IN THE SUPREME COURT OF THE STATE OF NEVADA

UNITEDHEALTH GROUP, UNITEDHEALTHCARE INSURANCE COMPANY; UNITED HEALTHCARE SERVICES, INC.; UMR, INC.; OXFORD HEALTH PLANS, INC.; SIERRA HEALTH AND LIFE INSURANCE CO., INC.; SIERRA HEALTH-CARE OPTIONS, INC.; and HEALTH PLAN OF NEVADA, INC.,

Petitioners,

vs.

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. dba RUBY CREST EMERGENCY MEDICINE,

Real Parties in Interest.

Case No. 81680

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

REAL PARTIES IN INTEREST OPPOSITION TO MOTION TO STAY

Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Real Parties in Interest

I. INTRODUCTION AND RELEVANT BACKGROUND

United's[1] motion for stay effectively requests that this Court overturn *Hansen*, 116 Nev. 650, 6 P.3d 982, and *Mikohn Gaming Corp.*, 120 Nev. 248, 89 P.3d 36, which stand for the principle that saving a party the expenditure of time or money is not a legitimate ground upon which to request a stay. United's motion for stay also requests that the Court embrace the same false premise as United's Petition: that is, the Health Care Providers'[2] claims implicate ERISA. United's argument once again relies on the faulty contention that complete preemption under ERISA Section 502(a) (codified at 29 U.S.C. § 1132(a)(1)(B)) can transmute the Health Care Providers' asserted state law claims to ERISA claims for adjudication in the federal courts. Motion at 2. This cannot happen because the law is settled that complete preemption is a jurisdictional doctrine which only allows a party removal from state court to federal court – a request that the District of Nevada already rejected. Exhibit A, February 20, 2020 Order at PA000088; *see, e.g.*, *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 914, 945 (9th Cir. 2009);

---

[1] "United" collectively refers to Petitioners UnitedHealth Group, UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Oxford Health Plans, Inc.; Sierra Health and Life Insurance Co., Inc.; Sierra Health-Care Options, Inc.; and Health Plan of Nevada, Inc.

[2] The "Health Care Providers" collectively refers to Real Parties in Interest 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").

Owayawa v. Am. United Life Ins. Co., No. CV 17-5018-JLV, 2018 WL 1175106, at *3 (D.S.D. Mar. 5, 2018). The law surrounding that jurisdictional doctrine is well-established in federal courts, law which the District Court applied. Motion App., Ex. 3 at 141, ¶ 5, Ex. 6 at 248-249, ¶ 6; *see also* Answer to Petition at Section IV(A)(1)(a). The District Court also correctly found that the Health Care Providers' claims are not conflict preempted. Motion App., Ex. 3 at 000140, ¶ 10, Ex. 6 at 00247, ¶ 10. Without either complete or conflict preemption, United's Petition simply seeks writ review of a garden variety NRCP 12(b)(5) motion to dismiss, for which United acknowledges it has a plan, speedy and adequate remedy in an appeal. That acknowledgment defeats United's Petition and so too should it defeat United's request for stay. Finally, the District Court refused to allow United to bypass its discovery obligations currently ordered through the guise of a stay request.

Based upon these factors, the District Court twice ruled that United's request for stay is defeated, after review of the four NRAP 8(c) factors. Motion App., Ex. 3 at 141-143, ¶¶ 4-9, Ex. 6 at 248-250, ¶¶ 5-10. Based upon those same considerations and others, the Health Care Providers urge this Court to also deny United's current motion to stay.

II. LEGAL ARGUMENT

A. Applicable Legal Standard.

This Court uniformly denies stay requests where the request arises from the

denial of a motion to dismiss and when the only claimed prejudice to a party requesting a stay is the saving of either time or money, both of which form the only basis for United's motion to stay. *See, e.g.*, Motion at 8 ("All of this expensive and burdensome discovery…."); at 10 ("expend resources conducting discovery on all claims…."). Also weighing against a stay, writ relief is not appropriate where a "plain, speedy, and adequate remedy" at law exists – which United admits that it has. *Pan v. Eighth Judicial Dist. Court*, 120 Nev. 222, 228, 88 P.3d 840, 843 (2004); *Smith v. Eighth Judicial Dist. Court*, 107 Nev. 674, 677, 818 P.2d 849, 851 (1991). No less important, the Court will consider whether "the underlying proceedings could be unnecessarily delayed by a stay." *Hansen v. Eighth Judicial Dist. Court ex rel. Cty. of Clark*, 116 Nev. 650, 658, 6 P.3d 982, 987 (2000).

B. All of the NRAP 8(c) Factors Weigh Against a Stay.

1. The Object of United's Writ Will Not Be Defeated if a Stay is Denied.

United's identified "object" of its Petition – whether this is a benefits case preempted by ERISA – will not be defeated if a stay is denied. Motion at 5-6. The District Court already considered and rejected this argument for three reasons. First, there is no scenario where United's complete preemption argument will result in dismissal of the First Amended Complaint because it is a jurisdictional doctrine that cannot be used to obtain dismissal of a state law claim. *See, e.g., Owayawa*, 2018 WL 1175106 at *3 ("[A]lthough complete preemption...can be used to invoke

federal question jurisdiction, Defendants cannot use [the doctrine] as a ground for dismissing Plaintiffs' claims under Federal Rule of Civil Procedure 12(b)(6)."). Motion App., Ex. 3 at 000141, ¶ 5, Ex. 6 at 000248-249, ¶ 6.

Nor will United's conflict preemption argument under ERISA Section 514 (codified at 29 U.S.C. § 1144) be meritorious. *Providence Health Plan v. McDowell*, 385 F.3d 1168, 1172 (9th Cir. 2004); Exhibit B, June 24, 2020 Order Denying United's Motion to Dismiss at PA000602-608. With reference to federal cases interpreting ERISA Section 514, the District Court concluded that "[t]he Ninth Circuit has made it clear that Section 514(a) does not apply to claims brought by third-party healthcare providers, like the Health Care Providers here." Ex. B at PA000603-604, ¶ 26 (citations omitted); and further found that the Health Care Providers' state common law and statutory claims do not have "a reference to" or "impermissible connection with" ERISA plans. *Id.* at PA000605, ¶ 32. The District Court specifically rejected United's reliance on outdated legal authority and efforts to conflate complete and conflict preemption analyses. *Id.* at PA000606-607, ¶¶ 34-35.

Second, United previously conceded there is a scenario where the Health Care Providers' pleading may not be dismissed in its entirety. Motion App., Ex. 5-A at 10:5-13. In United's motion to stay this argument is now conspicuously absent, although it can still be gleaned from United's discussion of the discovery

limitations in ERISA-governed matters. Motion at 3. Nevertheless, the legal authority is clear that partial relief does not provide entitlement to a stay. *Moore v. Eighth Judicial Dist. Court In & For Clark Cty.*, 96 Nev. 415, 417, 610 P.2d 188, 189 (1980).

Third, even if United's Petition is granted in full (which the Health Care Providers respectfully submit is unlikely), such a determination will not obviate the need for discovery because the claims at issue can be re-pled as ERISA claims for which certain discovery can be obtained – a concession United is resigned to make. Motion at 6. As such, the "object" of the Petition is not really dismissal of the First Amended Complaint, but merely United's attempt to narrow the scope of discovery.

United relies on a declaration by Sandra Way to argue how expensive and burdensome discovery may be for United. Motion App., Ex. 10. This is the same declaration on which United relied in advancing the losing argument to the District Court, who made factual findings which United appears to contest before this Court via its motion to stay.[3] Exhibit C, September 28, 2020 Order Granting, In Part

[3] United seemingly uses its motion to stay as an avenue to obtain reconsideration of the District Court's orders compelling United's participation in discovery and production of documents and further attempts to thwart the Health Care Providers' access to legitimate discovery. Motion at 8. United's abuse of the discovery process has been documented by the District Court:

(continued)

Plaintiffs' Motion To Compel Defendants' Production Of Claims File For At-Issue Claims, Or, In The Alternative, Motion In Limine, at RPA 013, ¶ 7, 014, ¶ 13. The Healthcare Providers respectfully submit that the Court should not grant a stay simply so United does not have to engage in discovery or discovery to which it now objects after the District Court Order rejected United's exact argument. Motion at 3; *see Mikohn Gaming Corp. v. McCrea*, 120 Nev. 248, 253, 89 P.3d 36, 39 (2004); *see also Hansen*, 116 Nev. at 658, 6 P.3d at 986-987.

2. United Is Not Likely To Prevail On The Merits Of The Writ Petition.

United claims that this Court has never addressed the scope of ERISA preemption in the case of out-of-network provider claims. Motion at 9. But this argument accelerates past the threshold issue of whether ERISA is even implicated in this case. It is not. Once United's improper ERISA premise is removed, United's entire Petition falls well short of meeting the high standard requiring writ review and therefore success appears unlikely.

Critically, the scope of ERISA's preemptive reach is a pure question of federal

---

- "The Court finds that United has not participated in discovery with sufficient effort and has not taken a rational approach to its discovery obligations." Exhibit D, October 27, 2020 Order Granting Plaintiffs' Motion to Compel List of Witnesses, Production of Documents an Answers to Interrogatories at ¶ 9.
- "The Court finds that United's discovery conduct in this action is unacceptable to the Court." Exhibit E, November 9, 2020 Order Setting United's Production & Response Schedule at ¶ 1.

law. *Close v. Sotheby's*, 909 F.3d 1204, 1208 (9th Cir. 2018). Federal courts, therefore, have published a broad array of case law interpreting ERISA and have provided a roadmap for courts to determine whether a cause of action is governed (or preempted) by ERISA. As the Health Care Providers set forth in their Answer to United's Petition, United's ERISA-based arguments are less than candid and often conflate conflict preemption under Section 514 and complete preemption under Section 502. Indeed, both the District of Nevada and the District Court, and a simple review of the First Amended Complaint reveals, none of the Health Care Providers' causes of action rely on ERISA or require any factfinder to look to any ERISA governed plan. Exhibit F at PA000091-139. The First Amended Complaint focuses on United's failure to correctly reimburse the Health Care Providers a reasonable rate of payment for their services as required by Nevada contract, common and statutory law. *Id.* at PA000093, ¶¶ 1-2, PA000100, ¶ 40, PA000123-136. In federal court ERISA parlance, this is a "rate" of payment case, not a "right" to payment case. *Marin Gen. Hosp.*, 581 F.3d at 948; *The Meadows v. Employers Health Ins.*, 47 F.3d 1006, 1008 (9th Cir. 1995); *California Spine & Neurosurgery Inst.*, 2019 WL 1974901 at *3.

Binding Ninth Circuit precedent makes clear that disputes concerning the rate of payment do not fall within ERISA and thus are not completely preempted. *Marin Gen. Hosp.*, 581 F.3d at 948; *see also California Spine & Neurosurgery Inst. v.*

Boston Scientific Corp., No. 18-cv-07610-LHK, 2019 WL 1974901, at *3 (N.D. Cal. May 3, 2019) ("Under Ninth Circuit law, ERISA does not preempt claims by a third party [medical provider] who sues an ERISA plan not as an assignee of a purported ERISA beneficiary, but as an independent entity claiming damages."). In addition, the Ninth Circuit also has held that ERISA's conflict preemption statute, Section 514, does not apply to claims brought by third-party healthcare providers, like the Health Care Providers here. *See Providence Health Plan*, 385 F.3d at 1172; *The Meadows*, 47 F.3d at 1008.[4]

Once stripped bare of the false assertion that ERISA has an impact on this case, United's Petition is nothing more than a challenge to a denial under NRCP

[4] Citing *Western Cab Co. v. Eighth Jud. Dist. Court*, 133 Nev. 65, 390 P.3d 662 (2017), United claims that this Court previously found ERISA preemption to be of such importance as to warrant writ review. Motion at 9. However, the central issue in *W. Cab Co.* turned on whether the Minimum Wage Amendment ("MWA") was invalid based on constitutional grounds. *Id.* As part of that question, the petitioner argued that the MWA was preempted by the National Labor Relations Act and ERISA, and was void for vagueness. *Id.* 133 Nev. 66, 390 P.3d at 666. A review of the decision belies United's claim that this Court found that ERISA preemption was "of such importance" so as to warrant writ review. Motion at 16. Rather, the principal reason for writ review was the fact the MWA would immediately impact, and if reversed would detrimentally harm, thousands if not hundreds of thousands of minimum wage Nevada employees. The ERISA review and other legal reviews were merely incidental to that fact. Nevertheless, this Court followed federal conflict preemption law and readily concluded that wages, a matter of traditional state concern, and specifically the MWA, was not conflict preempted because it did not "refer to or have a connection with" a benefit plan. *W. Cab. Co.*, 133 Nev. at 71, 390 P.3d at 669. Like wages, the interpretation of a contract, as well as alternative common law claim and Nevada statutory claims, are traditional matters of state concern and do not "refer to or have a connection" with a benefit plan.

12(b)(5) for which writ review is typically denied. In light of the applicable legal standard governing motions to dismiss and the District Court's specific findings that the First Amended Complaint's allegations, if true, state actionable claims for relief, the Healthcare Providers respectfully submit that United's Petition will be denied and therefore United is not likely to prevail on its writ and has not stated substantial issue under its writ.

3. United Will Not Suffer Irreparable Harm if the Court Denies the Motion.

The only prejudice claimed by United is the expenditure of money and time which this Court knows well does not provide stay relief. *Hansen*, 116 Nev. at 658, 6 P.3d at 986-987. Tellingly, United hesitates to expressly call potential discovery costs "irreparable harm." Motion at 10-11. Nor could it because the *Hansen* court made it clear: litigation expenses such as "lengthy and time-consuming discovery, trial preparation, and trial...**while potentially substantial**, are neither irreparable nor serious." *Hansen*, 116 Nev. at 658, 6 P.3d at 986-987 (emphasis added). Since that is all United complains of, United has failed to prove any prejudice or harm if a stay is denied.[5]

[5] United's argument is nevertheless confounding because on the one hand United claims the length of time for a stay will be brief (Motion at 10, 11), while concurrently claiming that it can only work so fast in pulling claims files (Motion at 3). If both are true, then United's burden in producing claims files will be as equally brief a period of time as the stay they request and that burden can easily be quantified *(continued)*

4. The Health Care Providers Will Suffer Significant and Irreparable Harm By a Stay.

The December 30, 2020 deadline for fact discovery is fast approaching. Exhibit G, Business Court Scheduling Order and Order Setting Civil Jury Trial at RPA 020. Granting an indefinite continuation in the discovery deadlines and, resultingly, delaying trial scheduled in this matter for August 2021 will produce unnecessary and undue prejudice to the Health Care Providers. The Health Care Providers already have been on the receiving end of United's continuing delay tactics in this case, as well as, denial of United's payment for the Health Care Providers' emergency medicine services provided long ago. *See, e.g.,* Ex. D at ¶ 9; Ex. E at ¶ 1. The *Hansen* court noted that, should "the underlying proceedings [] be unnecessarily delayed by a stay," then that could constitute irreparable or serious injury to the party opposing the stay. *Hansen*, 116 Nev. at 658, 6 P.3d at 987. That irreparable and serious injury has, and will continue to plague the Health Care Providers, but will be unnecessarily compounded if a stay is imposed.

III. CONCLUSION

Based on the foregoing, the Health Care Providers respectfully request that the Court deny United's motion to stay in its entirety.

– and it will not be much. In reality, United's circular argument cannot be reconciled and it certainly does not explain how United can overcome the fact that the crux of its request is besieged by *Hansen*.

DATED this 30th day of November, 2020.

McDONALD CARANO LLP

By: */s/ Pat Lundvall*

Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 30th day of November, 2020, I caused a true and correct copy of the foregoing **REAL PARTIES IN INTEREST OPPOSITION TO MOTION TO STAY** to be served via this Court's E-Flex Electronic Filing system in the above-captioned case, upon the following:

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
lroberts@wwhgd.com
cbalkenbush@wwhgd.com
bllewellyn@wwhgd.com

Attorneys for Defendants

/s/ Marianne Carter
An employee of McDonald Carano LLP

EXHIBIT A

EXHIBIT A

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

* * *

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., et al., Plaintiff(s), v. UNITEDHEALTH GROUP, INC., et al., Defendant(s).	Case No. 2:19-CV-832 JCM (VCF) ORDER

Presently before the court is plaintiffs' Fremont Emergency Services; Team Physicians of Nevada-Mandavia; Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("plaintiffs") amended motion to remand. (ECF No. 49). Defendant United Healthcare Insurance Company ("United") filed a response (ECF No. 64), to which plaintiffs replied (ECF No. 71).

I. Background

Plaintiffs are professional emergency medical service groups that staff the emergency departments at hospitals and other facilities throughout Nevada. (ECF No. 40 at 5). Plaintiffs have been providing emergency services and care to patients in the emergency department, regardless of an individual's insurance coverage or ability to pay. *Id.*

United and plaintiffs have never had a written agreement governing the rates of reimbursement for emergency services rendered. *Id.* at 6. Nonetheless, plaintiffs have submitted claims to United seeking reimbursement for emergency care and United has routinely paid them.

Id. at 10. From 2008–2017, United normally paid plaintiffs at a range of 75–90%. *Id.* However, beginning in 2019, United continued to pay the claims submitted but reduced the rates of reimbursement to levels ranging from 12–60%, below the usual and customary rates. *Id.*

Plaintiffs' amended complaint asserts eight state law causes of action, all stemming from United's alleged underpayment of claims. *Id.* at 32–44. Plaintiffs originally brought suit against United in the Eighth Judicial District Court, and United timely removed the action. (ECF No. 1). Plaintiffs now move to remand the case. (ECF No. 49).

II. Legal Standard

Pursuant to 28 U.S.C. § 1441(a), "any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending." 28 U.S.C. § 1441(a). "A federal court is presumed to lack jurisdiction in a particular case unless the contrary affirmatively appears." *Stock West, Inc. v. Confederated Tribes of Colville Reservation*, 873 F.2d 1221, 1225 (9th Cir. 1989).

Upon notice of removability, a defendant has thirty days to remove a case to federal court once he knows or should have known that the case was removable. *Durham v. Lockheed Martin Corp.*, 445 F.3d 1247, 1250 (9th Cir. 2006) (citing 28 U.S.C. § 1446(b)(2)). Defendants are not charged with notice of removability "until they've received a paper that gives them enough information to remove." *Id.* at 1251.

Specifically, "the 'thirty day time period [for removal] . . . starts to run from defendant's receipt of the initial pleading only when that pleading affirmatively reveals on its face' the facts necessary for federal court jurisdiction." *Id.* at 1250 (quoting *Harris v. Bankers Life & Casualty Co.*, 425 F.3d 689, 690–91 (9th Cir. 2005) (alterations in original)). "Otherwise, the thirty-day

clock doesn't begin ticking until a defendant receives 'a copy of an amended pleading, motion, order or other paper' from which it can determine that the case is removable. *Id*. (quoting 28 U.S.C. § 1446(b)(3)).

A plaintiff may challenge removal by timely filing a motion to remand. 28 U.S.C. § 1447(c). On a motion to remand, the removing defendant faces a strong presumption against removal, and bears the burden of establishing that removal is proper. *Sanchez v. Monumental Life Ins. Co.*, 102 F.3d 398, 403–04 (9th Cir. 1996); *Gaus v. Miles, Inc.*, 980 F.2d 564, 566–67 (9th Cir. 1992).

III. Discussion

As an initial matter, United bears the burden of proving that plaintiffs' complaint contains a cause of action within this court's jurisdiction. "In scrutinizing a complaint in search of a federal question, a court applies the well-pleaded complaint rule." *Ansley*, 340 F.3d at 861 (citing *Caterpillar Inc. v. Williams*, 482 U.S. 386, 392 (1987)). "For removal to be appropriate under the well-pleaded complaint rule, a federal question must appear on the face of a properly pleaded complaint." *Id.* (citing *Rivet v. Regions Bank of La.*, 522 U.S. 470, 475 (1998)).

The "well-pleaded complaint rule" governs federal question jurisdiction. This rule provides that district courts can exercise jurisdiction under 28 U.S.C. § 1331 only when a federal question appears on the face of a well-pleaded complaint. *See, e.g., Caterpillar Inc. v. Williams*, 482 U.S. 386, 392 (1987). Thus, a plaintiff "may avoid federal jurisdiction by exclusive reliance on state law." *Id*. Moreover, "an anticipated or actual federal defense generally does not qualify a case for removal[.]" *Jefferson County v. Acker*, 527 U.S. 423, 431 (1999).

Although plaintiffs bring claims solely under state law, United argues that removal is proper under 28 U.S.C § 1441 based on the exception of complete preemption by § 502(a) of

ERISA. For the reasons set forth below, the court finds that defendant's asserted basis for removal is improper and grants plaintiffs' motion to remand.

"ERISA is one of only a few federal statutes under which two types of preemption may arise: conflict preemption and complete preemption." *Conn. State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F. 3d 1337, 1343 (11th Cir. 2009). While conflict preemption is a defense to preempted state law claims, the doctrine does not normally allow for removal to federal court. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 207 (2004). On the other hand, complete preemption is a judicially recognized exception to the well-pleaded complaint rule that allows removal of claims within the scope of ERISA § 502(a) to federal court. *Davila* 542 U.S. at 209; *Marin General Hosp. v. Modesto & Empire Traction Co*., 581 F.3d 941, 945 (9th Cir. 2009).

In *Davila*, the Supreme Court established a two-pronged test to determine whether a state law claim is completely preempted by ERISA. *Davila*, 542 U.S. at 210. Complete preemption exists only when (1) a plaintiff "could have brought his claim under ERISA § 502(a)(1)(b)," and (2) "there is no other independent legal duty that is implicated by a defendant's actions." *Id.* at 210. The test is conjunctive; a claim is completely preempted only if both prongs are satisfied. *Marin*, 581 F.3d at 947.

Under prong 1 of the *Davila* test, the Ninth Circuit has distinguished between claims involving the "right to payment" and claims involving the proper "amount of payment." *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Grp., Inc*., 187 F.3d 1045, 1051 (9th Cir. 1999). Claims involving the "right to payment" generally fall within the scope of § 502(a)(1)(b), while claims involving the "amount of payment" generally fall outside the scope of § 502(a)(1)(b). *Id.*

Although *Blue Cross* preceded *Davila*, the Ninth Circuit has expressly found that its analysis and holding are consistent with the *Davila* framework and remain good law. *Marin*, 581 F.3d at 948.

Here, plaintiffs allege claims disputing the amount of payment from United. (ECF No. 40). They do not contend they are owed an additional amount from the patients' ERISA plans. *See id.* Instead, they allege these claims arise from their alleged implied-in-fact contract with United. *Id.*

United attempts to distinguish the implied-in-fact contract from other types of contracts referenced in the case law. (ECF No. 64). However, Nevada courts have found that implied-in-fact agreements and express agreements have the same legal effects. *See Magnum Opes Constr. v. Sanpete Steel Corp.*, 2013 WL 7158997 (Nev. 2013); *Certified Fire Prot. Inc. v. Precision Constr.*, 283 P. 3d 250, 256 (Nev. 2012).

Consequently, the court finds that plaintiffs' claims fall outside the scope of § 502(a) of ERISA, failing prong 1 of the *Davila* test. No further analysis under *Davila* is necessary. Plaintiffs' motion to remand is granted.

Additionally, while plaintiffs correctly indicate that 28 U.S.C § 1447(c) allows the court to impose attorney's fees and costs on a party who improperly removes a case to federal court, "Congress has unambiguously left the award of fees to the discretion of the district court." *Gotro v. R & B Realty Group*, 69 F.3d 1485, 1487 (9th Cir. 1995) (*citing Moore v. Permanente Medical Group*, 981 F.2d 443, 446 (9th Cir. 1992). There was a reasonable dispute concerning whether the complete preemption exception under ERISA § 502 applied to the claims. Therefore, the court declines to award attorney's fees to the plaintiffs.

. . .

. . .

IV. Conclusion

Accordingly,

IT IS HEREBY ORDERED, ADJUDGED, and DECREED that plaintiffs' amended motion to remand (ECF No. 49) be, and the same hereby is, GRANTED.

IT IS FURTHER ORDERED that the matter of *Fremont Emergency Services (Mandavia), Ltd. v. United Healthcare Insurance Company et al.*, case number 2:19-cv-00832-JCM-VCF, be, and the same hereby is, REMANDED to the Eighth Judicial District Court.

The clerk shall close the case accordingly.

DATED February 20, 2020.

James C. Mahan

UNITED STATES DISTRICT JUDGE

EXHIBIT B

EXHIBIT B

ELECTRONICALLY SERVED
6/24/2020 2:45 PM

Electronically Filed
06/24/2020 2:45 PM
CLERK OF THE COURT

ODM
Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs

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 **ORDER DENYING DEFENDANTS' (1) MOTION TO DISMISS FIRST AMENDED COMPLAINT; AND (2) SUPPLEMENTAL BRIEF IN SUPPORT OF THEIR MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT ADDRESSING PLAINTIFFS' EIGHTH CLAIM FOR RELIEF**

This matter came before the Court on June 5 and 9, 2020 on the (1) Motion to Dismiss Plaintiffs' First Amended Complaint ("Motion"); and (2) Supplemental Brief in Support of

Motion To Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim For Relief ("Supplement") filed by defendants UnitedHealth Group, Inc., UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Oxford Health Plans, Inc. (the foregoing United entities are referred to as the "UH Parties"); Sierra Health and Life Insurance Co., Inc.; Sierra Health-Care Options, Inc.; and Health Plan of Nevada, Inc. (Sierra Health, Sierra Health-Care and Health Plan of Nevada are referred to as the "Sierra Affiliates") (UH Parties and Sierra Affiliates are collectively referred to as "United"). Pat Lundvall, Amanda M. Perach and Kristen T. Gallagher, McDonald Carano LLP, appeared on behalf of 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"). D. Lee Roberts, Jr. and Colby L. Balkenbush, Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC, appeared on behalf of United.

The Court, having considered the Motion and Supplement, the Health Care Providers' opposition to the Motion and Supplement and United's replies thereto, and the argument of counsel at the hearings on this matter, makes the following findings of fact, conclusions of law and Order:

FINDINGS OF FACT RELEVANT TO THE COURT'S DECISION

Procedural History

1. On April 15, 2019, Fremont filed the original Complaint against UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Oxford Health Plans, Inc.; Sierra Health and Life Insurance Co., Inc.; Sierra Health-Care Options, Inc.; and Health Plan of Nevada, Inc. (collectively, "Removing Defendants") and asserted claims for breach of implied-in-fact contract, breach of implied-in-fact contract, tortious breach of the implied covenant of good faith and fair dealing, unjust enrichment, violation of NRS 686A.020 and 686A.310, violations of Nevada Prompt Pay statutes and regulations, violations of Nevada Consumer Fraud & Deceptive Trade Practices Acts, and declaratory judgment. *See generally* Compl.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

2. As the Health Care Providers allege, all of these legal claims are based on United's underpayment of claims which it had determined were payable and paid, *i.e.*, a dispute over the proper rates of payment rather than the right to payment. Compl. ¶ 27.

3. On May 14, 2019, the Removing Defendants filed a Notice of Removal with this Court, contending that the state law claims asserted are completely preempted by Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1132(a)(1)(B). *See* Notice of Removal.

4. In the removed action in the United States District Court, District of Nevada (the "Federal District Court"), Case No. 2:19-cv-00832-JCM-VCF, on May 21, 2019, the Removing Defendants filed a Motion to Dismiss arguing, *inter alia*, that each of Fremont's claims are preempted by complete preemption and conflict preemption and that even if such claims are not preempted, they fail as a matter of law.

5. On May 24, 2019, Fremont filed a Motion to Remand (ECF No. 5) on the basis that this case, which only involves questions of the proper rate of payment, and not the right to payment, is not completely preempted by ERISA.

6. With the Federal District Court's permission, the Health Care Providers filed their First Amended Complaint (the "FAC") on January 7, 2020. The FAC added plaintiffs Team Physicians and Ruby Crest, defendant UnitedHealth Group, Inc. and a claim for violation of NRS 207.350 *et seq.* ("NV RICO")

7. Given the procedural posture of the action, the Federal District Court directed the Health Care Providers to file an amended motion to remand, which they did on January 18, 2020 (ECF No. 49).

8. After completed briefing, the Federal District Court granted the Amended Motion to Remand, expressly rejecting United's argument that the Health Care Providers' claims were completely preempted by ERISA, the same arguments that United reasserts in the Motion to Dismiss pending before the Court. The Federal District Court recognized the Ninth Circuit has distinguished between claims involving the "right to payment" and claims involving the "proper "amount of payment." *Marin General Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941,

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

948 (9th Cir. 2009); *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1051 (9th Cir. 1999). The Federal District Court found that the Health Care Providers' claims fall outside the scope of Section 502(a) of ERISA, failing the first prong of the test articulated by *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004) because they:

> [D]o not contend they are owed an additional amount from the patients' ERISA plans." Instead, they allege these claims arise from their alleged implied-in-fact contract with United.
>
> United attempts to distinguish the implied-in-fact contract from other types of contracts referenced in the case law. (ECF No. 64). However, Nevada courts have found that implied-in-fact agreements and express agreements have the same legal effects. *See Magnum Opes Constr. v. Sanpete Steel Corp.*, 2013 WL 7158997 (Nev. 2013); *Certified Fire Prot. Inc. v. Precision Constr.*, 283 P. 3d 250, 256 (Nev. 2012). Consequently, the court finds that plaintiffs' claims fall outside the scope of § 502(a) of ERISA, failing prong 1 of the Davila test.

See Notice of Entry of Remand Order, Remand Order at 5:4-13.

9. After remand and pursuant to a May 15, 2020 Order, the Health Care Providers filed the FAC in this state court action.

10. United filed the Motion and Supplement addressing the Health Care Providers' claim for violation of NRS 207.350 *et seq.* (eighth claim for relief). The Health Care Providers filed oppositions to the Motion and Supplement.

11. The Court heard oral argument on June 5 and 9, 2020 and issued its ruling at the conclusion of the June 9, 2020 hearing, directing the Health Care Providers' counsel to submit an order consistent with its oral ruling as well as consistent with the Health Care Providers' Oppositions to the Motion and Supplement.

Relevant Allegations Concerning the Relationship Between the Parties and the Dispute

12. The Health Care Providers are professional emergency medicine service groups that staff the emergency departments at ten hospitals and other facilities throughout Nevada. FAC ¶¶ 3-5.

13. Defendants ("United") are large health insurance companies and claims administrators. FAC ¶¶ 6-13. United provides healthcare benefits to its members ("United's Members"), including coverage for emergency care. FAC ¶¶ 19, 33.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

14. The Health Care Providers and the hospitals whose emergency departments they staff are obligated by both federal and Nevada law and medical ethics to render emergency services and care to all patients who present in the emergency department, regardless of an individual's insurance coverage or ability to pay. FAC ¶ 18; *see also* Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd; NRS 439B.410.

15. The Health Care Providers have submitted claims to United seeking reimbursement for this emergency care. FAC ¶¶ 25-26, 40. United, in turn, has paid the Health Care Providers. *Id*.

16. As the Health Care Providers allege, this longstanding and historical practice establishes the basis for an implied-in-fact contract, as well as the usual and customary (or reasonable) rates of reimbursement for the emergency services. FAC ¶¶ 54, 189-206, 216-226.

17. The Health Care Providers allege that, thereafter, United continued to pay the Health Care Providers' claims for emergency services, but arbitrarily and drastically reduced the rates of reimbursement to levels below the billed charges and usual and customary rates. FAC ¶ 55.

18. United is responsible for administering and/or paying for certain emergency medical services provided by Fremont which are at issue in the litigation. FAC ¶¶ 6-13. United provides, either directly or through arrangements with providers such as hospitals and Fremont, healthcare benefits to its members. FAC ¶ 19.

19. The Health Care Providers allege that United arbitrarily began manipulating the rate of payment for claims submitted by the Health Care Providers. United drastically reduced the rates at which they paid the Health Care Providers for emergency services for some claims, but not others. FAC ¶ 57.

20. For each of the healthcare claims at issue in this litigation, United has already determined that each claim is payable; however, it paid the claim at an artificially reduced rate. *Id*. at ¶ 27.

…

…

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

21. The Health Care Providers allege that there is no open question of whether the claim should be covered under a health plan or whether it is payable – United already answered those questions affirmatively when it paid the claims.

22. Rather, the Court finds that, as the Health Care Providers allege, the questions to be answered in this case are whether United paid the claim at rates that complied with applicable state law as set forth in the Health Care Providers' claims.

23. The Health Care Providers also allege a Nevada state law claim for civil racketeering ("NV RICO") against United because they have been financially harmed by an orchestrated scheme crafted and implemented by an Enterprise consisting of United and third parties including National Care Network, LLC dba Data iSight ("Data iSight") to artificially and fraudulently reduce payment rates and manipulate the related benchmark pricing data to "support" United's position.

24. In support of the NV RICO claim, the Health Care Providers allege, among other facts, as follows:

a. 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. FAC ¶ 91.

b. 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. FAC ¶ 92.

c. 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. FAC ¶ 93.

d. Defendants then proposed a contractual rate for their employer funded plans that was roughly half the average reasonable rate at which Defendants have historically

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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. FAC ¶ 94.

e. Defendants' proposed rate was neither reasonable nor fair. FAC ¶ 95.

f. 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%. FAC ¶ 96.

g. 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%. FAC ¶ 97.

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

i. 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. FAC ¶ 99.

j. 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. FAC ¶ 100.

k. 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

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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. FAC ¶ 101.

l. 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. FAC ¶ 102.

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

n. 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. FAC ¶ 104.

o. 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. FAC ¶ 105.

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

q. 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. FAC ¶ 107.

r. 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

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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. FAC ¶ 108.

s. 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. FAC ¶ 109.

25. The Health Care Providers allege that United's and Data iSight's scheme has been in development and implementation over the last several years (FAC ¶¶ 90-109) and that United and Data iSight concealed the scheme (*id.* ¶¶ 123-131). As claims were processed and Data iSight increasingly emerged as a new entity providing supposed benchmark pricing, the Health Care Providers' representatives became aware of reductions in payments and began uncovering the scheme. *Id.* ¶¶ 132-141; ¶¶ 104-105, 109 (recounting communications from United in July 2019 regarding the plan to drastically cut payment rates with no objective basis); ¶ 108 (August 2019 threats and intended leverage aimed at intentionally interfering with existing contracts); ¶ 136 (July 2019 communications with Data iSight).

26. The Health Care Providers allege that this scheme is not new: United was previously caught manipulating and skewing payment rates for out-of-network providers. *Id.* ¶ 70.

27. The Health Care Providers further allege:

a. 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. FAC ¶ 71.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

b. 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. FAC ¶ 72.

c. 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. FAC ¶ 73.

d. 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." FAC ¶ 74.

e. 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.). FAC ¶ 75.

f. 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. FAC ¶ 76.

g. 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. FAC ¶ 77.

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

i. 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 Health Group affiliate will "in many cases" pay the lower of a provider's actual billed charge or "the reasonable and customary amount," "the

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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. FAC ¶ 79.

28. Based on the foregoing and a review of all of the allegations in the FAC, the Court finds that each of the Health Care Providers' causes of action contain sufficient factual allegations to meet the applicable pleading standard and an actionable claim exists in every instance. Taking the FAC as true, which is required under a NRCP 12(b)(5) motion, the Court finds that relief could be granted in favor of the Health Care Providers if, in fact, the proof and determination at trial is made.

29. Any of the foregoing factual statements that are more properly considered conclusions of law should be deemed so. Any of the following conclusions of law that are more properly considered factual statements should be deemed so.

CONCLUSIONS OF LAW

ERISA Preemption

ERISA Overview

30. ERISA was passed by Congress in 1974 primarily to address "mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds. *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 946 (2016); *Skillin v. Rady Children's Hosp.-San Diego*, 226 Cal. Rptr. 3d 505, 509 (Ct. App. 2017).

31. "The comprehensive and reticulated statute, contains elaborate provisions for the regulation of employee benefit plans." *Skillin*, 226 Cal. Rptr. 3d 505, 509. It sets forth reporting and disclosure obligations for plans, imposes a fiduciary standard of care for plan administrators, and establishes schedules for the vesting and accrual of pension benefits." *Massachusetts v. Morash*, 490 U.S. 107, 112–113, 109 S. Ct. 1668 (1989).

32. "ERISA does not guarantee substantive benefits. The statute, instead, seeks to make the benefits promised by an employer more secure by mandating certain oversight systems and other standard procedures." *Gobeille*, 136 S.Ct. at 943.

…

…

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

33. ERISA is "one of only a few federal statutes under which two types of preemption may arise: conflict preemption and complete preemption." *Conn. State Dental Ass'n v. Anthem Health Plans, Inc*., 591 F.3d 1337, 1343 (11th Cir. 2009).

34. These two forms of preemption are doctrinally distinct. *Cleghorn v. Blue Shield of Cal.*, 408 F.3d 1222, 1225 (9th Cir. 2005) (these "two strands to ERISA's powerful preemptive force, differ in their purpose and function.") (internal quotations omitted).

Complete Preemption

1. Separately, ERISA completely preempts state law only to the extent that the state law "duplicates, supplements, or supplants the ERISA civil enforcement remedy." *Davila*, 542 U.S. at 209. Section 502 (codified at 29 U.S.C. § 1132) sets forth "a comprehensive scheme of civil remedies to enforce ERISA's provisions." *Rudel v. Hawai'i Mgmt. All. Ass'n*, 937 F.3d 1262, 1269-70 (9th Cir. 2019), cert. denied sub nom. *HI Mgmt. All. Assoc. v. Rudel*, 19-752, 2020 WL 871750 (U.S. Feb. 24, 2020).

2. Section 502's purpose is to ensure that federal courts remain the only forum and vehicle for adjudicating claims for benefits under ERISA. *Marin Gen. Hosp.*, 581 F.3d at 945.

3. Complete preemption is a jurisdictional doctrine and cannot be used to obtain dismissal of a state law claim on a Rule 12(b)(5) motion to dismiss. *Owayawa v. Am. United Life Ins. Co.*, CV 17-5018-JLV, 2018 WL 1175106, at *3 (D.S.D. Mar. 5, 2018) ("[A]lthough complete preemption...can be used to invoke federal question jurisdiction, Defendants cannot use [the doctrine] as a ground for dismissing Plaintiffs' claims under Federal Rule of Civil Procedure 12(b)(6)."); *Summit Estate, Inc. v. Cigna Healthcare of Cal., Inc.*, Case No. 17-CV-03871, 2017 WL 4517111, at *13 (N.D. Cal. Oct. 10, 2017) (complete preemption under § 1132(a) is "really a jurisdictional rather than a preemption doctrine….[and was] created...as a basis for federal question removal jurisdiction under 28 U.S.C. § 1441(a)."); *Marin Gen. Hosp.*, 581 F.3d at 945 (complete preemption under ERISA is not a ***defense*** to a state law claim); *Mid-Town Surgical Ctr., L.L.P. v. Humana Health Plan of Tex., Inc.*, 16 F. Supp. 3d 767, 779 (S.D. Tex. 2014) ("complete preemption ***is not grounds for dismissal***, but instead a mechanism to confer federal jurisdiction on a state-law claim that is in fact an ERISA claim."); *Autonation,*

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

Inc. v. United Healthcare Ins. Co., 423 F.Supp.2d 1265, 1268 (S.D. Fla. 2006) (complete preemption is a jurisdictional doctrine which converts state law claims into federal claims for purposes of removal, but does not dismiss claims).

4. The Court concludes that complete preemption is not a defense to a state law claim; therefore, it cannot serve as the foundation of an argument in a Rule 12(b)(5) motion to dismiss.

5. Binding Ninth Circuit precedent makes clear that disputes concerning rates of payment do not fall within ERISA's scope and are not subject to complete preemption. *Marin Gen. Hosp.,* 581 F.3d at 948 (9th Cir. 2009); *see also California Spine & Neurosurgery Inst. v. Boston Scientific Corp.*, No. 18-CV-07610-LHK, 2019 WL 1974901, at *3 ("Under Ninth Circuit law, ERISA does not preempt claims by a third party [medical provider] who sues an ERISA plan not as an assignee of a purported ERISA beneficiary, but as an independent entity claiming damages.").

6. The Court concludes that this dispute is one concerning rates of payment (*see, e.g.,* FAC ¶¶ 43, 265); therefore, none of the claims asserted in the FAC fall within ERISA's scope and the claims are not subject to complete preemption.

7. The Court further considered the two-part test set forth in *Davila*, 542 U.S. at 210- 211, and concluded that neither prong is met.

8. *Davila* provides complete preemption applies only where: (1) a plaintiff "could have brought his claim under ERISA § 502(a)(1)(B)," and (2) "no other independent legal duty . . . is implicated by a defendant's actions." *Id.* at 210. The test is conjunctive; a claim is completely preempted only if both prongs are satisfied. *McCulloch Orthopaedic Surgical Servs., PLLC v. Aetna Inc.*, 857 F.3d 141, 146 (2d Cir. 2017).

9. Regarding the first *Davila* prong, the Court concludes that the Health Care Providers' claims challenge the ***rates*** of reimbursement paid for covered healthcare services, rather than the right to reimbursement for such services, therefore they do not fall within the scope of § 502(a)(1)(B). FAC ¶¶ 1, 26; 1 n.1 ("The Health Care Providers also do not assert any claims…with respect to the right to payment under any ERISA plan."); *Conn. State Dental*

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

Ass'n., 591 F.3d at 1349-50; *Lone Star OB/GYN Associates v. Aetna Health Inc.*, 579 F.3d 525, 531 (5th Cir. 2009); *Montefiore*, 642 F.3d at 325; *CardioNet Inc. v. Cigna Health Corp.*, 751 F.3d 165, 177-78 (3d Cir. 2014); *Blue Cross of Cal.*, 187 F.3d at 1051 (affirming remand of health care providers' state law claim for breach of contract because the dispute was "not over the right to payment, which might be said to depend on the patients' assignments to the Providers, but the amount, or level, of payment, which depends on the terms of the provider agreements."); s*ee also Garber v. United Healthcare Corp.*, 2016 WL 1734089, at *3-5 (E.D.N.Y. May 2, 2016); *Long Island Thoracic Surgery, P.C. v. Building Serv. 32BJ Health Fund*, 2019 WL 5060495, at *2 (E.D.N.Y. Oct. 9, 2019); *Premier Inpatient Partners LLC v. Aetna Health & Life Ins. Co.*, 371 F. Supp. 3d 1056, 1068-74 (M.D. Fla. 2019); *Gulf-to-Bay Anesthesiology Assocs. v. UnitedHealthCare of Fla., Inc.*, 2018 WL 3640405, at *3 (M.D. Fla. July 20, 2018); *Hialeah Anesthesia Specialists, LLC v. Coventry Health Care of Fla., Inc.*, 258 F. Supp. 3d 1323, 1327-30 (S.D. Fla. 2017); *N. Jersey Brain & Spine Ctr. v. MultiPlan, Inc.*, 2018 WL 6592956, at *7 (D.N.J. Dec. 14, 2018); *E. Coast Advanced Plastic Surgery v. AmeriHealth*, 2018 WL 1226104, at *3 (D.N.J. Mar. 9, 2018).

10. The second *Davila* prong looks to whether an independent legal duty is implicated by the defendant's actions. 542 U.S. at 210. "If there is some other independent legal duty beyond that imposed by an ERISA plan, a claim based on that duty is not completely preempted . . . ." *Marin*, 581 F.3d at 949. "A legal duty is independent if it is not based on an obligation under an ERISA plan, or it would exist whether or not an ERISA plan existed." *N.J. Carpenters and the Trs. Thereof v. Tishman Constr. Corp. of N.J.*, 760 F.3d 297, 303 (3d Cir. 2014).

11. Claims predicated upon duties imposed by state common and statutory law do not satisfy *Davila's* second prong. *See, e.g., McCulloch*, 857 F.3d at 150 (second *Davila* prong unsatisfied because "[plaintiff's] promissory-estoppel claim against Aetna arises not from an alleged violation of some right contained in the plan, but rather from a freestanding state-law duty grounded in conceptions of equity and fairness."); *Wurtz v. Rawlings Co., LLC*, 761 F.3d 232, 243 (2d Cir. 2014) ("[W]hile defendants' reimbursement claims relate to plaintiffs' plans, this is not the test for complete preemption. Plaintiffs' claims do not derive from their plans or require

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

investigation into the terms of their plans; rather, they derive from [a state statute]."); *Bay Area Surgical*, 2012 WL 3235999, at *4 (second *Davila* prong unsatisfied because plaintiff alleging claim under an oral agreement "is suing on its own right pursuant to an independent obligation, and its claims would exist regardless of an ERISA plan."); *Christ Hosp. v. Local 1102 Health and Benefit Fund*, 2011 WL 5042062, at *4 (D.N.J. Oct. 24, 2011) (second *Davila* prong unsatisfied where claims "depend[ed] on the operation of a third-party contract" between plaintiff medical provider and defendant ERISA plan, rather than on the terms of the ERISA plan).

12. The Court concludes that the Health Care Providers' claims are founded on independent legal duties beyond that imposed by an ERISA plan, therefore the claims do not satisfy *Davila's* second prong.

13. Further, the Court finds the Federal District Court's Order granting the Health Care Providers' Amended Motion to Remand to be persuasive. There, in accord with the overwhelming weight of legal authority, the Federal District Court concluded that a third-party medical provider's challenge to the rate of payment afforded by an ERISA plan on indisputably covered claims for reimbursement is not completely preempted.

14. The Court does not find merit in United's argument that the claims asserted in the FAC are preempted because an implied-in-fact agreement is different than a written, oral or quasi contract. In Nevada, implied-in-fact agreements and express agreements stand on equal footing. *See Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 379, 283 P.3d 250, 256 (2012) (an implied-in-fact contract "is a true contract that arises from the tacit agreement of the parties."); *Smith v. Recrion Corp.*, 91 Nev. 666, 668, 541 P.2d 663, 665 (1975) ("Both express and implied contracts are founded on an ascertained agreement."); *Magnum Opes Const. v. Sanpete Steel Corp.*, 2013 WL 7158997 (Nev. Nov. 1, 2013) (quoting 1 Williston on Contracts § 1:5 (4th ed. 2007) (noting that the legal effects of express and implied-in-fact contracts are identical); *Cashill v. Second Judicial Dist. Court of State ex rel. Cty. of Washoe*, 128 Nev. 887, 381 P.3d 600 (2012) (unpublished) ("The distinction between express and implied in fact contracts relates only to the manifestation of assent; both types are based upon the expressed or apparent intention of the parties."). As a result, the Court concludes that implied-in-fact

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

agreements are treated the same as written, oral and quasi contracts in Nevada and, consequently, the caselaw rejecting ERISA preemption for claims arising out of such contracts equally applies to implied-in-fact agreements.

15. The Court does not find *Pilot Life Ins. v. Dedeaux,* 481 U.S. 41, 57, 107 S. Ct. 1549, 1558 (1987), a case cited by United, to be analogous or persuasive in light of the FAC's allegations.

16. The Court also does not find merit in United's argument that the state law claims threaten to disrupt nationally uniform plan administration by "seeking to use state law claims to force the plans to pay more." Motion at 3:22-23. Other courts have similarly rejected United's argument, finding that "state law claims brought by health care providers against plan insurers too tenuously affect ERISA plans to be preempted." *Lordmann Enters., Inc. v. Equicor, Inc.*, 32 F.3d 1529, 1533 (11th Cir. 1994); *Glastein v. Aetna, Inc.*, 2018 WL 4562467, at *3 n.4 (D.N.J. Sept. 24, 2018) (collecting cases); *Rocky Mountain Holdings LLC v. Blue Cross and Blue Shield of Fla., Inc.*, 2008 WL 3833236, at *5 (M.D. Fla. Aug. 13, 2008) (collecting cases); *Med. & Chirurgical Facility of the State of Md. v. Aetna U.S. Healthcare, Inc.*, 221 F. Supp. 2d 618, 619-20 (D. Md. 2002) (collecting cases).

17. Despite a heading in the Supplement that suggests the Court can dismiss the Health Care Provider's NV RICO claim on complete preemption grounds, United does not cite to any case that discusses or holds that ERISA's Section 502 (complete preemption) preempts a state civil racketeering claim. Thus, the Court finds no merit in United's argument.

18. To the extent any of United's other arguments specific to its Motion and Supplement regarding complete preemption are not specifically addressed herein, the Court considered all of the defenses raised in the Motion and Supplement, as well as all arguments made during oral argument, and the Court does not find merit to any of them.

Conflict Preemption

19. Section 514 (codified at 29 U.S.C. § 1144) contains ERISA's conflict preemption provision. It expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan[.]" 29 U.S.C. § 1144(a).

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

20. However, § 514 saves from preemption "any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A). The saving clause functions to preserve a state's traditional regulatory power over insurance, banking, and securities. *Rudel*, 937 F.3d at 1269-70; *Gobeille*, 136 S. Ct. at 943.

21. Section 514, however, does not confer federal jurisdiction. *Marin Gen. Hosp.*, 581 F.3d at 945.

22. In addressing conflict preemption under ERISA, the "starting presumption" is that "Congress does not intend to supplant state law," and "'that the historic police powers of the States were not to be superseded by [ERISA] unless that was the clear and manifest purpose of Congress.'" *Viad Corp v. MoneyGram Int'l, Inc.*, No. 1 CA-CV 15-0053, 2016 WL 6436827, at *2 (Ariz. Ct. App. Nov. 1, 2016), as amended (May 3, 2017) (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*, 514 U.S. 645, 654-55 (1995)).

23. The proper analysis under Section 514(a) starts with a presumption that ERISA does not supplant state law claims.

24. A common law claim "relates to" an employee benefit plan governed by ERISA "if it has a connection with or reference to such a plan." *Providence Health Plan v. McDowell*, 385 F.3d 1168, 1172 (9th Cir. 2004); *see also Blue Cross of Cal.*, 187 F.3d at 1052 (9th Cir. 1999).

25. The Supreme Court has limited the parameters of § 514(a) preemption to two categories of state laws. *Gobeille*, 136 S.Ct. at 943. Those categories are: (1) laws "with a reference to ERISA plans," which include laws which "act[ ] immediately and exclusively upon ERISA plans . . .or where the existence of ERISA plans is essential to the law's operation," and (2) laws with "an impermissible connection with ERISA plans, meaning a state law that governs a central matter of plan administration or interferes with nationally uniform plan administration." *Id.*

26. The Ninth Circuit has made it clear that § 514(a) does not apply to claims brought by third-party healthcare providers, like the Health Care Providers here. *Morris B. Silver M.D., Inc. v. Int'l Longshore & Warehouse etc.*, 2 Cal. App. 5th 793, 799, 206 Cal. Rptr. 3d 461, 466

(Ct. App. 2016); *Providence Health Plan*, 385 F.3d at 1172; *Abraham v. Norcal Waste Sys., Inc.*, 265 F.3d 811, 820–21 (9th Cir.2001); *Blue Cross of Cal.*, 187 F.3d at 1052–53; *see also The Meadows v. Employers Health Ins.*, 47 F.3d 1006, 1008 (9th Cir. 1995) (stating that § 1144(a) does not preempt "claims by a third-party who sues an ERISA plan not as an assignee of a purported ERISA beneficiary, but as an independent entity claiming damages").

27. Other jurisdictions have also made it clear that § 514(a) claims by third-party providers arising out of analogous circumstances to those asserted by Health Care Providers here, are not preempted. *See, e.g., Memorial Hosp. System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 243–246 (5th Cir. 1990) (holding hospital's claim for deceptive and unfair practices arising from representations regarding coverage not preempted and articulating two-factor test); *see also Access Mediquip LLC v. UnitedHealthcare Ins. Co.*, 662 F.3d 376, 385 (5th Cir. 2011) ("The state law underlying Access's misrepresentation claims does not purport to regulate what benefits United provides to the beneficiaries of its ERISA plans, but rather what representations it makes to third parties about the extent to which it will pay for their services."); *Depot, Inc. v. Caring for Montanans, Inc.*, 915 F.3d 643, 667 (9th Cir. 2019), *cert. denied*, 140 S. Ct. 223 (2019) ("State-law claims are based on other independent legal duties when they are in no way based on an obligation under an ERISA plan and would exist whether or not an ERISA plan existed.") (citing *Marin Gen. Hosp.*, 581 F.3d at 950) (internal alteration omitted).

28. The Court agrees with the foregoing legal authority that the relationship between the parties – i.e. provider/insurer –is not a relationship that is intended to be governed by Section 514(a). As a result, the Court concludes that none of the Health Care Providers' claims set forth in the FAC are subject to conflict preemption.

29. The Court further finds that the Health Care Providers' state-law claims do not fall within either of the *Gobeille* categories because the Health Care Providers allege that they have an implied-in-fact contract with United, which obligates United, under Nevada law, to pay the Health Care Providers reasonable compensation (FAC ¶¶ 189-206), and that, alternatively, Nevada law of unjust enrichment obligates United to pay the Health Care Providers the reasonable value for their services. *Id.* ¶¶ 216-226.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

30. Under controlling Supreme Court precedent, ERISA preempts only those state laws "with a reference to" or "impermissible connection with" ERISA plans. The Health Care Providers' common law and statutory claims fall into neither category.

31. The Health Care Providers' state law claims are not subject to conflict preemption because they neither seek recovery under an ERISA plan, require examination of an ERISA plan, nor implicate any discernible goal of ERISA. Because the Health Care Providers are pursuing the instant lawsuit in their own capacity and not as assignees, the Health Care Providers' claims are not preempted. The Court or jury will not need to reference any ERISA plan to resolve the question of at what rate Nevada law requires United to reimburse the Health Care Providers for the services in question.

32. Therefore, the Court concludes that the Health Care Providers have not pled claims for ERISA benefits. *See Blue Cross of California Inc. v. Insys Therapeutics Inc.*, 390 F. Supp. 3d 996, 1004 (D. Ariz. 2019) (holding that state-law claims for common law fraud, misrepresentation, negligent misrepresentation, unjust enrichment, civil conspiracy, tortious interference with contract, and statutory claims for unfair and deceptive competition and practices were not subject to conflict preemption); *Spinedex v. Physical Therapy, U.S.A., Inc. v. Arizona*, No. 04-CV-1576-PHX-JAT, 2005 WL 3821387, at *8 (D. Ariz. Nov. 9, 2005); *Almont Ambulatory Surgery Center, LLC v. UnitedHealth Grp., Inc.*, 121 F. Supp. 3d 950, 962-71 (C.D. Cal. 2015); *Scripps Health v. Schaller Anderson, LLC*, No. 12-CV-252-AJB(DHB), 2012 WL 2390760, at *2-*6 (S.D. Cal. Jun. 22, 2012); *Ass'n of N.J. Chiropractors v. Aetna, Inc.*, No. CIV.A. 09-3761 JAP, 2012 WL 1638166, at *5-7 (D.N.J. May 8, 2012); *United Healthcare Servs., Inc. v. Sanctuary Surgical Ctr., Inc.*, 5 F. Supp. 3d 1350, 1363 (S.D. Fla. 2014)); *Aetna Life Ins. Co. v. Huntingdon Valley Surgery Ctr.*, 2015 WL 1954287, at *10 (E.D. Pa. Apr. 30, 2015) (holding that the out-of-network provider claims for unjust enrichment and breach of contract were not preempted by ERISA because the plaintiff's state law claims were independent of the ERISA beneficiaries' rights under any ERISA plan); *Jewish Lifeline Network, Inc. v. Oxford Health Plans (NJ), Inc.*, 2015 WL 2371635, at *3 (D.N.J. May 18, 2015) (ERISA

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

preemption "does not foreclose a plaintiff from pleading a state law claim based on a legal duty that is independent from ERISA or an ERISA-governed plan").

33. The United States Supreme Court and more recent Ninth Circuit cases have declined to adopt a literal interpretation of the "relates to" language. In *New York State Conference of Blue Cross & Blue Shield Plans*, 514 U.S. at 654, 115 S. Ct. at 1671, the court clarified that the "starting presumption" is that Congress does not intend to supplant state law. *See also Bertoni v. Stock Bldg. Supply*, 989 So. 2d 670, 674–75 (Fla. Dist. Ct. App. 2008). It went on to describe the "relates to" language of the preemption statute as "unhelpful," and instructed that one is instead to look "to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* at 656, 115 S.Ct. 1671. The *Travelers* court noted that in light of the objectives of ERISA and its preemption clause, Congress intended to preempt "state laws providing alternative enforcement mechanisms" for employees to obtain ERISA plan benefits. *Id.* at 658, 115 S.Ct. 1671; *see also Egelhoff v. Egelhoff ex rel. Breiner*, 121 S. Ct. 1322, 1327 (2001) ("But at the same time, we have recognized that the term "relate to" cannot be taken "to extend to the furthest stretch of its indeterminacy," or else "for all practical purposes pre-emption would never run its course).

34. In the face of this controlling law, United relies on outdated and a now-rejected overbroad interpretations of Section 514(a). *See Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1439 (9th Cir. 1990). United argues that the "relates to" language in the preemption provision of Section 514 (a) is one of the "broadest preemption clauses ever enacted by Congress." However, the Court does not find merit in United's argument and therefore rejects the argument.

35. The Court also finds that United relies on legal authority that is inapplicable to a conflict preemption analysis because it addresses complete preemption under Section 502(a) of ERISA. The cases cited by United involved claims expressly seeking ERISA benefits and/or brought directly by plan members rather than third-party medical providers. *See e.g. Aetna Life Ins. Co. v. Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000), as amended on denial of reh'g and reh'g en banc (Nov. 3, 2000) (employee plan member's counterclaims directly against plan administrator conflict preempted); *Blau v. Del Monte Corp.*, 748 F.2d 1348 (9th Cir. 1984)

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

(nonunion salaried employees brought suit against employer for benefits under employee welfare plan); *Parlanti v. MGM Mirage*, No. 2:05-CV-1259-ECR-RJJ, 2006 WL 8442532, at *1 (D. Nev. Feb. 15, 2006) (plaintiff directly sued former employer over supplemental executive retirement plan).

36. The Court does not find merit in United's argument that the Health Care Providers' claims expressly depend on the existence of the employee welfare benefit plans and the administration of claims for benefits submitted under those plans. This argument has been rejected by other courts and the Court agrees with the Health Care Providers that this is not the test for conflict preemption. *See In re Managed Care Litig.*, 2011 WL 1595153, at *5 (S.D. Fla. Mar. 31, 2011).

37. The Court also considered and does not find merit to United's attempt to distinguish self-funded plans from other employee-sponsored plans. Self-funded ERISA plans are only shielded from state laws (insurance or otherwise) that "*relate to*" ERISA. *See FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) ("[S]elf-funded ERISA plans are exempt from state regulation insofar as that regulation 'relate[s] to' the plans. State laws directed toward the [self-funded] plans are pre-empted because they relate to an employee benefit plan but are not 'saved' because they do not regulate insurance.") (emphasis added). The Court therefore rejects the argument raised by United.

38. The Court has also considered United's argument that the NV RICO claim is subject to complete preemption under *Moorman v. UnumProvident Corp.*, CIV.A. 104CV2075BBM, 2007 WL 4984162, at *1 (N.D. Ga. Oct. 30, 2007), but the Court does not find merit to United's position for the reasons set forth in the Health Care Providers' Opposition to the Supplement and at the related hearings.

39. Instead, the Court concludes that the FAC's allegations sufficiently detail improper conduct to manipulate and deflate reimbursement payment rates so that United can then point to that same manufactured data as justification for paying the Health Care Providers a fraction of what they are owed for the emergency medicine services provided. FAC ¶¶ 90-188, ¶¶ 261-273.

40. To the extent any of United's other arguments specific to its Motion and Supplement regarding conflict preemption are not specifically addressed herein, the Court considered all of the defenses raised in the Motion and Supplement, as well as all arguments made during oral argument, and the Court does not find merit to any of them.

NRCP 12(b)(5) Legal Standard

41. Rule 8(a)(2) of the Nevada Rules of Civil Procedure states that a complaint shall contain "a short and plain statement of the claim showing that the pleader is entitled to relief." NRCP 8(a)(2). Thus, Nevada is a notice-pleading state and a pleading is liberally construed to "place into issue matter which is fairly noticed to the adverse party." *Chavez v. Robberson Steel Co.*, 94 Nev. 597, 598, 584 P.2d 159, 160 (Nev. 1978); *Hay v. Hay*, 100 Nev. 196, 198, 678 P.2d 672, 674 (1984). In other words, so long as the "adverse party has adequate notice of the nature of the claim and relief sought," trial courts should allow a pleading to survive any challenge asking for dismissal. *Hay*, 100 Nev. at 198, 678 P.2d at 674; *see also Liston v. Las Vegas Metro. Police Dept.*, 111 Nev. 1575, 1579, 908 P.2d 720, 723 (1995).

42. When examining whether a defendant received notice of the claims against it, Nevada courts have recognized that notice is "knowledge of facts which would naturally lead a…person to make inquiry of everything which such injury pursued in good faith would disclose." *Liston*, 111 Nev. at 1579, 908 P.2d at 723. Furthermore, a plaintiff is not required to give itemized descriptions of evidence but rather "need only broadly recite the 'ultimate facts' necessary to set forth the elements of a cognizable claim that a party believes can be proven at trial." *Nutton v. Sunset Station, Inc.*, 131 Nev. 279, 290, 357 P.3d 966, 974 (Nev. App. 2015).

43. Accordingly, in considering the dismissal of a complaint pursuant to NRCP 12(b)(5), a court must "determine whether or not the challenged pleading sets forth allegations sufficient to make out the elements of a right to relief." *Bemis v. Estate of Bemis*, 114 Nev. 1021, 1021, 967 P.2d 437, 439 (1998) (citing *Edgar v. Wagner*, 101 Nev. 226, 227, 699 P.2d 110, 111 (1985)).

44. A district court is required to accept all factual allegations as true and to draw all inferences in favor of the non-moving party; dismissal is only proper where there is a complete

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

lack of a cognizable legal theory. *See Buzz Stew, LLC v. City of North Las Vegas*, 124 Nev. 224, 228-229, 181 P.3d 670, 672 (2008); *Garcia v. Prudential Ins. Co. of Am.*, 129 Nev. 15, 19, 293 P.3d 869, 871-72 (2013).

45. A complaint should only be dismissed "if it appears beyond a doubt that [the plaintiff] could prove no set of facts, which, if true, would entitle [the plaintiff] to relief." *Buzz Stew, LLC*, 124 Nev. at 228, 181 P.3d at 672.

The Health Care Providers' Claims

Breach of Implied-in-Fact Contract

46. A plaintiff states a claim for breach of contract, whether express or implied, by alleging: (1) the existence of a valid contract, (2) a breach by the defendant, and (3) damage as a result of the breach. *Saini v. Int'l Game Tech*., 434 F. Supp. 2d 913, 919-20 (D. Nev. 2006) (*citing Richardson v. Jones*, 1 Nev. 405, 405 (1865)); *Recrion Corp*., 541 P.2d at 664 (recognizing the elements of breach of express and implied contract claims are the same).

47. In an implied contract, such intent is inferred from the conduct of the parties and other relevant facts and circumstances. *Warrington v. Empey*, 95 Nev. 136, 138–139 (1979). The terms of an implied contract can also be manifested by conduct or by other customs. *Recrion Corp.*, 541 P.2d at 668; *Nevada Ass'n Servs., Inc. v. First Am. Title Ins. Co*., No. 2:11-cv-02015-KD-VCF, 2012 WL 3096706, at *3 (D. Nev. July 30, 2012) (denying motion to dismiss on breach of contract claim because the plaintiff stated "a plausible claim that, through a course of dealing involving hundreds of transactions over several years, Defendants and Plaintiff manifested an intent to be bound and agreed to material terms of an implied contract.").

48. In *Nevada Ass'n Servs., Inc*., the district court also noted that a motion to dismiss is not the proper place for such a factual evaluation of whether parties entered into an implied contract because "it necessarily requires examination of the facts and circumstance." *Id*.

49. The Health Care Providers allege an implied-in-fact agreement exists between the Health Care Providers and Defendants, specifically alleging that "there is no written agreement between Defendants and the Health Care Providers for the healthcare claims at issue in this

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

litigation; the Health Care Providers are therefore designated as a 'non-participating' or 'out-of-network' provider for all of the claims at issue." FAC ¶ 20; *see also* FAC ¶¶ 189-206.

50. Thus, the FAC adequately alleges a claim for breach of implied-in-fact contract.

51. To the extent any of United's other arguments specific to its Motion regarding the Health Care Providers' claim for breach of implied-in-fact contract are not specifically addressed herein, the Court considered all of the defenses raised in the Motion, as well as all arguments made during oral argument, and the Court does not find merit to any of them.

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

52. In Nevada, a plaintiff need only allege three elements to assert a claim for tortious breach of the implied covenant of good faith and fair dealing: (1) an enforceable contract (2) "a special relationship between the tortfeasor and the tort victim…a relationship of trust and special reliance" and (3) the conduct of the tortfeasor must go beyond the bounds of ordinary liability for breach of contract. *Martin v. Sears, Roebuck and Co.*, 111 Nev. 923, 929, 899 P.2d 551, 555 (1995).

53. The special relationship required in *Martin* is characterized by elements of public interest, adhesion, and fiduciary responsibility." *Ins. Co. of the W. v. Gibson Tile Co.,* 122 Nev. 455, 461, 134 P.3d 698, 702 (2006).

54. Moreover, a tortious breach of the covenant requires that "the party in the superior or entrusted position has engaged in grievous and perfidious misconduct." *Great Am. Ins. Co. v. Gen. Builders, Inc.,* 113 Nev. 346, 355, 934 P.2d 257, 263 (1997) (internal quotes and citations omitted).

55. The Health Care Providers have satisfied its pleading requirements under NRCP 8(a), and at this stage in litigation, the Health Care Providers have articulated a special relationship exists between United and the Health Care Providers. FAC ¶¶ 207-215.

56. The Court does not find merit to United's argument that *Aluevich v. Harrah's*, 99 Nev. 215, 218, 660 P.2d 986, 987 (1983) stands for the proposition that this claim for relief cannot apply to sophisticated parties in the commercial realm.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

57. To the extent United contends that a higher pleading standard is required for a claim of tortious breach of implied covenant of good faith and fair dealing, the Court does not find merit to that argument.

58. To the extent any of United's other arguments specific to its Motion regarding the Health Care Providers' claim for tortious breach of the implied covenant of good faith and fair dealing are not specifically addressed herein, the Court considered all of the defenses raised in the Motion, as well as all arguments made during oral argument, and the Court does not find merit to any of them.

Alternative Claim for Unjust Enrichment

59. Nevada law permits recovery for unjust enrichment where a plaintiff provides an indirect benefit to the defendant that defendant accepts without adequate compensation, as United has done here. *Topaz Mut. Co. v. Marsh*, 108 Nev. 845, 856, 839 P.2d 606, 613 (1992) (recognizing that benefit in unjust enrichment claim can be indirect).

60. The overwhelming majority of cases considering this issue conclude that where a state allows for an indirect benefit to provide the basis for an unjust enrichment claim, a claim of unjust enrichment against an insurer is actionable. *See Emergency Physicians LLC v. Arkansas Health & Wellness Health Plan, Inc*., No. 4:17-CV-00492-KGB, 2018 WL 3039517, at *5 (E.D. Ark. Jan. 31, 2018) (finding that because Texas law allows for an indirect benefit to sustain a claim for unjust enrichment, a claim for unjust enrichment based on indirect benefits received by insurer for services provided to insureds was actionable); *Bell v. Blue Cross of California*, 131 Cal. App. 4th 211, 221, 31 Cal. Rptr. 3d 688, 695–96 (2005) (emergency provider had standing to assert quantum meruit claim against payor because "he who has 'performed the duty of another by supplying a third person with necessaries…is entitled to restitution…"); *El Paso Healthcare System, Ltd. v. Molina Healthcare of New Mexico*, 683 F.Supp.2d 454, 461–462 (W.D. Tex. 2010) (insurer "receive[d] the benefit of having its obligations to its plan members, and to the state in the interests of plan members, discharged."); *Appalachian Reg'l Healthcare vs. Coventry Health & Life Ins*. Co., 2013 WL 1314154 at *4 (E.D. Ky. Mar. 28, 2013) (granting summary judgment to provider on unjust enrichment claim where plaintiff's services allowed

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

managed care organization to discharge its duty to provide coverage to Medicaid patients); *Fisher v. Blue Cross Blue Shield of Texas, Inc*., 2011 WL 11703781, at *8 (N.D. Tex. June 27, 2011) (defendant insurer received the benefit of having its obligations to its plan members discharged.); *Forest Ambulatory Surgical Associates, L.P. v. United Healthcare Ins. Co*., 2013 WL 11323600, at *10 (C.D. Cal. March 12, 2013) ("Plaintiff sufficiently stated a claim upon which relief can be granted because the allegations ... establish that Defendants received the benefit of having their obligations to the [policyholders] discharged."); *River Park Hosp., Inc. v. BlueCross BlueShield of Tennessee, Inc.*, 173 S.W.3d 43, 58-59 (Tenn. Ct. App. 2002) (MCO was unjustly enriched by hospital's emergency services provided to the insurer's enrollees); *New York City Health & Hosps. Corp. v. Wellcare of New York*, Inc., 35 Misc. 3d 250, 251, 937 N.Y.S.2d 540, 541, 546 (2011) (non-contracted hospital's unjust enrichment claim for systematic underpayment for emergency services by MCO should not be dismissed under New York law).

61. Nevada law permits an unjust enrichment claim to lie on assertions of United's receipt of a material, indirect benefit from the Health Care Providers' services. Thus, the Court concludes that the Health Care Providers sufficiently allege an alternative claim for unjust enrichment by the contention that their provision of services to United's Members allows United to discharge its duties under its contracts with its Members to cover medically necessary emergency healthcare services, thereby creating an indirect benefit to United, giving rise to an actionable claim for unjust enrichment under Nevada law. FAC ¶¶ 216-226.

62. To the extent any of United's other arguments specific to its Motion regarding the Health Care Providers' alternative claim for unjust enrichment are not specifically addressed herein, the Court considered all of the defenses raised in the Motion, as well as all arguments made during oral argument, and the Court does not find merit to any of them.

Violation of NRS 686A.020 and 686A3.10

63. Under NRS 686A.020, "[a] person shall not engage in this state in any practice which is defined in NRS 686A.010 to 686A.310, inclusive, as, or determined pursuant to NRS

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

686A.170 to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance."

64. 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).

65. The plain language of NRS 686A.310 does not prohibit a third party, such as the Health Care Providers, from raising claims under NRS 686A.310, but, instead, provides that claims may be asserted by the Commissioner and an insured. 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.").

66. As the Health Care Providers allege in Paragraphs 64, 66, 230 of the FAC, United has failed to comply with NRS 686A.310(1)(e) by failing to pay the Health Care Providers' medical professionals the usual and customary rate for emergency care provided to United's members.

67. The Health Care Providers also sufficiently allege that United has acted in bad faith regarding its obligation to pay the usual and customary fee (*see, e.g.,* FAC ¶¶ 57, 69, 233); therefore, pursuant to NRS 42.005, the Health Care Providers are entitled to maintain their claim to recover punitive damages against United associated with this claim.

68. The Court does not find merit to United's argument that *Gunny v. Allstate Ins. Co.*, 108 Nev. 344, 346, 830 P.2d 1335, 1336 (1992) stands for the proposition that Nevada's Unfair Insurance Practices Act "does not create a private right of action against insurers in favor of third party claimants like Fremont." Motion at 23:16-17. Nor is *Gunny* analogous because the Health Care Providers allege the existence of an implied-in-fact contract with United and, consequently, a claim asserted by a medical services provider under NRS 686A.020 and 686A.310 is actionable. The absence of a contract between Gunny and the insurer makes this case distinguishable.

…

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

69. To the extent any of United's other arguments specific to its Motion regarding the Health Care Providers' claim for Violation of NRS 686A.020 and 686A3.10 are not specifically addressed herein, the Court considered all of the defenses raised in the Motion, as well as all arguments made during oral argument, and the Court does not find merit to any of them.

Violations of Nevada Prompt Pay Statutes and Regulations

70. 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, United was obligated to pay the Health Care Providers the usual and customary rate within 30 days of receipt of the claim.

71. The Court concludes that the Health Care Providers adequately allege in the FAC that United has failed to reimburse the Health Care Providers at the usual and customary rate within 30 days of the submission of the claim. FAC ¶ 237. The Health Care Providers further allege that United has failed to reimburse the Health Care Providers at the usual and customary rate at all. *Id.*

72. Additionally, the Health Care Providers adequately state a claim for violation of NV Prompt Pay Laws by alleging that United has only paid part of the subject claims that have been approved and are fully payable. *Id.* ¶ 238.

73. As a result, the FAC adequately alleges that United has 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. If established, United is liable to the Health Care Providers for statutory penalties.

74. Moreover, United did not challenge the Health Care Providers' claim for violation of NV Prompt Pay Laws under NRCP 12(b)(5).

75. To the extent any of United's other arguments specific to its Motion regarding the Health Care Providers' claim for Violations of Nevada Prompt Pay statutes and regulations are

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

not specifically addressed herein, the Court considered all of the defenses raised in the Motion, as well as all arguments made during oral argument, and the Court does not find merit to any of them.

Violations of Nevada Consumer Fraud & Deceptive Trade Practices Acts

76. The Nevada Deceptive Trade Practices Act (DTPA) prohibits United 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 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.

77. 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.

78. The Health Care Providers sufficiently allege that United has violated the DTPA and the Consumer Fraud Statute through its acts, practices, and omissions described in the FAC, 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 United's members in violation of their legal obligations. FAC ¶ 246.

79. The Nevada Supreme Court has held that violations of DTPA do not need to be proven with the same level of particularity as fraud claims. *Betsinger v. D.R. Horton, Inc*., 232 P.3d 433, 436 (2010) (holding that a violation of the DTPA need not be proven under the clear and convincing standard as is required for a fraud claim).

80. Even if this Court were to require that this claim be subject to heightened pleading standards, the Court concludes that the Health Care Providers pled the claim for violation of

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

DTPA with particularity. FAC ¶ 246; *see also* ¶¶ 25, 57, 65.

81. The Health Care Providers sufficiently allege that United violated "a state or federal statute or regulation relating to the sale or lease of goods or services" with allegations that United has violated NRS 679B.152, NRS 686A.020, 686A.310, 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) and NAC 686A.675 by failing to timely pay claims submitted at a usual and customary rate within 30 days of receipt of the claim. FAC ¶¶ 243-249. The Health Care Providers expressly state that the UH Parties began to violate these provisions in July 2017 (FAC ¶ 254) and the Sierra Affiliates in March 2019 (*id.* ¶ 255) and continue to violate such provisions through the present date. Nothing further is required to establish that this claim is actionable. As such, the Health Care Providers sufficiently allege this portion of the DTPA claim.

82. The Health Care Providers also sufficiently allege that the DPTA has been violated by United's use of "coercion, duress or intimidation in a transaction." FAC ¶ 244. Specifically, the Health Care Providers allege that United is "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." FAC ¶ 246.

83. Further, the Health Care Providers allege:

> 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.

FAC ¶ 65.

…

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

84. Based on the foregoing, the Health Care Providers sufficiently allege who engaged in these bad acts (the United entities) when such parties engaged in these acts (from 2017 to present, FAC ¶ 90) and the scope of the bad acts alleged (improperly lowering amounts paid to leverage negotiations) (FAC ¶ 65).

85. The Health Care Providers also sufficiently allege that United has knowingly misrepresented the "legal rights, obligations or remedies of a party to a transaction." FAC ¶ 244. Specifically, the Health Care Providers assert that by paying claims at artificially reduced rates, United is representing that these claims are being paid at usual and customary and reasonable rates when such a representation is inaccurate. With respect to the UH Parties, this conduct commenced in July 2017 (FAC ¶ 254); and with respect to the Sierra Affiliates this conduct commenced in September 2019 (*id.* ¶ 255) and continues to present date and each Defendant has engaged in these bad acts. Thus, the Health Care Providers sufficiently allege this aspect of its claim for violation of DTPA.

86. As is detailed in the FAC, the Court finds that if claims based on violation of DTPA require a heightened pleading standard, the Health Care Providers have satisfied such a standard.

87. The Court considered United's argument that it is improper to lump all the defendant parties together in the Health Care Providers' allegations, but the Court rejects the argument. The Health Care Providers allege that United has improperly engaged in artificially reducing the rates paid to the Health Care Providers for an ulterior purpose. Thus, it is permissible for the Health Care Providers to make an allegation which encompasses all of these parties. To force the Health Care Providers to reallege this same claim using each of the Defendants' names would be inefficient and unnecessary under these circumstances.

88. To the extent any of United's other arguments specific to its Motion regarding the Health Care Providers' claim for are not specifically addressed herein, the Court considered all of the defenses raised in the Motion, as well as all arguments made during oral argument, and the Court does not find merit to any of them.

…

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

89. United argues that the Health Care Providers are not "victims" under NRS 41.600; however, the Court does not find merit to the argument based on Nevada law.

90. NRS 41.600(1) provides that "[a]n action may be brought by any person who is a victim of consumer fraud." The statute does not define the scope of "victim," but upon review of the deceptive trade practice statutes as a whole, the legislature did not intend to limit the scope of this term.

91. The term "victim of consumer fraud" is broad and includes "any person" who is a victim of consumer fraud, including business competitors, consumers and even businesses which do not have competing interests. *Del Webb Community, Inc. v. Partington*, 652 F.3d 1145, 1153 (9th Cir. 2011).

92. Even under the narrow definition of "victim" adopted by *Igbinovia v. State*, 111 Nev. 699, 706, 895 P.2d 1304, 1308 (1995), limiting the term to passive victims who suffered a loss that was "unexpected and occurs without voluntary participation of the person suffering the harm or loss," the Health Care Providers qualify as victims.

93. The Health Care Providers allege they do not voluntarily provide services to out of network patients. Rather, state law mandates that the Health Care Providers provide emergency medical services to any person presenting to an emergency room in need of emergency medical services. NRS 439B.410(1) ("each hospital … has an obligation to provide emergency services and care, including care provided by physicians…regardless of the financial status of the patient.").

94. The Health Care Providers allege that the provision of services to United's Members was not voluntary and the loss the Health Care Providers have suffered was unexpected given that United is refusing to pay usual and customary rates and the reasonable value of the services provided despite previously doing so. Thus, the Court concludes that, accepting all allegations of the Health Care Providers as true, the Health Care Providers are not active participants in United's fraudulent conduct and are "victims" under NRS 41.600(1) even if the definition of "victim" is limited in the way United proposes.

…

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

95. The Court also does not find United's argument that the term "victim of consumer fraud" is to be construed narrowly such that the Health Care Providers would be excluded from the definition under NRS 41.600.

96. To the extent any of United's other arguments specific to its Motion regarding the Health Care Providers' claim for Violations of Nevada Consumer Fraud & Deceptive Trade Practices Acts are not specifically addressed herein, the Court considered all of the defenses raised in the Motion, as well as all arguments made during oral argument, and the Court does not find merit to any of them.

Declaratory judgment

97. United did not challenge the Health Care Provider's declaratory relief claim under a NRCP 12(b)(5) standard. As a result, this claim is not subject to dismissal for failure to state a claim for relief.

Violation of NRS 207.350 et seq. (NV RICO)

98. Under Nevada law, any person who is injured in his 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. NRS 207.470(1).

99. Pursuant to NRS 207.470 and NRS 207.400, to state a civil RICO cause of action requires a plaintiff to allege that defendants have:

> engag[ed] in at least two crimes related to racketeering 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, if at least one of the incidents occurred after July 1, 1983, and the last of the incidents occurred within 5 years after a prior commission of a crime related to racketeering.

NRS 207.390. "Crimes related to racketeering" are enumerated in NRS 207.360 and include the crime of obtaining money or property valued at $650 or more, violation of 205.377 and involuntary servitude, the crimes that the Health Care Providers allege. NRS 207.360(28), (35), (36).

100. In order to recover, three conditions must be met: (1) the plaintiff's injury must

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

flow from the defendant's violation of a predicate Nevada RICO act; (2) the injury must be proximately caused by the defendant's violation of the predicate act; and (3) the plaintiff must not have participated in the commission of the predicate act. *Allum v. Valley Bank of Nevada*, 109 Nev. 280, 283, 849 P.2d 297, 299 (1993).

101. "A state RICO complaint need allege no more than that which is set forth in the Nevada statute." *Siragusa v. Brown*, 114 Nev. 1384, 1399, 971 P.2d 801, 811 (1998).

102. While Nevada's civil RICO statutes are patterned after the federal RICO statutes, Nevada's statute differs in some respects. *Hale v. Burkhardt,* 104 Nev. 632, 634-635, 764 P.2d 866, 867-868 (1988).

103. The Court concludes that the FAC satisfies each of these elements and United's challenges must be rejected for the following reasons.

104. To have standing to bring a civil RICO claim, a plaintiff must allege injury that flowed from the violation of a predicate RICO act. *Allum*, 109 Nev. at 284, 849 P.2d at 300 (citing *Holmes v. Securities Investor Protection Corp.*, 503 U.S. 258, 266-268 (1992)); *Brown v. Kinross Gold, U.S.A.*, 378 F. Supp. 2d 1280, 1287 (D. Nev. 2005).

105. A plaintiff satisfies this requirement by alleging "some direct relation between the injury asserted and the injurious conduct alleged." *Holmes*, 503 U.S. at 266-268; *Canyon County v. Syngenta Seeds, Inc.*, 519 F.3d 969, 980 (9th Cir. 2008) (a court evaluates proximate causation under federal civil RICO by asking "whether the alleged violation led directly to the plaintiff's injuries."); *Allum*, 109 Nev. at 286, 849 P.2d at 301.

106. Proximate cause is a factual issue not appropriate for resolution on a Rule 12(b)(5) motion. *Yamaha Motor Co., U.S.A. v. Arnoult*, 114 Nev. 233, 238, 955 P.2d 661, 664-665 (1998).

107. The requirement of proximate cause seeks to "limit a person's responsibility for the consequences of that person's own acts." *Painters & Allied Trades Dist. Council 82 Health Care Fund v. Takeda Pharmaceuticals Co. Ltd.*, 943 F.3d 1243, 1248 (9th Cir. 2019) (allegations sufficient to satisfy RICO's proximate cause requirement where the plaintiff alleged a third party had relied on the defendants' false statements).

108. The proximate causation analysis is concerned with: (1) whether plaintiff would

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

have difficulty showing its damages flowed from defendant conduct; (2) whether there is a risk of double recovery; and (3) whether others are positioned to make the same claims. *Holmes* at 503 U.S. at 269. These factors emphasize that proximate cause is "a flexible concept that does not lend itself to a black-letter rule that will dictate the result in every case." *Takeda Pharmaceuticals Co. Ltd.*, 2019 WL 6484263, at *5.

109. Similarly, the Ninth Circuit has developed three non-exhaustive factors to determine whether the proximate causation requirement has been met: (1) whether there are more direct victims of the alleged wrongful conduct who can be counted on to vindicate the law as private attorneys general; (2) whether it will be difficult to ascertain the amount of the plaintiffs damages attributable to defendant's wrongful conduct; and (3) whether the courts will have to adopt complicated rules apportioning damages to obviate the risk of multiple recoveries. *Brown v. Bettinger*, No. 2:15-cv-00331-APG, 2015 WL 4162505, at *4 (D. Nev. July 8, 2015) (citing *Mendoza v. Zirkle Fruit Co.*, 301 F.3d 1163, 1168–69 (9th Cir. 2002). Here, as they allege, the Health Care Providers are directly impacted by the scheme, they can ascertain their damages attributable to the scheme and there are no complicated rules to apportion damages to avoid multiple recoveries because the Health Care Providers only seek to recover their damages.

110. The Court concludes that the three *Holmes* (and reiterated in *Mendoza v. Amalgamated Transit Union Int'l*, No. 2:18-cv-959-JCM-NJK, 2019 WL 4221078, at *6 (D. Nev. Sept. 5, 2019)) factors are met.

111. Accepting all of the allegations in the FAC as true, the Health Care Providers are directly being defrauded by the Enterprises' scheme (*see, e.g.*, FAC ¶¶ 148, 187-188) and no one else is better suited to bring this action. FAC ¶¶ 102, 107-109, 113-115, 148.

112. The Court concludes that the foregoing allegations squarely link the scheme to manipulate and reduce rate payment data to an actual reduction in payment for emergency services to the Health Care Providers.

113. Further, the Court does not find merit to United's argument that there is a risk of double recovery because the Health Care Providers only seek recovery for emergency services they rendered and no one else is positioned to make the same Nevada civil RICO claims regarding

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

the emergency services at issue in this case. *Holmes*, 503 U.S. at 266-268.

114. The Court also considered, and rejects, United's argument that (1) the civil racketeering allegations fail because the alleged underpayment has no causal connection to alleged misrepresentations as the Health Care Providers are required to provide emergency care under federal and state law; and (2) United previewed its scheme, resulting in a break in the causal connection. Supplement at 5:14-6:3. Both of arguments misunderstand the proximate cause inquiry.

115. Instead, the Court concludes that the FAC sufficiently alleges proximate cause because the facts the Health Care Providers allege – that there was a change in United's reimbursement rates and the Health Care Providers' relied on the prior reimbursement – support a finding of proximate cause.

116. The Court concludes that the Health Care Providers sufficiently allege that they are the direct victims of the predicate acts of obtaining money by false pretenses, multiple transactions involving fraud or deceit and involuntary servitude.

117. The Court does not find merit in United's argument that the Health Care Providers failed to plead the civil RICO claim with the requisite particularity under NRCP 9(b). Supplement at 6:18-25; *see* FAC ¶¶ 100-188, 261-273.

118. The Court has also considered and rejected United's argument that the civil racketeering claims should be dismissed because the Health Care Providers "lumped" the United Defendants together (Supplement at 9:18-23). The Court concludes that the cases on which United relies involve allegations that are not analogous. In *Doane v. First Franklin Financial*, No. 2:11-CV-02130-MCE, 2012 WL 2129369, at *6 (E.D. Cal. June 12, 2012), the pleadings referred to multiple, unrelated defendants and where the complaints at issue were otherwise wholly deficient, "conclusory, convoluted, vague and generally fail to satisfy the pleading standards under Rule 8(a) or 9(b)."

119. The Court finds that the FAC contains substantial allegations that detail the alleged scheme and United's involvement.

…

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

120. Section 205.377 provides, in part:

> A person shall not, in the course of an enterprise or occupation, knowingly and with the intent to defraud, engage in an act, practice or course of business or employ a device, scheme or artifice which operates or would operate as a fraud or deceit upon a person by means of a false representation or omission of a material fact that: (a) The person knows to be false or omitted; (b) The person intends another to rely on; and (c) Results in a loss to any person who relied on the false representation or omission…

121. "False pretense is a representation of some fact or circumstance which is not true and is calculated to mislead, and may consist of any words or actions intended to deceive." *Hale*, 104 Nev. at 636–37, 764 P.2d at 869; NRS 205.380. Specifically, the Health Care Providers have provided ample allegations to support a claim for violation of NRS 205.377 and for obtaining money by false pretenses in violation of NRS 207.360(28).

122. The Court finds that the Health Care Providers sufficiently allege the elements for two fraud-based predicate acts in violation of NRS 205.377 (multiple transactions involving fraud or deceit in course of enterprise or occupation) and for obtaining possession of money or property by false pretenses.

123. Specifically, in establishing the elements of NRS 205.377, the Court concludes that Health Care Providers have sufficiently pled that in at least two transactions (*see, e.g., id.* ¶ 115), the Enterprise intended to defraud, engage in an act, practice or course of business or employ a device, scheme or artifice which operates or would operate as a fraud or deceit upon a person by means of a false representation or omission of a material fact (*see, e.g., id.* ¶¶ 177-179, 182, 183); that the Enterprise knows to be false or omitted (*see, e.g.,* ¶¶ 99, 100, 102, 107, 109, 113, 271); upon which United intends the Health Care Providers to rely (*see e.g. id.* ¶¶ 111, 183-185); and which has resulted and continues to result in losses to the Health Care Providers who relied on the false representations or omissions (*see, e.g., id.* ¶¶ 187-188).

124. The FAC also sufficiently alleges "Defendants illegally conduct the affairs of the Enterprise, and/or control the Enterprise, that includes Data iSight though a pattern of unlawful activity." FAC ¶ 112.

125. With respect to the claim under NRS 207.360(28), the Health Care Providers

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

sufficiently allege that the Enterprise intended to defraud the Health Care Providers through written false representations (*see, e.g., id.* ¶¶ 126, 177-178), causing the Health Care Providers' reliance thereon (*see, e.g., id.* ¶¶ 111, 183-185). FAC ¶¶ 123-126; *see also* ¶¶ 149-188.

126. Under NRS 207.360(36), involuntary servitude is defined as:

> 1. A person who knowingly subjects, or attempts to subject, another person to forced labor or services by:
> ***
> (c) Abusing or threatening to abuse the law or legal process;
> ***
> (f) Causing or threatening to cause financial harm to any person,
>
> ➥ is guilty of holding a person in involuntary servitude.

NRS 200.463(1).

127. The Court concludes that the FAC sufficiently pleads such a claim premised on subsections (c) and (f) of NRS 200.463(1) by alleging that United has developed and implemented a scheme that forces the Health Care Providers to perform services at arbitrarily deflated payment rates and has threatened to abuse the law or legal process by interfering with other contracts, disclaiming it has an obligation to pay a reasonable rate for emergency services and has caused and threatened to cause financial harm to the Health Care Providers. *See* FAC ¶¶ 21, 55, 69, 108-109, ¶¶ 90-188.

128. The Court has considered and rejected the cases United relied upon and concludes that the cases are not analogous. Supplement at 11:17-26.

129. An "enterprise" is defined in NRS 207.380:

> "Enterprise" includes:
> 1. Any natural person, sole proprietorship, partnership, corporation, business trust or other legal entity; and
> 2. Any union, association or other group of persons associated in fact although not a legal entity.
>
> ➥ The term includes illicit as well as licit enterprises and governmental as well as other entities.

130. United contends that the Health Care Providers have failed to adequately plead the existence of an "enterprise" under NRS 205.377 (multiple transactions involving fraud or deceit in the course of enterprise). Supplement at 12:12.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

131. The Court concludes that the existence of an enterprise is not required in connection with violations of NRS 207.400(1)(d), (1)(f) or (1)(i). *See* NRS 207.470. Therefore, this argument can only be applicable to violations of NRS 207.400(1)(a)-(c) and 1(j).

132. The Court concludes that, for all unlawful acts that require the existence of an enterprise, the Health Care Providers adequately allege the existence of an enterprise in paragraphs 121 and 122 of the FAC. *See also* FAC ¶¶ 112, 115, 124.

133. Further the FAC provides sufficient factual allegations, namely that United and third-party entities, including Data iSight have joined together to falsely claim to provide transparent, objective and geographically-adjusted determinations of reimbursement rates; and they illegally conduct the affairs of the Enterprise, and/or control the Enterprise through a pattern of unlawful activity. *Id.* ¶¶ 112, 115, 124.

134. The Court has also considered and rejects United's argument that the alleged Enterprise's conduct should be overlooked because United purports to have "an ordinary commercial contractual relationship…through MultiPlan's Data iSight tool." Supplement at 13:19-21; *see, e.g., Gomez v. Guthy-Renker*, No. EDCV 14–01425 JGB (KKx), 2015 WL 4270042 (C.D. Cal. July 13, 2015). The Court concludes that the Health Care Providers allege "something more" than a routine contract. FAC ¶ 115.

135. As the Health Care Providers allege, United would not be able to operate its deceptive scheme absent Data iSight's purported functioning as a third-party supplier of transparent, market-based benchmark data. Assuming all allegations in the FAC as true, Data iSight is conduit through which United seeks to color its arbitrary, deficient payments with the false appearance of good faith objectivity. The Court concludes that these allegations sufficiently detail the existence of an "enterprise" under Nevada law.

…

…

…

…

…

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

Accordingly, good cause appearing, therefor,

ORDER

IT IS HEREBY ORDERED that United's Motion is DENIED in its entirety.

IT IS FURTHER ORDERED that United's Supplement is DENIED in its entirety.

DATED this ___ day of June, 2020.

Dated this 24th day of June, 2020

Nancy L Allf

DISTRICT COURT JUDGE JD

A7B FD7 9E00 6B2D

Submitted by:

Nancy Allf

McDONALD CARANO LLP

By: */s/ Kristen T. Gallagher*

Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

DISTRICT COURT
CLARK COUNTY, NEVADA

Fremont Emergency Services (Mandavia) Ltd, Plaintiff(s) vs. United Healthcare Insurance Company, Defendant(s)	CASE NO: A-19-792978-B DEPT. NO. Department 27

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Order Denying Motion was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:
Service Date: 6/24/2020

Audra Bonney	abonney@wwhgd.com
Cindy Bowman	cbowman@wwhgd.com
D. Lee Roberts	lroberts@wwhgd.com
Raiza Anne Torrenueva	rtorrenueva@wwhgd.com
Colby Balkenbush	cbalkenbush@wwhgd.com
Brittany Llewellyn	bllewellyn@wwhgd.com
Pat Lundvall	plundvall@mcdonaldcarano.com
Kristen Gallagher	kgallagher@mcdonaldcarano.com
Amanda Perach	aperach@mcdonaldcarano.com
Beau Nelson	bnelson@mcdonaldcarano.com
Marianne Carter	mcarter@mcdonaldcarano.com
Karen Surowiec	ksurowiec@mcdonaldcarano.com

Flor Gonzalez-Pacheco	FGonzalez-Pacheco@wwhgd.com
Kelly Gaez	kgaez@wwhgd.com
Kimberly Kirn	kkirn@mcdonaldcarano.com

EXHIBIT C

EXHIBIT C

ELECTRONICALLY SERVED
9/28/2020 2:37 PM

Electronically Filed
09/28/2020 2:37 PM
CLERK OF THE COURT

ORDG
Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs

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 **ORDER GRANTING, IN PART PLAINTIFFS' MOTION TO COMPEL DEFENDANTS' PRODUCTION OF CLAIMS FILE FOR AT-ISSUE CLAIMS, OR, IN THE ALTERNATIVE, MOTION IN LIMINE**

This matter came before the Court on September 9, 2020 on 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's ("Ruby Crest" and collectively the "Health Care Providers") Motion to Compel Defendants' Production of Claims File for At-Issue Claims Or, In the Alternative, Motion in Limine on Order Shortening Time (the "Motion"). Pat Lundvall and Amanda M. Perach, McDonald Carano LLP, appeared on behalf of the Health Care Providers. Lee Roberts and Colby L. Balkenbush, Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC, appeared on behalf of defendants UnitedHealth Group, Inc.; UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Oxford Health Plans, Inc.; Sierra Health and Life Insurance Co., Inc.; Sierra Health-Care Options, Inc.; and Health Plan of Nevada, Inc.'s (collectively, "United").

The Court, having considered the Motion, United's opposition, and the argument of counsel at the hearing on this matter, finds and orders as follows:

1. The Health Care Providers propounded their First Set of Interrogatories ("Interrogatories") and First Set of Requests for Production of Documents ("RFPs") on United on or around December 9, 2019.

2. In response to 19 RFPs**,** Resp. to RFP Nos. 3-7, 11-13, 15-20, 24, 37, 39-40, 42 (collectively, the "At-Issue RFPs"), United repeats the following objection with variation to acknowledge the request at issue (in bold):

> Fremont has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. **To produce the documents and communications related to any decision to reduce payment on a CLAIM**, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.
>
> Fremont has asserted 15,210 claims where it alleges that Defendants did not reimburse Fremont for the full amount billed. **To produce the documents and communications that relate to the methodology used to calculate the amount of reimbursement paid on Fremont's claims**, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual claims, review the records for privileged/protected information and then produce them. As explained more fully in the burden declaration attached as Exhibit 1 to, this would be unduly

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

> burdensome as Defendants believe it will take 2 hours to pull each individual claim file for a total of 30,420 hours of employee labor.

3. ~~With respect to 5 Interrogatories, Answers to Interrog. Nos. 1, 5, 7, 8, 12~~ NLA ~~(collectively, the "At-Issue Interrogatories"), United repeats the same objection with the same variation to account for the question:~~

> Assuming those are the claims Fremont intended to refer to, Defendants object to this Interrogatory on the basis that it is unduly burdensome and seeks information that is not proportional to the needs of the case. Fremont has asserted 15,210 CLAIMS where it alleges that Defendants did not reimburse Fremont for the full amount billed. To determine how the amount of reimbursement for NLA each CLAIM was determined, Defendants would, among other things, have to pull the administrative record for each of the 15,210 individual CLAIMS and analyze it. As explained more fully in the burden declaration attached as Exhibit 1, this would be unduly burdensome and not proportional to the needs of the case as Defendants believe it will take 2 hours to pull each individual administrative record for a total of 30,420 hours of employee labor.

4. Each of these objections is based on United's assertion that it is unduly burdensome to retrieve and produce what United refers to as the "administrative record."

5. On February 10, 2020, counsel for the Health Care Providers offered to reduce United's burden of producing certain Explanation of Benefits forms ("EOBs") and Providers Remittance Advice forms ("PRAs") by matching data contained in the Health Care Providers' at-issue claims spreadsheets:

> In advance of Wednesday's hearing, below is a discovery proposal that would result in an expedited ability for the parties to agree on the health care claims data and would eliminate or greatly reduce the need for United to collect and produce provider remittance forms/provider EOBs except for where the parties identify a discrepancy in the billed amount or allowed amounts or as specified below. Similarly, it would eliminate or greatly reduce the need for Fremont to collect and produce HCFA forms and related billing documents. Please review and let me know in advance of Wednesday's hearing whether United will agree to the following:
>
> The Health Care Providers have already produced a spreadsheet that includes member name and Defendants' claim no. (to the extent available in Health Care Providers' automated system), in addition to other fields:
>
> - Within 14 days, United provides matched spreadsheets and identifies any discrepancy in billed or allowed amounts fields;
> - Within 7 days thereafter, for claims upon which the billed and allowed data match, parties stipulate that there is no need for further production of EOBs and provider remittances for evidentiary purposes related to establishing the existence of the claim, services

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

provided, amount billed by Health Care Providers and amount allowed by United.

- Approximately every quarter, this process will take place again with any new claims included in the Litigation Claims Spreadsheet that accrued after the previous spreadsheet was submitted.

United produces all EOBs/provider remittances for all Data iSight processed NV claims submitted by the Health Care Providers; and

United and the Health Care Providers respectively agree to provide a market file, i.e. a spreadsheet of payments from other payers (Health Care Providers) or a spreadsheet of payments to other providers (United) in the market which de-identifies the specific payer or provider, as applicable (for the time period 2016-Present). The parties agree to meet and confer promptly to agree on specified fields.

6. Counsel for United and the Health Care Providers engaged in meet and confers on these objections on June 9, 15 and 23 (addressing RFP Nos. 11, 12, 13, 21, 27, 37 and 44) and July 20, 21 and August 3, 2020 (addressing RFP Nos. 3-7, 11-13, 15-20, 24, 37, 39-40, 42 and Interrog. Nos. 1, 5, 7, 8 and 12)

7. United representative Sandra Way ("Way") provided a declaration (the "Way Declaration") setting forth the contention that it would take four full-time United representatives working for three years to pull records for the at-issue claims in this litigation. The Way Declaration does not state she has tried to review or retrieve any information in connection with this litigation.

8. During meet and confer efforts, United's counsel stated that the only responsive documents that existed with respect to the At-Issue RFPs appeared in the "administrative record" and that it was standing on its undue burden objection.

9. Thereafter, the Health Care Providers filed the subject Motion.

10. The Health Care Providers have disclosed spreadsheets which list each of the at-issue claims (the "At-Issue Claims") in FESM00344 and intend to supplement these spreadsheets on a regular basis (collectively the "Claims Spreadsheets").

11. In opposition to the Motion, United states that the documents relating to the At-Issue Claims that would be responsive to the At-Issue RFPs consist of the "administrative record" for each claim and that the "administrative record" consists of five categories of documents:

a. Member Explanations of Benefits ("EOBs");

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

b. Provider EOBs and/or Provider Remittance Advices ("PRAs");

c. Appeals documents;

d. Any other documents comprising the administrative record, such as correspondence or clinical records submitted by the provider with its claim for reimbursement;

e. The plan documents in effect at the time of service.

(collectively, the "Administrative Record")

12. The party from whom discovery is sought, must show that the information is not reasonably accessible because of undue burden or cost. NRCP 26(b)(2)(B). "[T]he fact that discovery may involve some inconvenience or expenses is not sufficient, standing alone, to avoid the discovery process." *Martinez v. James River Ins. Co.*, No. 2:19-cv-01646-RFB-NJK, 2020 WL 1975371, at *1 (D. Nev. Apr. 24, 2020).

13. The Way Declaration does not assert that claim information is not reasonably accessible because of undue burden, nor does she assert any particular cost associated with retrieving and producing the information.

14. As a result, the Way Declaration does not meet the considerations under NRCP 26(b)(2)(B).

15. Even if United could make that showing, the Court "may nonetheless order discovery from such sources if the requesting party shows good cause, considering the limitations of Rule 26(b)(2)(C)." NRCP 26(b)(2)(B).

16. There is no basis for the Court to limit the claim-file discovery under NRCP 26(b)(2)(C) because (1) the discovery sought is not unreasonably cumulative or duplicative, and cannot be obtained from a source other than United, much less from another source that is more convenient, less burdensome, or less expensive; (2) the Health Care Providers have not had ample opportunity to obtain the information by discovery in the action; and (3) the proposed discovery is not outside the scope permitted by Rule 26(b)(1).

17. The Court has considered United's argument that the Motion should be denied based on the Doctrine of Unclean Hands. The Court finds that that argument has no merit.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

18. The Court has also considered United's argument that the method of production of the Administrative Records would not be proportional to the needs of the case. United's proposal to employ statistical sampling methodology, require the parties to employ experts to attempt to match each party's claims data, and/or only require the parties to produce documents related to a smaller set of the at-issue claims does not sufficiently address the discovery needed for the Health Care Providers to prosecute this case. ~~The Court further finds that the discovery sought in the Motion is proportional to the needs of this case considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information,~~ the ~~parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit.~~ NLA

Accordingly, good cause appearing, therefor,

ORDER

IT IS HEREBY ORDERED that the Health Care Providers' Motion to Compel Defendants' Production of Claims File for At-Issue is GRANTED.

IT IS FURTHER ORDERED that the Health Care Providers' alternative Motion in Limine is premature and is therefore DENIED WITHOUT PREJUDICE.

IT IS FURTHER ORDERED that United's objections based on undue burden for the At-Issue RFPs and At-Issue Interrogatories are hereby OVERRULED.

IT IS FURTHER ORDERED that United shall produce all Administrative Records for each of the At-Issue Claims on or before September 23, 2020. NLA ~~In the event United does not dispute certain claim information contained in the Claim Spreadsheets, United shall not be required to produce EOBs or PRAs for the particular At-Issue Claims which are undisputed.~~

~~**IT IS FURTHER ORDERED** that United shall timely supplement its production of Administrative Records for each of the At-Issue Claims upon disclosure of new Claim Spreadsheets by the Health Care Providers.~~ NLA

IT IS FURTHER ORDERED that there will be a Status Check on the performance of United's production of those documents set for three weeks from the entry of this order to inform the Judge what production will be possible and when.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

NLA

~~**IT IS FURTHER ORDERED** that a status check on United's compliance with this Order shall take place on September 30, 2030 at 1:30 p.m~~.

IT IS SO ORDERED.

Dated this 28th day of September, 2020

Nancy L Allf

DISTRICT COURT JUDGE

15B A6E F22F E3DA NB
Nancy Allf
District Court Judge

Submitted by:

McDONALD CARANO LLP

By: */s/ Amanda Perach*
Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs

Approved as to form and content:

WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC

By: */s/*
D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn, Esq.
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
lroberts@wwhgd.com
cbalkenbush@wwhgd.com
bllewellyn@wwhgd.com

Attorneys for Defendants

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

CSERV

DISTRICT COURT
CLARK COUNTY, NEVADA

Fremont Emergency Services (Mandavia) Ltd, Plaintiff(s) vs. United Healthcare Insurance Company, Defendant(s)	CASE NO: A-19-792978-B DEPT. NO. Department 27

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Order Granting was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

Service Date: 9/28/2020

Audra Bonney	abonney@wwhgd.com
Cindy Bowman	cbowman@wwhgd.com
D. Lee Roberts	lroberts@wwhgd.com
Raiza Anne Torrenueva	rtorrenueva@wwhgd.com
Colby Balkenbush	cbalkenbush@wwhgd.com
Brittany Llewellyn	bllewellyn@wwhgd.com
Pat Lundvall	plundvall@mcdonaldcarano.com
Kristen Gallagher	kgallagher@mcdonaldcarano.com
Amanda Perach	aperach@mcdonaldcarano.com
Beau Nelson	bnelson@mcdonaldcarano.com

Marianne Carter	mcarter@mcdonaldcarano.com
Karen Surowiec	ksurowiec@mcdonaldcarano.com
Flor Gonzalez-Pacheco	FGonzalez-Pacheco@wwhgd.com
Kelly Gaez	kgaez@wwhgd.com
Kimberly Kirn	kkirn@mcdonaldcarano.com

EXHIBIT D

EXHIBIT D

OGM
Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs

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

ORDER GRANTING PLAINTIFFS' MOTION TO COMPEL DEFENDANTS' LIST OF WITNESSES, PRODUCTION OF DOCUMENTS AND ANSWERS TO INTERROGATORIES ON ORDER SHORTENING TIME

This matter came before the Court on October 8, 2020 on the Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on

Order Shortening Time (the "Motion") filed by 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"). Pat Lundvall, Kristen T. Gallagher and Amanda M. Perach, McDonald Carano LLP, appeared on behalf of the Health Care Providers. Lee Roberts and Colby L. Balkenbush, Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC, appeared on behalf of defendants UnitedHealth Group, Inc.; UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Oxford Health Plans, Inc.; Sierra Health and Life Insurance Co., Inc.; Sierra Health-Care Options, Inc.; and Health Plan of Nevada, Inc.'s (collectively, "United").

The Court, having considered the Motion, United's opposition, and the argument of counsel at the hearing on this matter and good cause appearing therefor, makes the following findings and Order:

FINDINGS OF FACT

1. On August 9, 2019, prior to remand to this Court, United made its initial disclosures pursuant to FRCP 26(a). On August 13, 2020 and August 31, 2020, United served its first and second supplement to initial disclosures. United's initial list of witnesses (detailed in the Joint Case Conference Report) did not include a single United representative. After the Health Care Providers pointed this out, United supplemented, listing only three United representatives on its Second Supplement to NRCP 16.1 list of witnesses. United identified one additional United witness in its Third Supplement to NRCP 16.1 list of witnesses.

2. On December 9, 2019, the Health Care Providers propounded their First Set of Interrogatories ("Interrogatories") and First Set of Requests for Production of Documents ("RFPs") on United.

3. On January 29, 2020, United served its objections and responses to the Health Care Providers' RFPs and answers to Interrogatories. On July 10, 2020, United served its Third Supplemental Responses to RFPs.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

4. As set forth in the Motion, the Health Care Providers discharged their meet and confer obligations pursuant to EDCR 2.34.

5. The scope of permissible discovery is broad. NRCP 26 permits parties to "obtain discovery regarding any nonprivileged matter that is relevant to any party's claims or defenses and proportional to the needs of the case…." *See* NRCP 26(b)(1). A party may move to compel disclosure of documents and electronically stored information and if a party fails to produce documents responsive to a request made pursuant to NRCP 34; as well as an answer to interrogatories. NRCP 37(a)(3)(B)(iii)-(iv). Furthermore, "an evasive or incomplete disclosure, answer, or response must be treated as a failure to disclose, answer, or respond" NRCP 37(a)(4).

6. The Health Care Providers moved to compel United to identify witnesses, as well as answer interrogatories and produce documents in connection with the following categories of information:

- The identity of United representatives and other third parties that have information about the allegations in the First Amended Complaint (NRCP 16.1 and Interrogatory No. 8);
- Market and reimbursement data related to out-of-network reimbursement rates and related documents and analyses (Interrogatory Nos. 12; RFP Nos. 14, 19, 20, 22, 23, 24, 33, 34, 35, 38,[1] 43);
- Methodology and sources of information used to determine amount to pay emergency services and care for out-of-network providers and use of the FAIR Health Database (Interrogatory Nos. 2, 3, 4, 10, 12; RFP Nos. 5, 8, 10, 15, 36, 38);
- Documents related to United's decision making and strategy in connection with its out-of-network reimbursement rates and implementation thereof (RFP Nos. 6, 7, 18, 32);
- Documents related to United's decision making and strategy in connection with its in-network reimbursement rates and implementation thereof (RFP Nos. 31);
- Rental, wrap, shared savings program or any other agreement that United contends allows it to pay less than full billed charges (Interrogatory Nos. 5, 7; RFP Nos. 9, 16);
- Market and reimbursement data related to in-network reimbursement rates and related documents and analyses (RFP Nos. 25, 26, 29, 30);

[1] RFP No. 38 is listed twice because it seeks documents concerning for both out-of-network and in-network adjudication of emergency services.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

- Documents related to United's relationship with Data iSight and/or other third parties (Interrogatory Nos. 9; RFP Nos. 11, 12 and 21);
- Documents and communications about the at-issue claims (RFP Nos. 3, 17);
- Documents regarding negotiations between United and the Health Care Providers' representatives (RFP No. 13, 27, 28);
- Documents regarding challenges from other out-of-network emergency medicine groups regarding reimbursement rates paid (RFP No. 41);
- Documents reflecting United's failure to effectuate a prompt settlement of any of the at-issue claims (RFP No. 42); and
- Documents relating to United's affirmative defenses (RFP No. 45).

7. For the reasons set forth in the Motion and at the hearing, the Court finds that the Health Care Providers have established grounds to compel United to supplement its list of witnesses, answers to Interrogatories, responses to RFPs and production of documents as requested in the Motion and set forth herein.

8. United's objections set forth in its Opposition and at the hearing are overruled in their entirety.

9. The Court finds that United has not participated in discovery with sufficient effort and has not taken a rational approach to its discovery obligations.

10. In the event that United does not meet the deadlines of the Court, the Court will have no choice but to make negative inferences.

Accordingly, good cause appearing, therefor,

ORDER

IT IS HEREBY ORDERED that the Health Care Providers' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time is GRANTED IN ITS ENTIRETY.

IT IS FURTHER ORDERED that United is hereby compelled to fully and completely supplement its list of witnesses, provide full and complete supplemental answers to Interrogatories and responses to Requests for Production of Documents and produce documents, as follows:

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

- The identity of United representatives and other third parties that have information about the allegations in the First Amended Complaint (NRCP 16.1 and Interrogatory No. 8);

- Market and reimbursement data related to out-of-network reimbursement rates and related documents and analyses (Interrogatory Nos. 12; RFP Nos. 14, 19, 20, 22, 23, 24, 33, 34, 35, 38,[2] 43);

- Methodology and sources of information used to determine amount to pay emergency services and care for out-of-network providers and use of the FAIR Health Database (Interrogatory Nos. 2, 3, 4, 10, 12; RFP Nos. 5, 8, 10, 15, 36, 38);

- Documents related to United's decision making and strategy in connection with its out-of-network reimbursement rates and implementation thereof (RFP Nos. 6, 7, 18, 32);
- Documents related to United's decision making and strategy in connection with its in-network reimbursement rates and implementation thereof (RFP Nos. 31);

- Rental, wrap, shared savings program or any other agreement that United contends allows it to pay less than full billed charges (Interrogatory Nos. 5, 7; RFP Nos. 9, 16);

- Market and reimbursement data related to in-network reimbursement rates and related documents and analyses (RFP Nos. 25, 26, 29, 30);

- Documents related to United's relationship with Data iSight and/or other third parties (Interrogatory Nos. 9; RFP Nos. 11, 12 and 21);

- Documents and communications about the at-issue claims (RFP Nos. 3, 17);

- Documents regarding negotiations between United and the Health Care Providers' representatives (RFP No. 13, 27, 28);

- Documents regarding challenges from other out-of-network emergency medicine groups regarding reimbursement rates paid (RFP No. 41);

- Documents reflecting United's failure to effectuate a prompt settlement of any of the at-issue claims (RFP No. 42); and

- Documents relating to United's affirmative defenses (RFP No. 45).

IT IS FURTHER ORDERED that United's Objections, both written and oral, to each of the foregoing interrogatories, requests for production of documents and initial disclosure obligations are OVERRULED in their entirety.

[2] RFP No. 38 is listed twice because it seeks documents concerning for both out-of-network and in-network adjudication of emergency services.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

IT IS FURTHER ORDERED that United shall produce documents identified in, and committed to, in its Opposition to the Motion on the following schedule:

- Market and reimbursement data for out-of-network and in-network providers for the Las Vegas, Nevada market by October 26, 2020 and for all other responsive Nevada and national level market and reimbursement data as set by the Court at the October 22, 2020 status check;
- Documents in support of United's affirmative defenses by November 6, 2020; and
- Data iSight closure reports by October 23, 2020.

IT IS FURTHER ORDERED that, by October 13, 2020, the Health Care Providers shall provide United a prioritization schedule of the remaining categories of information and documents subject to this Order; and by October 20, 2020, United shall respond with proposed dates of production and an explanation for same.

IT IS FURTHER ORDERED that the Court will hold a status check on October 22, 2020 at 10:00 a.m. to discuss United's compliance with this Order, the Health Care Provider's prioritization schedule and to set deadlines by which United shall supplement and produce the following:

- The identity of United representatives and other third parties that have information about the allegations in the First Amended Complaint (NRCP 16.1 and Interrogatory No. 8);
- Market and reimbursement data related to out-of-network reimbursement rates and related documents and analyses (Interrogatory Nos. 12; RFP Nos. 14, 19, 20, 22, 23, 24, 33, 34, 35, 38, 43);
- Methodology and sources of information used to determine amount to pay emergency services and care for out-of-network providers and use of the FAIR Health Database (Interrogatory Nos. 2, 3, 4, 10, 12; RFP Nos. 5, 8, 10, 15, 36, 38);
- Documents related to United's decision making and strategy in connection with its out-of-network reimbursement rates and implementation thereof (RFP Nos. 6, 7, 18, 32);
- Documents related to United's decision making and strategy in connection with its in-network reimbursement rates and implementation thereof (RFP Nos. 31);

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

- Rental, wrap, shared savings program or any other agreement that United contends allows it to pay less than full billed charges (Interrogatory Nos. 5, 7; RFP Nos. 9, 16);
- Market and reimbursement data related to in-network reimbursement rates and related documents and analyses (RFP Nos. 25, 26, 29, 30);
- Documents related to United's relationship with Data iSight and/or other third parties (Interrogatory Nos. 9; RFP Nos. 11, 12 and 21);
- Documents and communications about the at-issue claims (RFP Nos. 3, 17);
- Documents regarding negotiations between United and the Health Care Providers' representatives (RFP No. 13, 27, 28);
- Documents regarding challenges from other out-of-network emergency medicine groups regarding reimbursement rates paid (RFP No. 41); and
- Documents reflecting United's failure to effectuate a prompt settlement of any of the at-issue claims (RFP No. 42).

IT IS SO ORDERED.

Dated this 27th day of October, 2020

Nancy L Allf

DISTRICT COURT JUDGE

32A 40D 89AE 2AC4
Nancy Allf
District Court Judge

Submitted by:

McDONALD CARANO LLP

By: */s/ Kristen T. Gallagher*
Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

CSERV

DISTRICT COURT
CLARK COUNTY, NEVADA

Fremont Emergency Services (Mandavia) Ltd, Plaintiff(s) vs. United Healthcare Insurance Company, Defendant(s)	CASE NO: A-19-792978-B DEPT. NO. Department 27

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Order Granting Motion was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

Service Date: 10/27/2020

Audra Bonney	abonney@wwhgd.com
Cindy Bowman	cbowman@wwhgd.com
D. Lee Roberts	lroberts@wwhgd.com
Raiza Anne Torrenueva	rtorrenueva@wwhgd.com
Colby Balkenbush	cbalkenbush@wwhgd.com
Brittany Llewellyn	bllewellyn@wwhgd.com
Pat Lundvall	plundvall@mcdonaldcarano.com
Kristen Gallagher	kgallagher@mcdonaldcarano.com
Amanda Perach	aperach@mcdonaldcarano.com
Beau Nelson	bnelson@mcdonaldcarano.com

Marianne Carter	mcarter@mcdonaldcarano.com
Karen Surowiec	ksurowiec@mcdonaldcarano.com
Flor Gonzalez-Pacheco	FGonzalez-Pacheco@wwhgd.com
Kelly Gaez	kgaez@wwhgd.com
Kimberly Kirn	kkirn@mcdonaldcarano.com

EXHIBIT E

EXHIBIT E

ORDR

Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs

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 **ORDER SETTING DEFENDANTS' PRODUCTION & RESPONSE SCHEDULE RE: ORDER GRANTING PLAINTIFFS' MOTION TO COMPEL DEFENDANTS' LIST OF WITNESSES, PRODUCTION OF DOCUMENTS AND ANSWERS TO INTERROGATORIES ON ORDER SHORTENING TIME**

This matter came before the Court on October 22, 2020 in follow-up to the Court's ruling at the October 8, 2020 hearing granting the Motion to Compel Defendants' List of Witnesses,

Production of Documents and Answers to Interrogatories on Order Shortening Time (the "Motion") filed by 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"). Kristen T. Gallagher and Amanda M. Perach, McDonald Carano LLP, appeared on behalf of the Health Care Providers. D. Lee Roberts and Brittany M. Llewellyn, Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC, appeared on behalf of defendants UnitedHealth Group, Inc.; UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Oxford Health Plans, Inc.; Sierra Health and Life Insurance Co., Inc.; Sierra Health-Care Options, Inc.; and Health Plan of Nevada, Inc. (collectively, "United").

The Court, having considered the parties' respective status reports and the argument of counsel at the hearing on this matter, as well as the Court's September 28, 2020 Order, its ruling at the October 8, 2020 hearing and good cause appearing therefor, makes the following findings and Order:

1. The Court finds that United's discovery conduct in this action is unacceptable to the Court.

2. The Court finds that United has failed to properly meet and confer with regard to the Court's directive to meet and confer on a claims data matching protocol in connection with the Court's September 28, 2020 Order Granting, in part, the Health Care Providers' Motion to Compel United's Production of Claims File for At-Issue Claims, or in the Alternative, Motion in Limine ("September 28 Order").

3. Since the September 9, 2020 hearing, United has produced approximately 50 records that United describes as the "administrative record" (to which the Health Care Providers object to because this is not an ERISA case). The Court finds that, given the December 31, 2020 fact discovery deadline, and the Court's September 28 Order, United shall produce a minimum of 2,000 claims files per month.

4. United shall exclude managed Medicare and Medicaid reimbursement rates from its production of market and reimbursement rates ~~because the rates are lower than commercial~~

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

~~payer reimbursement rates; therefore, United's attempt to include managed Medicare and Medicaid data is rejected as unrelated to the Health Care Providers' claims~~. Notwithstanding the foregoing, the Court does not make any admissibility ruling of this data at this stage of the litigation.

5. The Court adopts the production and supplement schedule provided for in the Health Care Providers' Status Report submitted in connection with the October 22, 2020 Status Check except that by ~~November 20, 2020 (a)~~ October 26, 2020 United shall produce (i) Nevada aggregate market and reimbursement data and (ii) Nevada ~~and national level~~ claims-by-claims market and reimbursement data; and (b) by November 20, 2020, United shall supplement Interrogatory No. 8.

Accordingly, good cause appearing, therefor,

ORDER

IT IS HEREBY ORDERED that, in connection with the Court's September 28 Order, United shall produce a minimum of 2,000 claims files per month.

IT IS FURTHER ORDERED that, in connection with the Court's September 28 Order, the parties shall further meet and confer on Friday, October 23, 2020 to identify a claim data matching protocol.

IT IS HEREBY ORDERED that, as previously ordered at the October 8, 2020 hearing, United is compelled to ~~fully and completely~~ supplement its list of witnesses pursuant to NRCP 16.1, provide full and complete supplemental answers to the Health Care Providers' First Set of Interrogatories and responses to their First Set of Requests for Production of Documents and produce documents, as follows and on the following schedule:

1. **October 22, 2020**:

(a) The identity of United representatives and other third parties that have information about the allegations in the First Amended Complaint (NRCP 16.1);

(b) Methodology and sources of information used to determine amount to pay emergency services and care for out-of-network providers and use of the FAIR Health Database (Interrogatory Nos. 2, 3, 4, 10, 12; RFP Nos. 5, 8, 10, 15, 36, 38);

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

(c) Market and reimbursement data related to out-of-network (Interrogatory Nos. 12; RFP Nos. 14, 19, 20, 22, 23, 24, 33, 34, 35, 38,1 43) and in-network (RFP Nos. 25, 26, 29, 30) reimbursement rates and related documents and analyses;

(d) Documents related to United's decision making and strategy in connection with its out-of-network (RFP Nos. 6, 7, 18, 32) and in-network (RFP Nos. 31) reimbursement rates and implementation thereof; and

(e) Documents and information related to United's relationship with Data iSight and/or other third parties (Interrogatory Nos. 9; RFP Nos. 11, 12 and 21).

2. **October 26, 2020**:

(a) Aggregated market and reimbursement level data related to out-of-network and in-network reimbursement rates for the Nevada market. Each provider may be de-identified for purposes of listing the reimbursement levels for each provider. This aggregated market data shall exclude managed Medicare and Medicaid data ~~because it is irrelevant and unrelated to the Health Care Providers' claims~~.

~~**3. October 30, 2020**~~:

(a) Documents regarding negotiations between United and the Health Care Providers' representatives (RFP No. 13, 27, 28);

(b) Documents and communications about the at-issue claims (RFP Nos. 3, 17); and

(c) Rental, wrap, shared savings program or any other agreement that United contends allows it to pay less than full billed charges (Interrogatory Nos. 5, 7; RFP Nos. 9, 16):

3. ~~4.~~ **November 6, 2020**:

(a) Documents regarding challenges from other out-of-network emergency medicine groups regarding reimbursement rates paid (RFP No. 41);

(b) Documents reflecting United's failure to effectuate a prompt settlement of any of the at-issue claims (RFP No. 42); and

(c) Documents relating to United's affirmative defenses (RFP No. 45).

…

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

4. ~~5.~~ **November 20, 2020**:

(a) The identity of United representatives and other third parties that have information in response to Interrogatory No. 8; and

5. October 26, 2020:

(b) Claims-by-claims market and reimbursement level data related to out-of-network and in-network reimbursement rates at the Nevada ~~and national level~~; and aggregated market and reimbursement level data related to out-of-network and in-network reimbursement rates at the national level. Both claims-by-claims and aggregated market data shall exclude managed Medicare and Medicaid data.

IT IS FURTHER ORDERED that in connection with the Court's September 28 Order the parties shall comply with the following claims data matching protocol:

1. [to be inserted by the Court pursuant to the Status Reports submitted by the parties on October 26, 2020].

IT IS SO ORDERED.

November 9, 2020

Dated this 9th day of November, 2020

Nancy L Allf

F49 637 5613 8F7F
Nancy Allf
District Court Judge

NB

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

Submitted by:

McDONALD CARANO LLP

By: */s/ Kristen T. Gallagher*

Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

CSERV

DISTRICT COURT
CLARK COUNTY, NEVADA

Fremont Emergency Services (Mandavia) Ltd, Plaintiff(s) vs. United Healthcare Insurance Company, Defendant(s)	CASE NO: A-19-792978-B DEPT. NO. Department 27

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Order was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

Service Date: 11/9/2020

Audra Bonney	abonney@wwhgd.com
Cindy Bowman	cbowman@wwhgd.com
D. Lee Roberts	lroberts@wwhgd.com
Raiza Anne Torrenueva	rtorrenueva@wwhgd.com
Colby Balkenbush	cbalkenbush@wwhgd.com
Brittany Llewellyn	bllewellyn@wwhgd.com
Pat Lundvall	plundvall@mcdonaldcarano.com
Kristen Gallagher	kgallagher@mcdonaldcarano.com
Amanda Perach	aperach@mcdonaldcarano.com
Beau Nelson	bnelson@mcdonaldcarano.com

Marianne Carter	mcarter@mcdonaldcarano.com
Karen Surowiec	ksurowiec@mcdonaldcarano.com
Flor Gonzalez-Pacheco	FGonzalez-Pacheco@wwhgd.com
Kelly Gaez	kgaez@wwhgd.com
Kimberly Kirn	kkirn@mcdonaldcarano.com

EXHIBIT F

EXHIBIT F

ACOM
Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs

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.

PAT LUNDVALL (NSBN 3761)
KRISTEN T. GALLAGHER (NSBN 9561)
AMANDA M. PERACH (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada-Mandavia, P.C. & Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

> 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.

…

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

…

…

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

"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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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:

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

> 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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

…

…

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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."

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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).

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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;

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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.

…

…

…

…

…

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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*

Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada-Mandavia, P.C. & Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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:

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Josephine E. Groh, Esq.
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
lroberts@wwhgd.corn
cbalkenbush@wwhgd.corn
jgroh@wwhgdcorn

Attorneys for Defendants UnitedHealthcare Insurance Company, United HealthCare Services, Inc., UMR, Inc., Oxford Health Plans Inc., Sierra Health and Life Insurance Co., Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc.

/s/ *Marianne Carter*
An employee of McDonald Carano LLP

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

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:

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn, Esq.
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
lroberts@wwhgd.corn
cbalkenbush@wwhgd.corn
bllewellyn@wwhgd.com

Attorneys for Defendants

/s/ Marianne Carter
An employee of McDonald Carano LLP

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

EXHIBIT G

EXHIBIT G

ELECTRONICALLY SERVED
10/8/2020 4:27 PM

Electronically Filed
10/08/2020 4:26 PM
CLERK OF THE COURT

SCHTO

DISTRICT COURT
CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, **Plaintiff(s),** **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**, **Defendant(s),**	CASE NO: **A-19-792978-B** DEPT. NO. **27** **ENTERED kl**

BUSINESS COURT SCHEDULING ORDER AND ORDER SETTING: (1) CIVIL JURY TRIAL; (2) CALENDAR CALL; AND (3) STATUS CHECK

This BUSINESS COURT SCHEDULING ORDER SETTING CIVIL JURY TRIAL AND CALENDAR CALL is entered following the Mandatory Rule 16 Conference held on July 23, 2020.

NANCY L. ALLF
DISTRICT JUDGE
DEPT XXVII
LAS VEGAS, NV 89155

Case Number: A-19-792978-B

Pursuant to NRCP 16.1(f) this case has been deemed complex and all discovery disputes will be resolved by this Court. This Order may be amended or modified by the Court upon good cause shown.

IT IS HEREBY ORDERED that the parties will comply with the following deadlines:

Discovery Cut Off Date:	**12/30/20**
Last Day to file motion to amend or add parties:	**10/01/20**
Initial expert witness designation:	**10/01/20**
Rebuttal expert disclosures due:	**11/01/21**
Final Date to file Motions in Limine or other Dispositive Motions	**01/29/21**
Status Check:	**02/04/21**
Calendar Call:	**03/11/21**
Trial Date:	**03/15/21**

IT IS HEREBY ORDERED THAT:

A. The above entitled case is set to be tried to a Jury on a **Five week stack** to begin, **March 15, 2021 at 10:30 a.m. The trial will be held in Department 27, Courtroom 3A located in the Regional Justice Center, 200 Lewis Avenue, Las Vegas, Nevada 89155.**

B. Calendar Call with the designated attorney and/or parties in proper person will be held on **March 11, 2021 at 10:30 a.m.** Parties must have the following ready for trial:

(1) Typed exhibit lists; with all stipulated exhibits marked;
(2) List of depositions;
(3) List of equipment needed for trial, including audiovisual equipment;[1]
(4) Courtesy copies of any legal briefs on trial issues; and
(5) Jury Instructions in two groups, opposed and unopposed. **Each side shall have ready for trial an agreed set of jury instructions, proposed form of verdict along with any additional proposed jury instructions.**

C. Parties are to appear on **February 4, 2021 at 9:30 a.m.** for a Status Check on trial readiness.

[1] **If counsel anticipates the need for audio visual equipment during the trial, a request must be submitted to the Court Recorder, Brynn White at (702) 671-0883 or via e-mail at whiteb@clarkcountycourts.us.**

NANCY L. ALLF
DISTRICT JUDGE
DEPT XXVII
LAS VEGAS, NV 89155

D. The Pre-Trial Memorandum must be filed no later than **March 8, 2021**, with a courtesy copy delivered to Department XXVII. All parties, (Attorneys and parties in proper person) **MUST** comply with **All REQUIREMENTS** of E.D.C.R. 2.67, 2.68 and 2.69. Counsel should include the Memorandum an identification of orders on all motions in limine or motions for partial summary judgment previously made, a summary of any anticipated legal issues remaining, a brief summary of the opinions to be offered by any witness to be called to offer opinion testimony as well as any objections to the opinion testimony.

E. All motions in limine, must be in writing and filed no later than **January 29, 2021**.

F. All original depositions anticipated to be used in any manner during the trial must be delivered to the clerk prior to the start of trial. If deposition testimony is anticipated to be used in lieu of live testimony, a designation (by page/line citation) of the portions of the testimony to be offered must be filed and served by facsimile or hand, two (2) judicial days prior to the start of trial. Any objections or counterdesignations (by page/line citation) of testimony must be filed and served by facsimile or hand, one (1) judicial day prior to the start of trial.

G. In accordance with EDCR 2.67, counsel shall meet, review, and discuss exhibits. All exhibits must comply with EDCR 2.27. Two (2) sets must be three hole punched and placed in three ring binders along with the exhibit list. The sets must be delivered to the clerk prior to start of trial. Any demonstrative exhibits including exemplars anticipated to be used must be disclosed prior to the calendar call. Pursuant to EDCR 2.68, counsel shall be prepared to stipulate or make specific objections to individual proposed exhibits. Unless otherwise agreed to by the parties, demonstrative exhibits are marked for identification but not admitted into evidence. Counsel shall advise the clerk prior to publication.

H. In accordance with EDCR 2.67, counsel shall meet, review, and discuss items to be included in the Jury Notebook. Pursuant to EDCR 2.68, at Calendar Call, counsel shall be prepared to stipulate or make specific objections to items to be included in the Jury Notebook.

NANCY L. ALLF
DISTRICT JUDGE
DEPT XXVII
LAS VEGAS, NV 89155

I. In accordance with EDCR 2.67, counsel shall meet and discuss pre-instructions to the jury, jury instructions, special interrogatories, if requested, and verdict forms. Each side shall provide the Court, at the Calendar Call, an agreed set of jury instructions and proposed form of verdict along with any additional proposed jury instructions with an electronic copy in Word format.

J. In accordance with EDCR 7.70, counsel shall file and serve by facsimile or hand, two (2) judicial days prior to Calendar Call voir dire proposed to be conducted pursuant to conducted pursuant to EDCR 2.68.

Counsel to contact Department 27 Court Clerk, Nicole McDevitt by email at mcdevittn@clarkcountycourts.us or telephone at (702) 671-0672 to schedule the delivery of exhibits.

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

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

Dated: October 8, 2020

Dated this 8th day of October, 2020

Nancy L Allf

NANCY ALLF
DISTRICT COURT JUDGE

B1A 6A7 2F2E 384D
Nancy Allf
District Court Judge

NANCY L. ALLF
DISTRICT JUDGE
DEPT XXVII
LAS VEGAS, NV 89155

CERTIFICATE OF SERVICE

I hereby certify that on or about the date filed, a copy of the foregoing Order was electronically served pursuant to N.E.F.C.R. Rule 9, to all registered parties in the Eighth Judicial District Court's Electronic Filing Program.

If indicated below, a copy of the foregoing was also:

☐ Mailed by United States Postal Service, Postage prepaid, to the proper parties listed below at their last known address(es) :

/s
Karen Lawrence
JUDICIAL EXECUTIVE ASSISTANT

NANCY L. ALLF
DISTRICT JUDGE
DEPT XXVII
LAS VEGAS, NV 89155

CSERV

DISTRICT COURT
CLARK COUNTY, NEVADA

Fremont Emergency Services (Mandavia) Ltd, Plaintiff(s) vs. United Healthcare Insurance Company, Defendant(s)	CASE NO: A-19-792978-B DEPT. NO. Department 27

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Scheduling and Trial Order was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

Service Date: 10/8/2020

Audra Bonney	abonney@wwhgd.com
Cindy Bowman	cbowman@wwhgd.com
D. Lee Roberts	lroberts@wwhgd.com
Raiza Anne Torrenueva	rtorrenueva@wwhgd.com
Colby Balkenbush	cbalkenbush@wwhgd.com
Brittany Llewellyn	bllewellyn@wwhgd.com
Pat Lundvall	plundvall@mcdonaldcarano.com
Kristen Gallagher	kgallagher@mcdonaldcarano.com
Amanda Perach	aperach@mcdonaldcarano.com
Beau Nelson	bnelson@mcdonaldcarano.com

Marianne Carter	mcarter@mcdonaldcarano.com
Karen Surowiec	ksurowiec@mcdonaldcarano.com
Flor Gonzalez-Pacheco	FGonzalez-Pacheco@wwhgd.com
Kelly Gaez	kgaez@wwhgd.com
Kimberly Kirn	kkirn@mcdonaldcarano.com

If indicated below, a copy of the above mentioned filings were also served by mail via United States Postal Service, postage prepaid, to the parties listed below at their last known addresses on 10/9/2020

D Roberts 6385 S Rainbow BLVD STE 400
Las Vegas, NV, 89118