. One month later, Member CA was treated in California and Member NV was treated in Nevada. The CA provider billed Defendants $937.00 for procedure code 99284. Defendants, via Data iSight, yet again allowed exactly $413.39. A Health Care Provider billed Defendants $763.00 for procedure code 99284 and, via Data iSight, Defendants again allowed exactly $413.39.

172. Two months later, on May 20, 2019, a provider treated Member PA in Pennsylvania and billed Defendants $1,094 for procedure code 99284, and Defendants, via Data iSight, allowed exactly $413.39.

Patient	Location	Date of Service	Billed Amount	CPT Code	Allowed Amount – "DataiSight™ Reprice"
WY	Wyoming	1/21/19	$779 .00	99284	$413.39
AZ	Arizona	1/25/19	$1,212.00	99284	$413.39
NH	New Hampshire	1/25/19	$1047.00	99284	$413.39
OK	Oklahoma	2/8/19	$990.00	99284	$413.39
KS	Kansas	2/10/19	$778.00	99284	$413.39
NM	New Mexico	2/10/19	$895.00	99284	$413.39
CA	California	3/25/19	$937.00	99284	$413.39
NV	Nevada	3/30/19	$763.00	99284	$413.39
PA	Pennsylvania	5/20/19	$1,094.00	99284	$413.39

173. Defendants falsely claim on their website to "frequently use" the 80th percentile of the FAIR Health Benchmark databases "to calculate how much to pay for out-of-network services."

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174. The 80th percentile of FAIR Health Benchmark databases clearly shows that reimbursement for the above non-participating provider charges, when actually based on a geographically-adjusted basis, would not only vary widely, but also all be higher than the allowed $413.39:

Location	CPT Code	80th Percentile of Fair Health Benchmark
Wyoming	99284	$1,105.00
New Hampshire	99284	$753.00
Oklahoma	99284	$1,076.00
Kansas	99284	$997.00
New Mexico	99284	$1,353.00
California	99284	$795.00
Pennsylvania	99284	$859.00
Arizona	99284	$1,265.00
Nevada	99284	$927.00

The Enterprise's Predicate Acts

175. To perpetuate the scheme and conceal it from the Health Care Providers, in or around 2018, Defendants and Data iSight entered into written agreements with each other that are consistent with Data iSight's agreements with similar health insurance companies.

176. Under those contracts, Data iSight would handle claims determinations for services rendered to Defendants' Members under pre-agreed thresholds set by Defendants.

177. By no later than 2019, Defendants and Data iSight then coordinated and effectuated the posting of false statements on websites and the communication of false statements to providers, including the Health Care Providers, in furtherance of the scheme.

178. These statements include Data iSight and its parent company posting that it would provide a transparent, defensible, market-based, and geographically-adjusted claims adjudication and payment process for providers.

179. Data iSight communicated to the Health Care Providers' representatives by phone and by email in June 2019 that, contrary to its website's claims to transparency, Data iSight could not provide a basis for its unreasonably low allowed amount, mustering only that "it is just an amount that is recommended and sent over to United [HealthCare]."

180. Finally, after weeks of pressure, Data iSight informed the Health Care Providers' representative by phone that it would, after all, allow payment on the contested claims at a reasonable rate: 85% of billed charges.

181. In short, the Enterprise perpetuated its scheme by communicating threats regarding reimbursement cuts to the Health Care Providers in late 2017 and 2018.

182. Then, after making good on those threats, the Enterprise communicated false and misleading information to the Health Care Providers and falsely denied that it had information requested by the Health Care Providers about the basis for the drastically-cut and unreasonable reimbursement rates that Defendants sought to impose.

183. In addition, since at least January 1, 2019, the Enterprise has furthered this scheme by communicating payment amounts and making reimbursement payments to the Health Care Providers at rates that were far below usual and customary rates and/or reasonable rates for the services provided.

184. For example, Defendants sent Fremont, a Remittance for emergency services provided to Members under multiple procedure codes, including the following for CPT Codes 99284 and 99285:

d. Member #17 was treated on May 14, 2019 at a billed charge of $1,428.00 (CPT Code 99285), for which Defendants, via Data iSight, allowed $435.20.

e. Member #18 was treated on May 18, 2019, at a billed charge of $1,428.00 (CPT Code 99285), for which Defendants, via Data iSight, allowed $435.20.

f. Yet, Member #19 was treated on March 25, 2019, at a billed charge of $973.00 (CPT Code 99285), for which Defendants, via MultiPlan, allowed $875.00 which is 90% of billed charges. This a reasonable rate, in line with the reasonable rates historically paid by Defendants to Fremont for non-participating provider services.

g. Further, for professional services provided by Team Physicians between January and June 2019, Defendants allowed and approved payments ranging from $294.60 (27% of billed charges in the amount of $1,084.00) up to 100%, or $1,084.00.

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185. Defendants and Data iSight expected that those unreasonable payments would be accepted in full satisfaction of the Health Care Providers' claims.

186. Defendants and Data iSight have received, and continue to receive, financial gains from their scheme to defraud the Health Care Providers.

187. For the services that the Health Care Providers provided to Defendants' Members in 2019, only 13% of the non-participating claims have, to date, been reimbursed at reasonable rates, resulting in millions of dollars in financial loss to the Health Care Providers.

188. The purpose of, and the direct and proximate result of the above-alleged Enterprise and scheme was, and continues to be, to unlawfully reimburse the Health Care Providers at unreasonable rates, to the harm of the Health Care Providers, and to the benefit of the Enterprise.

FIRST CLAIM FOR RELIEF

(Breach of Implied-in-Fact Contract)

189. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

190. At all material times, the Health Care Providers were obligated under federal and Nevada law to provide emergency medicine services to all patients presenting at the emergency departments they staff, including Defendants' Patients.

191. At all material times, Defendants were obligated to provide coverage for emergency medicine services to all of its Members.

192. At all material times, Defendants knew that the Health Care Providers were non-participating emergency medicine groups that provided emergency medicine services to Patients.

193. From July 1, 2017 to the present, Fremont has undertaken to provide emergency medicine services to UH Parties' Patients, and the UH Parties have undertaken to pay for such services provided to UH Parties' Patients. And from prior to May 2015 to the present, Team Physicians and Ruby Crest have undertaken to provide emergency medicine services to UH

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Parties' Patients, and the UH Parties have undertaken to pay for such services provided to UH Parties' Patients.

194. From approximately March 1, 2019 to the present Fremont has undertaken to provide emergency medicine services to the Sierra Affiliates' and HPN's Patients, and Sierra Affiliates and HPN have undertaken to pay for such services provided to their Patients. And from prior to May 2015 to the present, Team Physicians and Ruby Crest have undertaken to provide emergency medicine services to Sierra Affiliates' and HPN's Patients, and Sierra Affiliates and HPN have undertaken to pay for such services provided to their Patients.

195. At all material times, Defendants were aware that the Health Care Providers were entitled to and expected to be paid at rates in accordance with the standards established under Nevada law.

196. At all material times, Defendants have received the Health Care Providers' bills for the emergency medicine services the Health Care Providers have provided and continue to provide to Defendants' Patients, and Defendants have consistently adjudicated and paid, and continue to adjudicate and pay, the Health Care Providers directly for the non-participating claims, albeit at amounts less than usual and customary.

197. Through the parties' conduct and respective undertaking of obligations concerning emergency medicine services provided by the Health Care Providers to Defendants' Patients, the parties implicitly agreed, and the Health Care Providers had a reasonable expectation and understanding, that Defendants would reimburse the Health Care Providers for non-participating claims at rates in accordance with the standards acceptable under Nevada law and in accordance with rates Defendants pay for other substantially identical claims also submitted by the Health Care Providers.

198. Under Nevada common law, including the doctrine of quantum meruit, the Defendants, by undertaking responsibility for payment to the Health Care Providers for the services rendered to Defendants' Patients, impliedly agreed to reimburse the Health Care Providers at rates, at a minimum, equivalent to the reasonable value of the professional emergency medical services provided by the Health Care Providers.

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199. Defendants, by undertaking responsibility for payment to the Health Care Providers for the services rendered to the Defendants' Patients, impliedly agreed to reimburse the Health Care Providers at rates, at a minimum, equivalent to the usual and customary rate or alternatively for the reasonable value of the professional emergency medical services provided by the Health Care Providers.

200. In breach of its implied contract with the Health Care Providers, Defendants have and continue to unreasonably and systemically adjudicate the non-participating claims at rates substantially below both the usual and customary fees in the geographic area and the reasonable value of the professional emergency medical services provided by the Health Care Providers to the Defendants' Patients.

201. The Health Care Providers have performed all obligations under the implied contract with the Defendants concerning emergency medical services to be performed for Patients.

202. At all material times, all conditions precedent have occurred that were necessary for Defendants to perform their obligations under their implied contract to pay the Health Care Providers for the non-participating claims, at a minimum, based upon the "usual and customary fees in that locality" or the reasonable value of the Health Care Providers' professional emergency medicine services

203. The Health Care Providers did not agree that the lower reimbursement rates paid by Defendants were reasonable or sufficient to compensate the Health Care Providers for the emergency medical services provided to Patients.

204. The Health Care Providers have suffered damages in an amount equal to the difference between the amounts paid by Defendants and the usual and customary fees professional emergency medicine services in the same locality, that remain unpaid by Defendants through the date of trial, plus the Health Care Providers' loss of use of that money; or in an amount equal to the difference between the amounts paid by Defendants and the reasonable value of their professional emergency medicine services, that remain unpaid by the Defendants through the date of trial, plus the Health Care Providers' loss of use of that money.

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205. As a result of the Defendants' breach of the implied contract to pay the Health Care Providers for the non-participating claims at the rates required by Nevada law, the Health Care Providers have suffered injury and is entitled to monetary damages from Defendants to compensate them for that injury in an amount in excess of $15,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

206. The Health Care Providers have been forced to retain counsel to prosecute this action and is entitled to receive their costs and attorneys' fees incurred herein.

SECOND CLAIM FOR RELIEF

(Tortious Breach of the Implied Covenant of Good Faith and Fair Dealing)

207. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

208. The Health Care Providers and Defendants had a valid implied-in-fact contract as alleged herein.

209. A special element of reliance or trust between the Health Care Providers and the Defendants, such that, Defendants were in a superior or entrusted position of knowledge.

210. That the Health Care Providers performed all or substantially all of their obligations pursuant to the implied-in-fact contract.

211. By paying substantially low rates that did not reasonably compensate the Health Care Providers the usual and customary rate or alternatively for the reasonable value of the services provide, Defendants performed in a manner that was unfaithful to the purpose of the implied-in-fact contract, or deliberately contravened the intention and sprit of the contract.

212. That Defendants' conduct was a substantial factor in causing damage to Fremont.

213. As a result of Defendants' tortious breach of the implied covenant of good faith and fair dealing, the Health Care Providers have suffered injury and is entitled to monetary damages from Defendants to compensate them for that injury in an amount in excess of $15,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

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214. The acts and omissions of Defendants as alleged herein were attended by circumstances of malice, oppression and/or fraud, thereby justifying an award of punitive or exemplary damages in an amount to be proven at trial.

215. The Health Care Providers have been forced to retain counsel to prosecute this action and is entitled to receive their costs and attorneys' fees incurred herein.

THIRD CLAIM FOR RELIEF

(Alternative Claim for Unjust Enrichment)

216. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

217. The Health Care Providers rendered valuable emergency services to the Patients.

218. Defendants received the benefit of having their healthcare obligations to their plan members discharged and their members received the benefit of the emergency care provided to them by the Health Care Providers.

219. As insurers or plan administrators, Defendants were reasonably notified that emergency medicine service providers such as the Health Care Providers would expect to be paid by Defendants for the emergency services provided to Patients.

220. Defendants accepted and retained the benefit of the services provided by the Health Care Providers at the request of the members of its Health Plans, knowing that the Health Care Providers expected to be paid a usual and customary fee based on locality, or alternatively for the reasonable value of services provided, for the medically necessary, covered emergency medicine services it performed for Defendants' Patients.

221. Defendants have received a benefit from the Health Care Providers' provision of services to its Patients and the resulting discharge of their healthcare obligations owed to their Patients.

222. Under the circumstances set forth above, it is unjust and inequitable for Defendants to retain the benefit they received without paying the value of that benefit; i.e., by paying the Health Care Providers at usual and customary rates, or alternatively for the reasonable value of services provided, for the claims that are the subject of this action and for all

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emergency medicine services that the Health Care Providers will continue to provide to Defendants' Members.

223. The Health Care Providers seek compensatory damages in an amount which will continue to accrue through the date of trial as a result of Defendants' continuing unjust enrichment.

224. As a result of the Defendants' actions, the Health Care Providers have been damaged in an amount in excess of $15,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

225. The Health Care Providers sue for the damages caused by the Defendants' conduct and is entitled to recover the difference between the amount the Defendants' paid for emergency care the Health Care Providers rendered to its members and the reasonable value of the service that the Health Care Providers rendered to Defendants by discharging their obligations to their plan members.

226. As a direct result of the Defendants' acts and omissions complained of herein, it has been necessary for the Health Care Providers to retain legal counsel and others to prosecute their claims. The Health Care Providers are thus entitled to an award of attorneys' fees and costs of suit incurred herein.

FOURTH CLAIM FOR RELIEF

(Violation of NRS 686A.020 and 686A.310)

227. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

228. The Nevada Insurance Code prohibits an insurer from engaging in an unfair settlement practices. NRS 686A.020, 686A.310.

229. One prohibited unfair claim settlement practice is "[f]ailing to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear." NRS 686A.310(1)(e).

230. As detailed above, Defendants have failed to comply with NRS 686A.310(1)(e) by failing to pay the Health Care Providers' medical professionals the usual and customary rate

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for emergency care provided to Defendants' members. By failing to pay the Health Care Providers' medical professionals the usual and customary rate Defendants have violated NRS 686A.310(1)(e) and committed an unfair settlement practice.

231. The Health Care Providers are therefore entitled to recover the difference between the amount Defendants paid for emergency care the Health Care Providers rendered to their members and the usual and customary rate, plus court costs and attorneys' fees.

232. The Health Care Providers are entitled to damages in an amount in excess of $15,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

233. Defendants have acted in bad faith regarding their obligation to pay the usual and customary fee; therefore, the Health Care Providers are entitled to recover punitive damages against Defendants.

234. As a direct result of Defendants' acts and omissions complained of herein, it has been necessary for the Health Care Providers to retain legal counsel and others to prosecute their claims. The Health Care Providers are thus entitled to an award of attorneys' fees and costs of suit incurred herein.

FIFTH CLAIM FOR RELIEF

(Violations of Nevada Prompt Pay Statutes & Regulations)

235. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

236. The Nevada Insurance Code requires an HMO, MCO or other health insurer to pay a healthcare provider's claim within 30 days of receipt of a claim. NRS 683A.0879 (third party administrator), NRS 689A.410 (Individual Health Insurance), NRS 689B.255 (Group and Blanket Health Insurance), NRS 689C.485 (Health Insurance for Small Employers), NRS 695C.185 (HMO), NAC 686A.675 (all insurers) (collectively, the "NV Prompt Pay Laws"). Thus, for all submitted claims, Defendants were obligated to pay the Health Care Providers the usual and customary rate within 30 days of receipt of the claim.

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237. Despite this obligation, as alleged herein, Defendants have failed to reimburse the Health Care Providers at the usual and customary rate within 30 days of the submission of the claim. Indeed, Defendants failed to reimburse the Health Care Providers at the usual and customary rate at all. Because Defendants have failed to reimburse the Health Care Providers at the usual and customary rate within 30 days of submission of the claims as the Nevada Insurance Code requires, Defendants are liable to the Health Care Providers for statutory penalties.

238. For all claims payable by plans that Defendants insure wherein it failed to pay at the usual and customary fee within 30 days, Defendants are liable to the Health Care Providers for penalties as provided for in the Nevada Insurance Code.

239. Additionally, Defendants have violated NV Prompt Pay Laws, by among things, only paying part of the subject claims that have been approved and are fully payable.

240. The Health Care Providers seek penalties payable to it for late-paid and partially paid claims under the NV Prompt Pay Laws.

241. The Health Care Providers are entitled to damages in an amount in excess of $15,000.00 to be determined at trial, including for its loss of the use of the money and its attorneys' fees.

242. Under the Nevada Insurance Code and NV Prompt Pay Laws, the Health Care Providers are also entitled to recover their reasonable attorneys' fees and costs.

SIXTH CLAIM FOR RELIEF

(Consumer Fraud & Deceptive Trade Practices Acts)

243. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

244. The Nevada Deceptive Trade Practices Act (DTPA) prohibits the UH Parties from engaging in "deceptive trade practices," including but not limited to (1) knowingly making a false representation in a transaction; (2) violating "a state or federal statute or regulation relating to the sale or lease of goods or services"; (3) using "coercion, duress or intimidation in a

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transaction"; and (4) knowingly misrepresent the "legal rights, obligations or remedies of a party to a transaction." NRS 598.0915(15), 598.0923(3), 598.0923(4), NRS 598.092(8), respectively.

245. The Nevada Consumer Fraud Statute provides that a legal action "may be brought by any person who is a victim of consumer fraud." NRS 41.600(1). "Consumer fraud" includes a deceptive trade practice as defined by the DTPA.

246. Defendants have violated the DTPA and the Consumer Fraud Statute through their acts, practices, and omissions described above, including but not limited to (a) wrongfully refusing to pay the Health Care Providers for the medically necessary, covered emergency services the Health Care Providers provided to Members in order to gain unfair leverage against the Health Care Providers now that they are out-of-network and in contract negotiations to potentially become a participating provider under a new contract in an effort to force the Health Care Providers to accept lower amounts than it is entitled for its services; and (b) engaging in systematic efforts to delay adjudication and payment of the Health Care Providers' claims for its services provided to UH Parties' members in violation of their legal obligations

247. As a result of Defendants' violations of the DTPA and the Consumer Fraud Statute, the Health Care Providers are entitled to damages in an amount in excess of $15,000.00 to be determined at trial.

248. Due to the willful and knowing engagement in deceptive trade practices, the Health Care Providers are entitled to recover treble damages and all profits derived from the knowing and willful violation.

249. As a direct result of Defendants' acts and omissions complained of herein, it has been necessary for the Health Care Providers to retain legal counsel and others to prosecute their claims. The Health Care Providers is thus entitled to an award of attorneys' fees and costs of suit incurred herein.

SEVENTH CLAIM FOR RELIEF

(Declaratory Judgment)

250. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

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251. This is a claim for declaratory judgment and actual damages pursuant to NRS 30.010 *et seq.*

252. As explained above, pursuant to federal and Nevada law, Defendants are required to cover and pay the Health Care Providers for the medically necessary, covered emergency medicine services the Health Care Providers have provided and continue to provide to Defendants' members.

253. Under Nevada law, Defendants are required to pay the Health Care Providers the usual and customary rate for that emergency care. Instead of reimbursing the Health Care Providers at the usual and customary rate or for the reasonable value of the professional medical services, Defendants have reimbursed them at reduced rates with no relation to the usual and customary rate.

254. Beginning in or about July 2017, Fremont became out-of-network with the UH Parties; and Team Physicians and Ruby Crest have never been in-network with the UH Parties. Since then, the UH Parties have demonstrated their refusal to timely settle insurance claims submitted by the Health Care Providers and have failed to pay the usual and customary rate based on this locality in violation of UH Parties' obligations under the Nevada Insurance Code, the parties' implied-in-fact contract and pursuant to Nevada law of unjust enrichment and quantum merit.

255. Beginning in or about March 2019, Fremont became out-of-network with the Sierra Affiliates and HPN and Physicians and Ruby Crest have never been in-network with the Sierra Affiliates or HPN. Upon information and belief, the Sierra Affiliates and HPN are failing to timely settle insurance claims submitted by the Health Care Providers and to pay the usual and customary rate based on this locality in violation of the Sierra Affiliates' and HPN's obligations under the Nevada Insurance Code, the parties' implied-in-fact contract and pursuant to Nevada law of unjust enrichment and quantum merit.

256. An actual, justiciable controversy therefore exists between the parties regarding the rate of payment for the Health Care Providers' emergency care that is the usual and customary rate that Defendants are obligated to pay.

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257. Pursuant to NRS 30.040 and 30.050, the Health Care Providers therefore request a declaration establishing the usual and customary rates that they are entitled to receive for claims between July 1, 2017 and trial, as well as a declaration that the UH Parties are required to pay to the Health Care Providers at a usual and customary rate for claims submitted thereafter.

258. Pursuant to NRS 30.040 and 30.050, Team Physicians and Ruby Crest therefore request a declaration establishing the usual and customary rates that they are entitled to receive for claims between July 1, 2017 and trial, as well as a declaration that the Sierra Affiliates and HPN are required to pay to Team Physicians and Ruby Crest at a usual and customary rate for claims submitted thereafter.

259. Pursuant to NRS 30.040 and 30.050, Fremont therefore request a declaration establishing the usual and customary rates that Fremont is entitled to receive for claims between March 1, 2019 and trial, as well as a declaration that the Sierra Affiliates and HPN are required to pay to Fremont at a usual and customary rate for claims submitted thereafter.

260. As a direct result of Defendants' acts and omissions complained of herein, it has been necessary for the Health Care Providers to retain legal counsel and others to prosecute their claims. The Health Care Providers are thus entitled to an award of attorneys' fees and costs of suit incurred herein.

EIGHTH CLAIM FOR RELIEF

(Violation of NRS 207.350 *et seq.*)

261. The Health Care Providers incorporate herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

262. Nevada RICO allows a private cause of action for racketeering. NRS 207.470 provides in pertinent part that:

> Any person who is injured in his or her business or property by reason of any violation of NRS 207.400 has a cause of action against a person causing such injury for three times the actual damages sustained. An injured person may also recover attorney's fees in the trial and appellate courts and costs of investigation and litigation reasonably incurred.

263. This claim arises under NRS 207.400(b), (c), (d) and (j).

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264. The Defendants committed the following crimes of racketeering activity: NRS 207.360(28) (obtaining possession of money or property valued at $650 or more), NRS 207.360(35) (any violation of NRS 205.377), and NRS 207.360(36) (involuntary servitude).

265. The Defendants engaged in racketeering enterprises as defined by NRS 207.380 involving their fraudulent misrepresentations to the Health Care Providers, and failing to pay and retaining significant sums of money that should have been paid to them for emergency medicine services provided to the Defendants' Members, but instead were directed to themselves and/or Data iSight.

266. As set forth above, since at least January 2019, Defendants have been and continue to be, a part of an association-in-fact enterprise within the meaning of NRS 207.380, comprised of at least Defendants and Data iSight, and which Enterprise was and is engaged in activities that span multiple states and affect interstate commerce and/or committed preparatory acts in furtherance thereof.

267. Each of the Defendants has an existence separate and distinct from the Enterprise, in addition to directly participating and acting as a part of the Enterprise.

268. Defendants and Data iSight had, and continue to have, the common and continuing purpose of dramatically reducing allowed provider reimbursement rates for their own pecuniary gain, by defrauding the Health Care Providers and preventing them from obtaining reasonable payment for the services they provided to Defendants' Members, in retaliation for the Health Care Providers' lawful refusal to agree to Defendants' massively discounted and unreasonable proposed contractual rates.

269. Since at least January 2019, the Defendants, have been and continue to be, engaged in preparations and implementation of a scheme to defraud the Health Care Providers by committing a series of unlawful acts designed to obtain a financial benefit by means of false or fraudulent pretenses, representations, promises or material omissions which constitute predicate unlawful activity under NRS 207.390 involving multiple instances of obtaining possession of money or property valued at $650 or more; multiple transactions involving fraud or deceit in course of enterprise or occupation and involuntary servitude in violation of NRS

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200.463. The Defendants have engaged in more than two related and continuous acts amounting to racketeering activity in violation of NRS 207.400(1)(a)-(d), (1)(f), (1)(h)-(i) pursuant to a scheme or artifice to defraud and to which the Defendants have committed for financial benefit and gain to the detriment of the Health Care Providers. The Defendants, on more than two occasions, have schemed with Data iSight to artificially and, without foundation, substantially decrease non-participating provider reimbursement rates while continuing to represent that the reimbursement rates are based on legitimate cost data or paid data.

270. The foregoing acts establish racketeering activity and are related to each other in that they further the joint goal of unfairly and illegally retaining financial benefit to the detriment of the Health Care Providers. In each of the examples provided herein, the acts alleged to establish a pattern of unlawful activity are related because they have the same or similar pattern, intents, results, accomplices, victims or methods of commission, or are otherwise interrelated by distinguishing characteristics and are not isolated incidents.

271. Each Defendant provides benefits to insured members, processes claims for services provided to members, and/or issues payments for services and knows and willingly participates in the scheme to defraud the Health Care Providers.

272. As a direct and proximate result of Defendants' violations of NRS 207.360(28), (35) and (36), the Health Care Providers have sustained a reasonably foreseeable injury in their business or property by a pattern of racketeering activity, suffering substantial financial losses, in an amount to be proven at trial, in violation of NRS 207.470.

273. Pursuant to NRS 207.470, the Health Care Providers are entitled to damages for three times the actual damages sustained, recovery of attorneys' fees in the trial and appellate courts and costs of investigation and litigation reasonably incurred.

REQUEST FOR RELIEF

WHEREFORE, the Health Care Providers request the following relief:

A. For awards of general and special damages in amounts in excess of $15,000.00, the exact amounts of which will be proven at trial;

B. Judgment in their favor on the First Amended Complaint;

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C. Awards of actual, consequential, general, and special damages in an amount in excess of $15,000.00, the exact amounts of which will be proven at trial;

D. An award of punitive damages, the exact amount of which will be proven at trial;

E. A declaratory judgment that Defendants' failure to pay the Health Care Providers a usual and customary fee or rate for this locality or alternatively, for the reasonable value of their services violates the Nevada law, breaches the parties' implied-in-fact contract, is a tortious breach of the implied covenant of good faith and fair dealing, and violates Nevada common law;

F. An order permanently enjoining Defendants from paying rates that do not represent usual and customary fees or rates for this locality or alternatively, that do not compensate the Health Care Providers for the reasonable value of their services; and enjoining Defendants and enjoining Defendants from engaging in acts or omissions that are violative of Nevada law;

G. Judgment against the Defendants and in favor of the Health Care Providers pursuant to the Eighth Claim for Relief in an amount constituting treble damages resulting from Defendants' underpayments to the Health Care Providers for the reasonable value of the emergency services provided to Defendants' Members and reasonable attorneys' fees and costs incurred in bringing this action;

H. The Health Care Providers costs and reasonable attorneys' fees pursuant to NRS 207.470;

I. Reasonable attorneys' fees and court costs;

J. Pre-judgment and post-judgment interest at the highest rates permitted by law; and

K. Such other and further relief as the Court may deem just and proper.

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JURY DEMAND

The Health Care Providers hereby demand trial by jury on all issues so triable.

DATED this 7th day of January, 2020.

McDONALD CARANO LLP

By: /s/ *Pat Lundvall*

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 7th day of January, 2020, I caused a true and correct copy of the foregoing **FIRST AMENDED COMPLAINT** to be served via the U.S. District Court's Notice of Electronic Filing system ("NEF") in the above-captioned case, upon the following:

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 15th day of May, 2020, I caused a true and correct copy of the foregoing **FIRST AMENDED COMPLAINT** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

Case No.: A-19-792978-B
Dept. No.: 27

DEFENDANTS' MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT

Hearing Date: June 5, 2020

Hearing Time: 1:00 PM

Defendants UnitedHealth Group, Inc., UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services, Inc. ("UHS"), UMR, Inc. ("UMR"), Oxford Health Plans, Inc. ("Oxford"), Sierra Health and Life Insurance Co., Inc. ("SHL"), Sierra Health-Care Options, Inc. ("SHO"), and Health Plan of Nevada, Inc. ("HPN") (collectively, "Defendants") hereby move to dismiss the claims asserted in Plaintiffs' First Amended Complaint ("Complaint") with prejudice, pursuant to the doctrines of ERISA conflict preemption and complete preemption as well as pursuant to Nev. R. Civ. P. 12(b)(5) for failure to state a claim upon which relief can be granted.

I. INTRODUCTION[1]

Plaintiffs are for profit out-of-network medical providers. Defendants administer health plans whose members have received medical treatment from Plaintiffs. 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 (with varying terms) to pay the same inflated amounts not afforded under the plans, Plaintiffs have brought a raft of deficient and improper state law claims.

However, all of Plaintiffs' claims are subject to dismissal because they suffer from the same defect—they relate to employee benefit plans and are thus preempted by the Employee Retirement Income Security Act ("ERISA"). ERISA's comprehensive scheme regulates

[1] Defendants removed this case to federal court on May 14, 2019. While this case was in federal court, Fremont Emergency Services (Mandavia), Ltd. ("Fremont") filed a motion to amend the complaint, which was granted. Fremont then filed a First Amended Complaint in federal court on January 7, 2020 that added two additional plaintiffs, one additional defendant, and a Nevada RICO claim. On February 20, 2020, the federal court found that it lacked subject matter jurisdiction and remanded this matter to the Eighth Judicial District Court. The Parties then stipulated to allow Plaintiffs to refile their First Amended Complaint in this Court, which Plaintiffs did on May 15, 2020. At Plaintiffs' request, Defendants are responding to Plaintiffs' first seven claims through this filing and responding to Plaintiffs' eighth cause of action, a Nevada RICO claim, through a separate supplemental filing. *See* Stipulation and Order submitted on May 26, 2020. However, this Motion and Defendants' supplemental filing addressing Plaintiffs' RICO claim shall collectively constitute Defendants' Motion to Dismiss Plaintiffs' First Amended Complaint.

employee benefit plans and provides the exclusive civil enforcement mechanism to deal with disputes related to these plans. State law claims that relate to an ERISA plan or that supplement or duplicate a federal claim that could have been brought under ERISA are subject to dismissal based on ERISA's expansive preemption reach. Thus, as detailed in this Motion, Plaintiffs' state law causes of action must be dismissed with prejudice.

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. ERISA's conflict preemption clause (29 U.S.C. § 1144(a)) has been called "one of the broadest preemption clauses ever enacted by Congress" and characterized as "clearly expansive." 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. Both types of preemption apply here, and both are fatal to Plaintiffs' state law claims.

Allowing Plaintiffs' state law claims to proceed would directly undermine the congressional intent behind ERISA—creating a uniform administrative scheme for all 50 states that guides the processing of claims and disbursement of benefits for employee health plans. Plaintiffs are challenging the amount that they received on more than 10,000 separate health plan benefit claims they submitted to Defendants for payment, and are seeking to use state law claims to force the plans to pay more. But the health plans at issue—virtually all of which are governed by ERISA—independently set the benefit rates that each plan promises to pay. And ERISA's expansive preemptive reach does not permit a plaintiff to use state law claims to effectively rewrite the controlling health plans by superimposing on them some different, uniformly higher amount of reimbursement requirement that is inconsistent with plan terms. Such claims are conflict preempted because they directly "relate to" ERISA plans. And such claims are completely preempted because they can and must be pursued as claims for benefits under ERISA § 502(a)(1)(b), pursuant to which the Court can assess whether each challenged payment was consistent with the terms of the applicable plan.

Plaintiffs will attempt to argue that their claims are not preempted because this is a "rate

of payment" case rather than a "right to payment" case. However, Plaintiffs' reliance on that purported distinction is wrong, as it only applies to situations where a plan or its agent *affirmatively promised* to pay some benefit rate that is different than the rates set by the plan, as may be the case with a network contract or oral promise that then serves as an independent source of legal obligation. This case does not fall into these categories: Plaintiffs *admit* that they lack a written contract, oral promise, or even a state statute setting benefit rates. The applicable employee benefit plans are the *only* documents that set forth the required rate of payment to Plaintiffs, and ERISA does not permit Plaintiffs to use state law claims to circumvent plan terms.

Moreover, to the extent a small number of the plans at issue, such as Affordable Care Act Exchange products, may not be governed by ERISA, such claims still must be dismissed, as Plaintiffs fail to allege viable state law claims for causes of actions under Rule 12(b)(5).

For all these reasons and those set forth below, Defendants request that the Court dismiss Plaintiffs' state law causes of action in their entirety and with prejudice.[2]

II. NEARLY ALL OF PLAINTIFFS' CLAIMS RELATE TO EMPLOYER SPONSORED ERISA PLANS AND ARE THUS SUBJECT TO PREEMPTION

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 preemption. In that circumstance, the court may consider evidence outside the complaint showing that the claims relate to employee benefit plans governed by ERISA.[3] The purpose of this exception to the general rule is to prevent plaintiffs, like Plaintiffs here, from attempting to thwart congressional intent that ERISA provide the exclusive remedy for these types of claims through artful pleading.

Plaintiffs' Complaint 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. Instead, all the

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[2] However, Plaintiffs should be given leave to replead their claims as statutory ERISA claims pursuant to 29 U.S.C. § 1132(a), subject to any defenses Defendants may have to such a claim.

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

Complaint identifies is the general time frame during which Plaintiffs allegedly provided medical services to Defendants' members and submitted claims/requests for processing and adjudication to Defendants. *See* Compl. at ¶¶ 25-26. Despite this, Defendants have determined that nearly all of the at-issue claims relate to ERISA-governed employee benefit plans and are thus conflict 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, based on the known information, all but one of the claims were made against ERISA-governed plans.[4] For the claims made against Oxford and SHO, all of the claims were made against ERISA governed plans.[5] For the claims made against SHL, approximately 72% of the claims were made against ERISA-governed plans.[6] For the claims made against HPN, approximately 84% of the claims were made against ERISA-governed plans.[7] In sum, over 90% of Plaintiffs' claims in the relevant period were for services provided to members of ERISA-governed plans.

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, if valid, 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.[8] As discussed in

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[4] **Exhibit 1** at ¶ 7 (UHIC, UHS and UMR Declaration).

[5] **Exhibit 2** at ¶ 7 (Oxford Declaration); **Exhibit 3** at ¶ 7 (SHO Declaration).

[6] **Exhibit 4** at ¶ 7 (SHL and HPN Declaration).

[7] *Id.* at ¶ 8.

[8] *See* **Exhibit 1** at ¶ 7 (UHIC, UHS and UMR Declaration), **Exhibit 4** at ¶¶ 7-8 (SHL and HPN Declaration); **Exhibit 2** at ¶ 7 (Oxford Declaration); **Exhibit 3** at ¶ 7 (SHO Declaration); *See also* **Exhibit 5** (sample claims forms to UMR during the 2017-2019 time period showing Box 27 "Accept Assignment" checked "YES"); **Exhibit 6** (sample claim forms to SHO during the same time period). Defendants have reviewed claim forms and related data for the claims that were made to the other entities 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. However, those claim forms can be produced if necessary.

more detail below, these assignments of benefits are critical because they render Plaintiffs the type of party, under the *Davila* test discussed in Section IV, 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.

III. LEGAL STANDARD FOR CONFLICT PREEMPTION UNDER ERISA

A. The ERISA Preemption Clause, Saving Clause and Deemer Clause

The Employee Retirement Income Security Act ("ERISA") is a federal legislative scheme that "comprehensively regulates" employee benefit plans. 29 U.S.C. § 1001(b); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44 (1987). ERISA comprehensively regulates, among other things, employee benefit plans that, "through the purchase of insurance or otherwise . . . [provide] medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, [or] death." 29 U.S.C. § 1002(1).

To ensure that plans and plan administrators would be subject to a uniform body of benefit laws, Congress capped off ERISA with three provisions relating to the preemptive effect of the federal legislation, which are set forth below:

1.) "Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws[9] insofar as they may now or hereafter **relate to** any employee benefit plan . . .". 29 U.S.C. § 1144(a) (pre-emption clause) (emphasis added).[10]

2.) "Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A) (saving clause).

3.) Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies,

[9] 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. § 1144(c)(1). Thus, ERISA preempts not only state statutes but also the common law of each state.

[10] In cases discussing conflict preemption, this section is also commonly referred to as § 514(a) of ERISA.

insurance contracts, banks, trust companies, or investment companies." 29 U.S.C. § 1144(b)(2)(B) (deemer clause).

The U.S. Supreme Court summarized how the above clauses work together as follows: "If a state law 'relate[s] to . . . employee benefit plan[s],' it is pre-empted. [29 U.S.C § 1144(a)] The saving clause excepts from the pre-emption clause laws that 'regulat[e] insurance.' [29 U.S.C § 1144(b)(2)A)]. The deemer clause makes clear that a state law that 'purport[s] to regulate insurance' cannot deem an employee benefit plan to be an insurance company. [29 U.S.C. § 1144(b)(2)(B)]." *Pilot Life Ins. Co.,* 481 U.S. at 45.

B. ERISA's "Relates to" Preemption Clause is Broad and Preempts any State Law Claim that Requires a Plan to Deviate from Plan Terms. Plaintiffs' Claims Conflict with the Plan Documents and Would Require the Court to Essentially Rewrite Them.

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); s*ee also Egelhoff v. Egelhoff*, 532 U.S. 141, 146 (2001) (calling the ERISA preemption clause "clearly expansive.").[11] "[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. "[T]o determine whether a state law has the forbidden connection, we look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." *Egelhoff*, 532 U.S. at 147.

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)

[11] Plaintiffs may argue in their response that the federal court has already rejected these preemption arguments when it granted Plaintiffs' motion to remand. Such an argument would be misplaced. Although the federal court found that complete preemption did not apply when it remanded this case, the defense of conflict preemption under § 514(a) of ERISA (aka 29 U.S.C. § 1144(a)) is 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) ("the defense of 'conflict preemption' is much broader because § 514 [of ERISA] is much broader than § 502(a).").

(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*, 532 U.S. at 147.

Here, that is exactly what Plaintiffs' state law claims attempt to do. Plaintiffs are out-of-network medical providers that allege they provided treatment to thousands of patients who were members of health plans administered/issued by Defendants. Compl. at ¶ 64. Plaintiffs further allege that the Defendants failed to adequately reimburse Plaintiffs for these services and they seek a judgment requiring the Defendants to "reimburse the Health Care Providers at the usual and customary rate. . . or alternatively for the reasonable value of the services provided." *Id.* at ¶¶ 21, 62, 69, and subparagraphs E and F of Plaintiffs' Request for Relief. However, each health plan at issue already provides for particular coverage and reimbursement for types of services rendered to plan members for services received from out-of-network providers like Plaintiffs. Thus, the remedy Plaintiffs seek via their state law claims is nothing less than a complete rewriting of the health plans at issue. Plaintiffs are essentially asking this Court to insert the terms "usual and customary rate" and "reasonable value" into each of the controlling health plans implicated by the at-issue claims, regardless of the plans' terms. As explained more fully below, courts have repeatedly found that ERISA does not permit a plaintiff to use a state law claim to rewrite and/or avoid a plan's payment terms. In sum, Plaintiffs' state law claims unquestionably "relate to" ERISA-governed health plans issued and/or administered by Defendants and are thus conflict preempted by ERISA.

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[12] 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. *Villescas v. CNA Ins. Companies*, 109 Nev. 1075, 1082, 864 P.2d 288, 293 (1993).[13]

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 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 and (4) Declaratory Judgment, 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

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[12] 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.

[13] Although the Nevada Supreme Court did not expressly reference Pilot Life's "Common Sense Test," other Nevada courts applying Nevada law have applied both the Common Sense Test and the McCarran-Ferguson Test. *See Brandner v. UNUM Life Ins. Co. of Am.*, 152 F. Supp. 2d 1219, 1226 (D. Nev. 2001)

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 and Uniform Declaratory Judgments Act 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 Act); NRS 30.040 (allowing a declaratory judgment claim to be brought for any "deed, written contract or other writings constituting a contract."). 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. As with ERISA's "relates to" preemption clause, the U.S. Supreme Court has construed the "deemer clause" broadly, stating:

> We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause. By forbidding States to deem employee benefit plans 'to be an insurance company or other insurer . . . or to be engaged in the business of insurance,' the deemer clause relieves plans from state laws 'purporting to regulate insurance.' As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation 'relate[s] to' the plans . . . State laws

> that directly regulate insurance are 'saved' but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws.

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 not to be in the business of insurance. In sum, ERISA conflict preemption presents an insurmountable barrier to Plaintiffs' state law claims.

IV. LEGAL STANDARD FOR COMPLETE PREEMPTION UNDER ERISA

A. 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, 107 S. Ct. 1542, 1546 (1987). One area where this doctrine applies is with certain claims related to employee benefit plans, such as employer-sponsored health insurance. *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 related to employee benefit plans. That mechanism is set forth in 29 U.S.C. § 1132(a)[14] and permits a "participant or beneficiary" to bring a special statutory ERISA claim over which state and federal courts have concurrent jurisdiction.[15] The statute reads as follows:

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

[15] 29 U.S.C. § 1132(e)(1) (providing that a statutory ERISA claim may be brought in state or federal court).

> A civil action may be brought—(1) by a participant or beneficiary— . . . (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

29 U.S.C. § 1132(a)(1)(B). The U.S. Supreme Court has found that this statute evidences congressional intent to completely preempt state law claims related to ERISA plans.

A finding of complete preemption means that the 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 ("any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted.").

B. 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, 124 S. Ct. at 2496.

The *Davila* test would be undisputedly met if a plan member paid for a covered medical treatment herself, received only partial reimbursement from the plan, and then brought suit against the plan administrator seeking additional reimbursement. *Id.* at 211. This would be a clear example of a "beneficiary or participant" seeking to recover benefits under an employee benefit plan (see 29 U.S.C. § 1132(a)(1)(B)), and ERISA flatly does not permit state law claims, however labeled, to be used as a mechanism to seek additional reimbursement from a plan outside the plan's terms. The employee's exclusive remedy for seeking additional payments from an ERISA plan is a statutory ERISA claim for benefits.

The result is the same if the employee plan member assigns her claim to the medical provider and the medical provider then brings suit against the plan administrator seeking

reimbursement for medical services. The Ninth Circuit has explicitly held that ERISA preempts the state law claims of a medical provider suing as the assignee of an employee's rights under an employee benefit plan governed by ERISA. *Misic v. Bldg. Serv. Employees Health & Welfare Tr.*, 789 F.2d 1374 (9th Cir. 1986) (upholding the dismissal of various state tort law claims and a claim under the California Unfair Insurance Practices Act as preempted by ERISA since the provider had accepted an assignment from the patients and thus had standing to bring an ERISA claim itself).

Here, just like the provider in *Misic*, Plaintiffs are out-of-network medical providers that provided medical services to members of health plans administered by Defendants. Compl. at ¶¶ 17-20, 39. Plaintiffs then requested payments from Defendants, representing that they had received assignments of the patients' plan benefits. *Id.* at ¶¶ 40, 43. As in *Misic*, Defendants here paid a portion of the amounts requested, but not the entire amount. *Id.*; *Misic*, 789 F.2d at 1376 ("The trust paid a portion of the amount billed, but less than the full 80%."). Plaintiffs have now brought suit seeking additional reimbursements from the applicable health plans and, in doing so, stand in the shoes of Defendants' members.

Both prongs of the *Davila* test are therefore met. The first element is met because Plaintiffs obtained assignments that give them standing to bring ERISA claims. *In Re Managed Care Litig.*, 298 F. Supp. 2d 1259, 1292 (S.D. Fla. 2003) (out-of-network providers' implied-in-fact contract claims were preempted because they received an assignment of benefits from the plan members). 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. The only question is whether Plaintiffs "*could*" have brought an ERISA claim, and Plaintiffs clearly could have done so.

Prong 2 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. Compl. at ¶ 20. Thus, the only legal duties owed to Plaintiffs (if any) flow from the terms of the applicable ERISA plans. Regardless of the labels used and Plaintiffs' attempt at artful pleading, all of Plaintiffs' claims are completely preempted.

V. LEGAL STANDARD FOR RULE 12(B)(5) MOTION TO DISMISS

Under NRCP 12(b)(5), this Court must dismiss a claim where the plaintiff can "prove no set of facts that would entitle him or her to relief." *Cohen v. Mirage Resorts, Inc.*, 119 Nev. 1, 22, 62 P.3d 720, 734 (2003); *see Hay v. Hay*, 100 Nev. 196, 198, 678 P.2d 672, 674 (1984) (providing that Nevada is a notice-pleading jurisdiction). A claim that fails as a matter of law on the face of the pleading warrants dismissal under NRCP 12(b)(5). *See Harrison v. Roitman*, 131 Nev. Adv. Op. 92, 362 P.3d 1138, 1139 (2015). In evaluating a motion to dismiss for failure to state a claim, the court must accept all factual allegations in the complaint as true, construe the complaint's allegations liberally, and draw all inferences in favor of the plaintiff. *See Simpson v. Mars Inc.*, 113 Nev. 188, 190, 929 P.2d 966, 967 (1997).

VI. PLAINTIFFS' CLAIM FOR BREACH OF IMPLIED-IN-FACT CONTRACT SHOULD BE DISMISSED

A. This Claim is Subject to Conflict Preemption

Courts regularly find this type of implied-in-fact contract claim subject to conflict preemption. *See Aetna Life Ins. Co. v. Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000) (internal citation omitted) ("We have held that ERISA preempts common law theories of breach of contract implied in fact, promissory estoppel, estoppel by conduct, fraud and deceit and breach of contract.") (emphasis added); *Blau v. Del Monte Corp*., 748 F.2d 1348, 1356 (9th Cir. 1984) (breach of implied-in-fact contract claim was conflict preempted) (abrogated on other grounds in *Dytrt v. Mountain States Tel. & Tel. Co*., 921 F.2d 889, 894, n. 4 (9th Cir. 1990); *Parlanti v. MGM Mirage*, No. 2:05-CV-1259-ECR-RJJ, 2006 WL 8442532, at *6 (D. Nev. Feb. 15, 2006) (breach of contract claim was both conflict preempted and completely preempted).

This is supported not only by law, but by common sense. Plaintiffs are 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. If, for example, a plan expressly provided that it would pay all medical claims at 150% of the benefit rate paid by Medicare,

Plaintiffs would ask the Court to apply their implied-in-fact contract logic to compel that plan to instead pay it a higher "usual and customary rate." That is a textbook case of the kind of claim that is conflict preempted. ERISA requires the Defendants to "specify the basis on which payments are made to and from [their plans]" and to administer their plans "in accordance with the documents and instruments governing the plan[s]," 29 U.S.C. § 1102(b)(4); 29 U.S.C. § 1104(a)(1)(D). Plaintiffs' implied-in-fact contract claim "relates to" employee benefit plans and is preempted as it seeks to have this Court conduct a wholesale rewriting of those plans' payment terms. To the extent Plaintiffs are entitled to any additional reimbursement, the amount of that reimbursement depends entirely on the rate of payment that is established by the plan documents.

B. This Claim is Subject to Complete Preemption

The *Davila* test for complete preemption is met here as (1) Plaintiffs have standing to bring a statutory § 502(a) ERISA claim due to the assignments of benefits they received from Defendants' plan members and (2) there is no legal obligation owed by Defendants other than those created by the ERISA benefit plans since Plaintiffs are out-of-network providers. Compl. at ¶ 17. The case law is in accord. *Melamed v. Blue Cross of California, 557 F. App'x 659, 661* (9th Cir. 2014) ("Melamed's breach of implied contract claim is completely preempted because through that claim, Melamed seeks reimbursement for benefits that exist "only because of [the defendant's] administration of ERISA-regulated benefit plans."); *In Re Managed Care Litig*., 298 F. Supp. 2d at 1292 (out-of-network providers' implied-in-fact contract claim was completely preempted); *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) (same).[16]

[16] Plaintiffs may argue in response that the Nevada Federal District Court found that complete preemption does not apply to Plaintiffs' Breach of Implied-in-Fact Contract claim in its February 20, 2020 order remanding this case to state court. However, the federal court erroneously relied on an inapplicable distinction between claims involving the "right to payment" vs. the "amount of payment." Remand Order at 4:24-28. Further, the federal court's remand order relies heavily on the "strong presumption against removal [to federal court]." *Id.* at 3:5-8. Here, unlike in the federal court proceeding, there is no presumption against complete preemption applying to Plaintiffs' claims. Further, this Court is not required to defer to the federal court's reasoning as all orders made by the federal court are now void since it found that it lacked jurisdiction all along. *See e.g., NCS Healthcare of Arkansas, Inc. v. W.P. Malone, Inc*., 350 Ark. 520, 526, 88 S.W.3d 852, 856 (2002) ("[A]fter remand from federal court, a case stands as if it had never been removed from state court, and what happened in federal court has no bearing on the proceeding in state court.").

C. This Claim Must be Dismissed Under NRCP 12(b)(5)

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); *Magnum Opes Const. v. Sanpete Steel Corp*., No. 60016, 2013 WL 7158997, at *2 (Nev. Nov. 1, 2013) (unpublished).

Here, Plaintiffs fail to state a claim as they have not sufficiently alleged any of the above three elements. Nowhere in the Complaint is there an allegation that the Defendants "intended to contract" with Plaintiffs. Nor is there any explanation of what "promises" were exchanged between the Parties and what the terms of those promises were. Reading the Complaint in the light most 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. Compl. at ¶¶ 193-194, 196-199. In essence, Plaintiffs argue that payments for some past services constitute a promise by Defendants to pay for all future services. *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[17] services that were provided without any contract in place.

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

Further, Plaintiffs rely only on the past consideration of prior payments to create the alleged implied-in-fact contract—a 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.

Alternatively, if Plaintiffs are attempting to rely on a state or federal statute to create the implied-in-fact contract, this theory also fails. The Complaint cites to the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd, and NRS 439B.410. Compl. at ¶¶ 18, 190. However, these statutes only relate to requirements that *hospitals provide* emergency services to *patients* regardless of the patients' ability to pay. They do not require payment by *insurers* to out-of-network providers, or say anything about a required rate of payment. Thus, Plaintiffs have failed to state a claim for implied-in-fact contract and this claim should be dismissed.

VII. PLAINTIFFS' CLAIM FOR TORTIOUS BREACH OF THE IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING SHOULD BE DISMISSED

A. This Claim is Subject to Conflict Preemption

Tortious breach claims are subject to conflict preemption. *Pilot Life Ins. Co.* 481 U.S. at 48–49 (claim for tortious breach of contract and the Mississippi law of bad faith were conflict preempted); *Bayona*, 223 F.3d at 1034 ("Here, Castro asserted counterclaims for breach of contract, tortious breach of the covenant of good faith and fair dealing, and fraud—all were based on common law and state causes of action, and all were preempted.") (emphasis added) (internal citation omitted); *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). In *Pilot Life*, the U.S. Supreme Court found that (1) such a claim is subject to conflict preemption under ERISA's "relates to" preemption clause and (2) a state's tortious breach common law does not seek to "regulate insurance" and thus does not fall within ERISA's saving clause. *Pilot Life*, 481 U.S. at 48–49. There is no reason for this Court to deviate from the reasoning in that case.

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B. This Claim is Subject to Complete Preemption

Like Plaintiffs' other state law claims, this claim seeks to recover money for medical services provided to members of employee benefit plans governed by ERISA. Compl. at ¶¶ 22-25, 54-56. Thus, reference to the plan is required to determine both coverage and the amount of reimbursement. This claim also attempts to "duplicate" or "supplement" the ERISA civil enforcement mechanism by seeking punitive damages against a plan administrator. Compl. at ¶ 214 and p. 45:3-4. Such claims are completely preempted. *See Estate of Burgard v. Bank of America, N.A.*, 2017 WL 1273869 (D. Nev. March 31, 2017) ("[I]t is well established that breach of contract claims—whether contractual or tortious—fall within section 502(a)."); *see also Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1009 (9th Cir. 1998) ("Extracontractual, compensatory and punitive damages are not available under ERISA.") (limitation on other grounds recognized in *A.F. v. Providence Health Plan*, 157 F. Supp. 3d 899, 916 (D. Or. 2016); *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138, 1146-47 (9th Cir. 2003) ("claim processing causes of action" which seek state law damages are "clearly" preempted under 29 U.S.C. § 1132(a)(1)(B) of ERISA).

C. This Claim Must be Dismissed Under NRCP 12(b)(5)

The implied covenant of good faith and fair dealing only arises if a valid contract exists between Plaintiffs and Defendants. *A.C. Shaw Const., Inc. v. Washoe Cty.*, 105 Nev. 913, 914, 784 P.2d 9, 10 (1989). Thus, as an initial matter, if the Court agrees that Plaintiffs have failed to allege an enforceable implied-in-fact contract, then it should end its analysis there and dismiss this claim, too.

In the alternative, even assuming that an implied-in-fact contract exists, this claim still fails. 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.[18] *Aluevich v. Harrah's*, 99 Nev. 215, 216, 660 P.2d 986, 986 (1983) (holding that claim for tortious breach of the implied covenant 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, while Plaintiffs have alleged that there was "[a] special element of reliance or trust between the Health Care Providers and the Defendants," this is an entirely conclusory allegation, Compl. at ¶ 209, which is not entitled to the assumption of truth typical of more specific allegations. Nor does the Complaint contain any other allegations explaining why there would be a "special relationship" between two sophisticated parties (Plaintiffs and Defendants) who do not even have an express written contractual relationship. *See* Compl. at ¶ 20 (admitting no written agreement exists); *see also id.*. at ¶¶ 3-5, 17 (admitting that Plaintiffs are sophisticated "professional emergency medicine services group[s]" that run major emergency rooms in Las Vegas, Fallon and Elko).

Moreover, as explained above, even if Plaintiffs had made more specific allegations to support this claim, it would still be subject to dismissal, as the Nevada Supreme Court has found as a matter of law that this tort does not apply to commercial contracts. *Aluevich*, 99 Nev. at 216, 660 P.2d at 986. Thus, Plaintiffs have failed to state a claim for tortious breach and this claim should be dismissed.

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[18] In addition, there is no reason to predict that the Nevada Supreme Court will expand the tort to the commercial realm anytime soon. The vast majority of jurisdictions have refused to do so. *Tort Remedies for Breach of Contract: The Expansion of Tortious Breach of the Implied Covenant of Good Faith and Fair Dealing into the Commercial Realm*, 86 COLUM. L. REV. 377, 390 (1986) ("Most jurisdictions have refused to apply the bad faith tort to the commercial context, limiting the tort to its application in the insurance context.").

VIII. PLAINTIFFS' CLAIM FOR UNJUST ENRICHMENT SHOULD BE DISMISSED

A. This Claim is Subject to Conflict Preemption

Plaintiffs' unjust enrichment claim "relates to" employee benefit plans governed by ERISA because to determine the appropriate benefit rate, the Court would need to refer to the payment terms in the plans at issue. Notably, Plaintiffs' allegations supporting their unjust enrichment claim specifically reference health plans. Compl. at ¶ 220. Courts regularly find such claims to be preempted. *Alcalde v. Blue Cross & Blue Shield of Fla., Inc*., 62 F. Supp. 3d 1360, 1365 (S.D. Fla. 2014) (medical provider's unjust enrichment claim against plan found to be conflict preempted); *Lab. Physicians, P.A. v. AvMed, Inc*., No. 8:08-CV-1726-T-26EAJ, 2009 WL 2486328, at *2 (M.D. Fla. Aug. 10, 2009) (same). ERISA requires that plans be administered "in accordance with the documents and instruments governing the plan[s]," 29 U.S.C. § 1104(a)(1)(D), yet Plaintiffs seek to use this claim to recover a different amount than they would be owed pursuant to the each plans' rate of payment terms for out-of-network providers. Thus, this claim clearly conflicts with ERISA and is preempted. Moreover, Nevada law on unjust enrichment would not fall within the ERISA saving clause as it is a law of general applicability that is not specifically aimed at regulating insurance companies.

B. This Claim is Subject to Complete Preemption

Courts have specifically held that a plaintiff-providers' unjust enrichment claims seeking to require health plans to pay amounts in excess of plan terms are subject to complete preemption. *Torrent & Ramos, M.D., P.A.*, 2004 WL 7320735, at *4 (out-of-network providers' unjust enrichment claim was completely preempted); *Hill v. Opus Corp*., 841 F. Supp. 2d 1070, 1086 (C.D. Cal. 2011) (unjust enrichment claim was subject to ERISA preemption); *Lodi Mem'l Hosp. Ass'n v. Tiger Lines, LLC*, No. 2:15-CV-00319-MCE, 2015 WL 5009093, at *8 (E.D. Cal. Aug. 20, 2015) (quantum meruit claim was subject to ERISA preemption); *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) (medical providers'

quantum meruit claim held to be completely preempted).[19]

C. This Claim Must be Dismissed Under NRCP 12(b)(5)

"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. v. Precision Constr.*, 128 Nev. 371, 381, 283 P.3d 250, 257 (2012). "[A] pleading of quantum meruit for unjust enrichment does not discharge the plaintiff's obligation to demonstrate that the defendant received a benefit from services provided." *Id.*

Here, Plaintiffs' claim fails as courts around the country routinely hold that providing medical services to a participant or beneficiary of a health plan 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 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."); *Adventist Health Sys./Sunbelt Inc. v. Med. Sav. Ins. Co.*, No. 6:03-CV-1121-ORL-19, 2004 WL 6225293, at *6 (M.D. Fla. Mar. 8, 2004) ("as a matter of commonsense, the benefits of healthcare treatment flow to patients, not insurance companies"); *Encompass Office Solutions, Inc. v. Ingenix, Inc.*, 775 F.Supp.2d 938, 966 n. 11 (E.D. Tex. 2011) (dismissing quantum meruit claim because benefit of medical treatment flowed only to insured, not insurer); *Electrostim Med. Servs., Inc. v. Health Care Serv. Corp.*, 962 F. Supp. 2d 887, 898–99 (S.D. Tex. 2013) (same) (reversed in part on other grounds in, 614 F. App'x 731 (5th Cir. 2015); *Travelers Indem. Co. of Connecticut v. Losco Grp., Inc.*, 150 F. Supp. 2d 556, 563 (S.D.N.Y. 2001) ("It is counterintuitive to say that services provided to an insured are also provided to its insurer. The insurance company derives no benefit from those services; indeed, what the insurer gets is a ripened obligation to pay money

[19] A copy of the *Hill Country* order, which was against TeamHealth affiliated medical providers, is attached hereto as **Exhibit 7**.

to the insured—which hardly can be called a benefit."); *Joseph M. Still Burn Ctrs., Inc. v. AmFed Nat'l Ins. Co*., 702 F.Supp.2d 1371, 1377 (S.D. Ga. 2010) (dismissing quantum meruit causes of action because the medical provider provided services to a patient, not the insurer, "and no cognizable, let alone measurable, benefit or value to [the insurer was] identified by [the provider]"); *Sinai Med. Ctr. v. Mid–West Nat. Life Ins. Co. of Tenn*., 118 F.Supp.2d 1002, 1013 (C.D.Cal. 2000) (stating that a medical provider's claim for quantum meruit lacked merit because it did not treat the patient at the insurance company's request).

Since the only benefit that Plaintiffs allege they conferred on the Defendants is the medical treatment of the Defendants' plan members, this claim fails as a matter of law and should be dismissed. *See* Compl. at ¶ 221.

IX. PLAINTIFFS' CLAIM FOR VIOLATION OF NRS 686A.020 AND 686A.310 SHOULD BE DISMISSED

A. This Claim is Subject to Conflict Preemption

The Nevada Supreme Court has 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."); *see also Thrall*, 2005 WL 8161321, at *2 (claim for violation of Nevada Unfair Claim Practices was preempted). The *Villescas* decision is directly on point and found not only that claims such as Plaintiffs' "relate to" an ERISA plan, but also that these claims do not fall within the ERISA saving clause. *Villescas*, 109 Nev. at 1083, 864 P.2d at 294. So, too, here. At bottom, Plaintiffs' claim under the Nevada Unfair Trade Practices Act is conflict preempted, as it relates to the processing of claims under ERISA-governed plans.

B. This Claim is Subject to Complete Preemption

Based on the Nevada Supreme Court's decision in *Villescas*, this claim is also subject to complete preemption under the *Davila* test. Plaintiffs have standing to bring a statutory ERISA claim against Defendants due to the assignments of benefits they received, and Defendants do

not owe any duty to Plaintiffs independent of the ERISA plans at issue.

C. This Claim Must be Dismissed Under NRCP 12(b)(5)

Plaintiffs assert that the Defendants violated the Nevada Unfair Insurance Practices Act by not paying more on Plaintiffs' claims. Plaintiffs specifically cite to NRS 686A.310(1)(e), which prohibits "[f]ailing to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear." Compl. ¶ 229.

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) In fact, 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."). The Court recently reaffirmed *Gunny's* central holding, stating as follows:

> NRS 686A,310(1)(e) provides that it is an unfair practice to '[f]ail[ ] to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear.' NRS 686A.310 expressly grants insureds a private right of action against insurance companies engaged in this unfair practice. This statute, however, does not provide a private right of action to third-party claimants.

Fulbrook v. Allstate Ins. Co., No. 61567, 2015 WL 439598, at *4 (Nev. Jan. 30, 2015) (citing to *Gunny*) (emphasis added) (unpublished). 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) ("We have no reason to disagree with [the] conclusion that the Act

created no private right of action in favor of third party claimants against the insurer.").

Here, Plaintiffs are undisputedly third party medical providers who provided medical services to participants of plans administered by Defendants. Plaintiffs are not "insureds" but rather "third party claimants" with no contractual relationship with Defendants. Therefore, this claim should be dismissed, as Plaintiffs lack standing to bring it.

X. PLAINTIFFS' CLAIM FOR VIOLATIONS OF NEVADA'S PROMPT PAY STATUTES AND REGULATIONS SHOULD BE DISMISSED

A. This Claim is Subject to Conflict Preemption

Plaintiffs allege that Defendants violated the Nevada prompt pay statutes, including NRS 683A.0879, NRS 689A.410, NRS 689B.255, NRS 689C.485, NRS 695C.185, and NAC 686A.675, by failing to reimburse Plaintiffs within 30 days of Plaintiffs' requests for payment. Compl. at ¶ 237. As a remedy for this alleged violation, Plaintiffs seek to recover Nevada statutory penalties. *Id.* at ¶¶ 237, 240.

Plaintiffs' prompt pay claim unquestionably "has a connection with or reference to" an ERISA plan, as the claim is based on Defendants' alleged failure to cause the plans at issue to "pay the Health Care Providers the usual and customary rate within 30 days of receipt of the claim." *Id.* at ¶ 236. 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. Further, this claim conflicts with the aforementioned ERISA requirement that Defendants comply with plan's payment terms (29 U.S.C. § 1102(b)(4) and 29 U.S.C. § 1104(a)(1)(D)) by seeking to have the Court superimpose a "usual and customary rate" term into each plan. Thus, 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.").

B. This Claim is Subject to Complete Preemption

This claim is completely preempted for several reasons. First, ERISA already provides a remedy for a plan administrator's failure to promptly pay claims. A plan participant or beneficiary may seek an injunction to force immediate payment. 29 U.S.C. § 1132(a)(1)(B) (action can be brought to "enforce his rights under the terms of the plan"); *Pryzbowski v. U.S. Healthcare, Inc*., 245 F.3d 266, 272 (3d Cir. 2001) (claims related to delay in processing claims were completely 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.). Nevada's prompt pay statute seeks to supplement this remedy and is thus completely preempted.

Second, courts have repeatedly found similar state "prompt pay" statutes preempted, unless the claim for payment specifically arises from an independent agreement between the provider and plan. *Compare Schoedinger v. United Healthcare of Midwest, Inc.*, 557 F.3d 872, 875–76 (8th Cir. 2009) (finding provider's claim, pursuant to an assignment of benefits from participant, for interest under Missouri prompt pay statute pre-empted by ERISA); *Productive MD, LLC v. Aetna Health, Inc.*, 969 F.Supp.2d 901, 938 (M.D. Tenn. 2013) (finding Tennessee Prompt Pay Act claim pre-empted because provider brought it as assignee of plan participant) *with In re Managed Care Litig.*, 298 F.Supp.2d at 1294 (finding no pre-emption of providers' prompt pay claims arising from "a separate relationship between the provider and plan administrator," rather than an assignment from plan participants). *See also America's Health Ins. Plans v. Hudgens*, 742 F.3d 1319 (11th Cir. 2014) (Georgia's prompt-pay provision was preempted as applied to self-funded ERISA plans because the provision interfered with uniform administration of benefits.); *Zipperer v. Premera Blue Cross Blue Shield of Alaska*, 2016 WL 4411490 (D. Alaska, August 16, 2016) (Alaska prompt pay statute was preempted); *Houston Methodist Hosp. v. Humana Ins. Co.*, 266 F. Supp. 3d 939 (S.D. Tex. 2017) (Texas Prompt Payment of Physicians and Providers Act was preempted); *OSF Healthcare Sys. v. Contech Constr. Prod. Inc.Group Comprehensive Health Care*, No. 1:13-CV-01554-SLDJEH, 2014 WL 4724394, at *7 (C.D. Ill. Sept. 23, 2014) (Illinois prompt-pay statute preempted by ERISA as

having an "impermissible connection to an ERISA plan."). There is no significant distinction between Nevada's prompt pay statute and those of other states that have been found to be preempted. These statutes seek to regulate the processing of claims under employee benefit plans, which infringes on the field occupied by ERISA. The Court should adopt the above courts' reasoning and find that Nevada's prompt pay statute is preempted as well.

Third, Plaintiffs' claim is preempted because it seeks to recover Nevada statutory penalties, which are not available under ERISA. *See e.g., Elliot*, 337 F.3d at 1147 (holding claim processing causes of action under state law which seek non-ERISA damages are preempted by ERISA).

XI. PLAINTIFFS' CLAIM FOR VIOLATIONS OF NEVADA'S CONSUMER FRAUD & DECEPTIVE TRADE PRACTICES ACTS SHOULD BE DISMISSED

A. This Claim is Subject to Conflict Preemption

Through this claim, Plaintiffs seek 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. Compl. at ¶¶ 244, 246. As part of this claim, Plaintiffs allege that Defendants are refusing to pay for "covered emergency services." *Id.* at ¶ 246. This claim is conflict preempted because (1) 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, and (2) the state law Plaintiffs rely on impermissibly "relates to" the processing of claims under an employee benefit plan. There is no reason for this Court to deviate 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) ("Plaintiff's breach of contract and unfair and deceptive trade practices [claims] are obviously preempted under ERISA . . . Plaintiff's claim for deceptive trade practices is a statutory cause of action that by its very terms is not specifically directed at insurance companies."); *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); *Olson v. General Dynamics Corp*., 960 F.2d 1418, 1422–23 (9th Cir. 1991) (claim challenging oral misrepresentation regarding the level of benefits provided by a plan is conflict preempted).

B. This Claim is Subject to Complete Preemption

This claim is completely preempted because, as discussed previously, the *Davila* test is met. Plaintiffs could have brought their challenge to the payment amounts that they received through a statutory ERISA claim pursuant to the assignments of benefits they received from Defendants' plan members. Defendants do not owe any independent legal obligation to Plaintiffs beyond that set forth in the ERISA plan documents since Plaintiffs are out-of-network providers.

Moreover, this claim seeks punitive treble damages and a disgorgement of profits against Defendants. Compl. at ¶ 248. All claims seeking such damages against an ERISA plan administrator are completely preempted. *Davila*, 542 U.S. at 209 ("any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted."); *Bast*, 150 F.3d at 1009 ("Extracontractual, compensatory and punitive damages are not available under ERISA."); *Elliot*, 337 F.3d at 1146-47 ("claim processing causes of action" which seek state law damages are "clearly" preempted under 29 U.S.C. § 1132(a)(1)(B) of ERISA).

C. This Claim Must be Dismissed Under NRCP 12(b)(5)

1. Plaintiffs Have Failed to Plead this Claim with Particularity

When a claim sounds in fraud, it must be pled with particularity. *See* NRCP 9(b) ("In alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake."). The Nevada Supreme Court has held that a claim for violation of the Nevada Deceptive Trade Practices Act sounds in fraud and thus is subject to the pleading requirements of NRCP 9(b). *Davenport v. Homecomings Fin.*, LLC, No. 56322, 2014 WL 1318964, at *3 (Nev. Mar. 31, 2014); *see also Sommers v. Cuddy*, No. 2:08-CV-78-RCJ-RJJ, 2012 WL 359339, at *4 (D. Nev. Feb. 2, 2012) ("a plaintiff must plead a deceptive trade

practices claim with Rule 9(b) particularity.").

To plead a fraud claim with particularity under NRCP 9(b), "[t]he circumstances that must be detailed include averments to the time, the place, the identity of the parties involved, and the nature of the fraud or mistake." *Brown v. Kellar*, 97 Nev. 582, 583–84, 636 P.2d 874, 874 (1981). The "allegations of fraud must be specific enough to give defendants notice of the particular misconduct which is alleged to constitute the fraud charged so that they can defend against the charge and not just deny that they have done anything wrong." *Swartz v. KPMG LLP*, 476 F.3d 756, 764 (9th Cir. 2007) (internal citation omitted).[20]

For a fraud claim against multiple defendants, "Rule 9(b) does not allow a complaint to merely lump multiple defendants together but requires plaintiffs to differentiate their allegations when suing more than one defendant . . . and inform each defendant separately of the allegations surrounding his alleged participation in the fraud. In the context of a fraud suit involving multiple defendants, a plaintiff must, at a minimum, identify the role of each defendant in the alleged fraudulent scheme." *Id.* at 764-765 (internal quotations and citations omitted).

Here, while Plaintiffs have alleged that *non-party* Data iSight made various false representations (Compl. at ¶¶ 128-188), the Complaint improperly lumps all the Defendants in with Data iSight by simply alleging they conspired together as part of a fraudulent "enterprise." Further, Plaintiffs have failed to point to *any* false representations by the actual Defendants. While the Complaint does make reference to certain specific statements made by individuals associated with Defendants during contract negotiations, none of the statements are alleged to have been false. *Id.* at ¶¶ 93, 97-98, 104, 106. Rather, the Plaintiffs have alleged that the Defendants told them rates of reimbursement were going to be reduced and those rates were in fact subsequently reduced (i.e. a true statement was made, not a false one) *Id.* at ¶¶ 81, 88. Plaintiffs go on to compound these errors by doing exactly what the Nevada Supreme Court has prohibited—lumping all the Defendants in this case together and failing to identify the role each Defendant played in the alleged fraudulent scheme. *Id.* at ¶¶ 243-249 (referring only to the

[20] Federal case law on this issue is strong persuasive authority as FRCP 9(b) is identical to NRCP 9(b).

"Defendants" generally in each allegation). For all these reasons, Plaintiffs have not pled this claim with particularity and it should be dismissed.

2. Plaintiffs are Not "Victims" Within the Meaning of NRS 41.600 and Thus Lack Standing to Bring a Claim

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 section 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), where it held that the Las Vegas Metropolitan Police Department was not a "victim" that could receive restitution for money used to purchase illegal drugs in a sting operation. *Id.* at 706, 895 at 1308. While noting the term was undefined, the court 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 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 Complaint 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. Compl. 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.

XII. PLAINTIFFS' CLAIM FOR DECLARATORY JUDGMENT SHOULD BE DISMISSED

A. This Claim is Subject to Conflict Preemption

Plaintiffs' declaratory judgment claim 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. Compl. at ¶¶ 257-259. But it would be impossible for this Court to determine the correct amount of reimbursement, if any, for Plaintiffs' medical services without referring to and interpreting the terms and conditions of the members' ERISA plans. At bottom, the relief sought by Plaintiffs—a declaration that they are entitled to receive the "usual and customary rate" for their services—would require this Court to alter or rewrite the ERISA plans altogether. This Court simply cannot issue the declaratory relief sought by Plaintiffs without consulting the language in the ERISA plans. Therefore, Plaintiffs' claim for declaratory judgment is preempted because it "relates to" these ERISA plans. *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").

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/ / /

B. This Claim is Subject to Complete Preemption

ERISA's civil enforcement statute specifically authorizes actions for declaratory judgment, providing that a plan participant or beneficiary can bring a civil action to "clarify any of his rights to future benefits." 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"). Plaintiffs seek a declaratory judgment under state law regarding the correct amount of reimbursement for the medical services that they performed on Defendants' members. Compl. at ¶¶ 257-259. Such a claim clearly duplicates the relief provided by 29 U.S.C. § 1132(a)(1)(B) of ERISA and therefore is completely preempted. *Davila*, 542 U.S. at 209 ("any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted.").

XIII. CONCLUSION

For all the above reasons, Defendants request that this Court dismiss Plaintiffs' state law claims with prejudice, but give Plaintiffs leave to attempt to plead a statutory claim under 29 U.S.C. § 1132(a)(1)(B) of ERISA.

Dated this 26th day of May, 2020.

/s/ Colby L. Balkenbush

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CERTIFICATE OF SERVICE

I hereby certify that on the 26th day of May, 2020, a true and correct copy of the foregoing **DEFENDANTS' MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT** was electronically filed/served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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EXHIBIT 1

UHIC, UHS and UMR Declaration

EXHIBIT 1

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WEINBERG WHEELER HUDGINS GUNN & DIAL

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC. dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC. dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832 **DECLARATION OF JANE STALINSKI IN SUPPORT OF DEFENDANTS' OPPOSITION TO MOTION TO REMAND**

I, Jane Stalinski, declare under penalty of perjury as follows:

1. I am an adult resident of Cuyahoga County in the state of Ohio, over 18 years of age, and I have personal knowledge of the matters set forth herein, except as stated upon information and belief, which matters I believe to be true.

2. I am a Legal Service Specialist for UnitedHealthcare Insurance Company ("UHIC") and its affiliates.

3. I submit this declaration in support of Defendants' Opposition to Fremont's Motion to Remand.

4. In the Complaint, Fremont Emergency Services (Mandavia), Ltd. ("Fremont") alleges that it provided medical treatment to Defendants UnitedHealthcare Insurance Company's ("UHIC"), United HealthCare Services, Inc.'s ("UHS"), and UMR, Inc.'s ("UMR") plan members from July 2017 to present and that Defendants failed to adequately reimburse Fremont for the medical services it provided. *See e.g.*, Complaint at ¶¶ 24-25.

5. Based on the allegations in the Complaint, I have conducted an investigation of the claims/requests for payment ("claims") that Fremont has submitted to UHIC, UHS and UMR. The results of this investigation are summarized below.

6. My understanding is that The Employee Retirement Income Security Act ("ERISA") defines an "employee welfare benefit plan" (hereinafter "employee benefit plan") as follows:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. § 1002.

7. In regard to the thousands of claims that Fremont sent to Defendants UHIC, UHS,

and UMR during the time period of July 2017 to present, all but one of the claims were made against employee benefit plans. Further, for all of Fremont's claims against UHIC, UHS, and UMR, the claim submission data indicates that Fremont received an assignment of benefits from the patient/plan member/insured and/or other authorized person.

8. In addition, I have reviewed the nature of the claims Fremont has asserted against UHIC, UHS and UMR and determined that some of the claims were denied in full and no partial payment was issued.

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

DATED this 20th day of June, 2019.

Jane Stalinski

Jane Stalinski

EXHIBIT 2

Oxford Declaration

EXHIBIT 2

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WEINBERG WHEELER HUDGINS GUNN & DIAL

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation. Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC. dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC. dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832 **DECLARATION OF MARYANN BRITTO IN SUPPORT OF OPPOSITION TO MOTION TO REMAND**

I, Maryann Britto, declare under penalty of perjury as follows:

1. I am an adult resident of Fairfield County, Connecticut, over 18 years of age, and I have personal knowledge of the matters set forth herein, except as stated upon information and belief, which matters I believe to be true.

2. I am a Legal Case Information Analyst for United Healthcare Services, Inc.

3. I submit this declaration in support of Defendants' Opposition to Fremont's Motion to Remand.

4. In the Complaint, Fremont Emergency Services (Mandavia), Ltd. ("Fremont") alleges that it provided medical treatment to Defendant Oxford Health Plans, Inc.'s ("Oxford") plan members from July 2017 to present and that Oxford failed to adequately reimburse Fremont for the medical services it provided. *See e.g.*, Complaint at ¶¶ 24-25.

5. Based on the allegations in the Complaint, I have conducted an investigation of the claims/requests for payment ("claims") that Fremont has submitted to Oxford. The results of this investigation are summarized below.

6. My understanding is that The Employee Retirement Income Security Act ("ERISA") defines an "employee welfare benefit plan" (hereinafter "employee benefit plan") as follows:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. § 1002.

7. In regard to the claims that Fremont sent to Defendant Oxford during the time period of July 2017 to present, all of the claims were made against employee benefit plans. Further, for all of Fremont's claims against Oxford, the claim submission data indicates that

Fremont received an assignment of benefits from the patient/plan member/insured and/or other authorized person.

8. In addition, I have reviewed the nature of the claims Fremont has asserted against Oxford and determined that some of the claims were denied in full and no partial payment was issued.

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

DATED this 21 day of June, 2019.

Maryann Britto

WEINBERG WHEELER HUDGINS GUNN & DIAL

EXHIBIT 3

SHO Declaration

EXHIBIT 3

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WEINBERG WHEELER HUDGINS GUNN & DIAL

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC. dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC. dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832 **DECLARATION OF SHAWNA REED IN SUPPORT OF DEFENDANTS' OPPOSITION TO MOTION TO REMAND**

I, Shawna Reed, declare under penalty of perjury as follows:

1. I am an adult resident of Clark County, Nevada, over 18 years of age, and I have personal knowledge of the matters set forth herein, except as stated upon information and belief, which matters I believe to be true.

2. I am the general manager for Sierra Health-Care Options, Inc. ("SHO") operations.

3. I submit this declaration in support of Defendants' Opposition to Fremont's Motion to Remand.

4. In the Complaint, Fremont Emergency Services (Mandavia), Ltd. ("Fremont") alleges that it provided medical treatment to Defendant SHO's plan members from July 2017 to present and that SHO failed to adequately reimburse Fremont for the medical services it provided. *See e.g.*, Complaint at ¶¶ 24-25.

5. Based on the allegations in the Complaint, I have conducted an investigation of the claims/requests for payment ("claims") that Fremont has submitted to SHO. The results of this investigation are summarized below.

6. My understanding is that The Employee Retirement Income Security Act ("ERISA") defines an "employee welfare benefit plan" (hereinafter "employee benefit plan") as follows:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

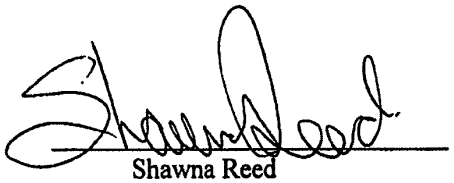
29 U.S.C. § 1002.

7. In regard to the claims that Fremont sent to Defendant SHO during the time period of July 2017 to present, all of the claims were made against employee benefit plans.

Further, for all of Fremont's claims against SHO, the claim submission data indicates that Fremont received an assignment of benefits from the patient/plan member/insured and/or other authorized person.

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

DATED this ___ day of June, 2019.



Shawna Reed

EXHIBIT 4

SHL and HPN Declaration

EXHIBIT 4

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC. dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC. dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832 **DECLARATION OF ELLEN SINCLAIR IN SUPPORT OF DEFENDANTS' OPPOSITION TO MOTION TO REMAND**

I, Ellen Sinclair, declare under penalty of perjury as follows:

1. I am an adult resident of Clark County, Nevada, over 18 years of age, and I have personal knowledge of the matters set forth herein, except as stated upon information and belief, which matters I believe to be true.

2. I am a Healthcare Economics Consultant for HPN/SHL.

3. I submit this declaration in support of Defendants' Opposition to Fremont's Motion to Remand.

4. In the Complaint, Fremont Emergency Services (Mandavia), Ltd. ("Fremont") alleges that it provided medical treatment to Defendants Sierra Health and Life Insurance Co.'s ("SHL") and Health Plan of Nevada, Inc.'s ("HPN") plan members from July 2017 to present and that Defendants failed to adequately reimburse Fremont for the medical services it provided. *See e.g.*, Complaint at ¶¶ 24-25.

5. Based on the allegations in the Complaint, I have conducted an investigation of the claims/requests for payment ("claims") that Fremont has submitted to SHL and HPN. The results of this investigation are summarized below.

6. My understanding is that The Employee Retirement Income Security Act ("ERISA") defines an "employee welfare benefit plan" (hereinafter "employee benefit plan") as follows:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. § 1002.

7. In regard to the claims that Fremont sent to Defendant SHL during the time period of July 2017 to present, approximately 72 percent of the claims were made against employee

benefit plans. Further, for all of Fremont's claims against SHL, the claim submission data indicates that Fremont received an assignment of benefits from the patient/plan member/insured and/or other authorized person.

8. In regard to the claims that Fremont sent to Defendant HPN during the time period of July 2017 to present, approximately 84 percent of the claims were made against employee benefit plans. Further, for all of Fremont's claims against HPN, the claim submission data indicates that Fremont received an assignment of benefits from the patient/plan member/insured and/or other authorized person.

9. In addition, I have reviewed the nature of the claims Fremont has asserted against SHL and HPN and determined that some of the claims were denied in full and no partial payment was issued.

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

DATED this 20 day of June, 2019.

Ellen Sinclair

Ellen Sinclair