IN THE SUPREME COURT OF THE STATE OF NEVADA

Supreme Court Case No. 81680
District Court Case No. A-19-792978

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

v.

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

and

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

PETITIONER'S REPLY IN SUPPORT OF THEIR PETITION FOR WRIT OF PROHIBITION, OR, ALTERNATIVELY, MANDAMUS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

Rules

INTRODUCTION

Plaintiffs make no compelling argument that the District Court was correct in denying the Defendants' Motion to Dismiss. The Defendants' opening brief ("Petition") establishes most critically that the state-law claims alleged here cannot escape the broad reach of ERISA. This is an important issue in Nevada; because removal to federal court is unavailable for conflict preemption, this issue must be litigated in state courts, and without a ruling from this Court there will be a lack of consistency and clarity at the district courts. This case also imposes on Defendants an extraordinary discovery burden—Plaintiffs are asserting 22,153 separate claims for reimbursement, each of which is subject to discovery—that would be moot if this Court finds that ERISA governs this dispute. ERISA's goal of "nationally uniform plan administration"[1] and its exclusive mechanism to "resolve disputes over benefits inexpensively and expeditiously"[2] will be thwarted absent issuance of the writ. Appeal is not an adequate remedy in this instance. Thus, the District Court's error, in conjunction with the importance of the ERISA preemption issue, necessitates issuance of the writ.

Plaintiffs offer sweeping statements about the supposed limited scope of ERISA, but provide no on-point case law to substantiate their arguments. Instead,

[1] *Gobeille v. Liberty Mut. Ins. Co*., 136, S. Ct. 936, 943 (2016).

[2] *Boyd v. Bert Bell/Pete Rozelle NFL Players Ret. Plan*, 410 F.3d 1173, 1178 (9th Cir. 2005).

Plaintiffs rely repeatedly on cases that are legally and factually dissimilar from this case. Preemption does not turn on broad labels or the legal form of a claim; it turns on whether claims relate to an ERISA plan. Cases where plaintiffs allege a separate contract or promise between the insurer and the provider bear no similarity or legal relevance to this case, where Plaintiffs *disclaim* any contractual relationship with Defendants. Cases where plaintiffs can rely on state statutes that set regulatory minimum payments which create an independent legal duty likewise bear no similarity or legal relevance to Nevada, where no such statute exists. Any duties owed by the Defendants to out-of-network providers, such as Plaintiffs here, can only flow from one source: the terms of Plaintiffs' patients' ERISA plans. Those ERISA plans, and no other contract, promise, statute, or duty, set forth the rate of payment that Defendants were required to pay Plaintiffs. Plaintiffs' arguments lack merit, and the relief sought by Defendants' Petition is warranted.

ARGUMENT

I. Writ Review is Warranted and Appropriate

A. ERISA preemption is an important issue of law that meets the standard for writ review

Plaintiffs' analysis of the narrow issue before this Court ignores a critical point. While writ relief is an extraordinary remedy, mandamus relief may issue within the discretion of this Court when petitions raise important issues of law in need of clarification, involve significant public policy concerns, and this Court's

review would promote sound judicial economy. *See Corporation of the Presiding Bishop of the Church of Jesus Christ of Latter-Day Saints v. Seventh Judicial District Court*, 132 Nev. 67, 366 P.3d 1117 (*citing Int'l Game Tech., Inc. v. Second Judicial District Court*, 122 Nev. 132, 142-43, 127 P.3d 1088, 1096 (2006)). Writ relief is justified where public policy will be served by the Court's invocation of its original jurisdiction. *Lowe Enter. Res. Partners, L.P. v. Eighth Jud. Dist. Court,* 118 Nev. 92, 97, 40 P.3d 405 (2002); *Business Computer Rentals v. State Treasurer,* 114 Nev. 63, 67, 953 P.2d 12 (1998).

Whether ERISA preempts state law claims for reimbursement to out-of-network providers by ERISA plans raises important issues of Nevada law and practice, and the district courts will struggle with the uncertainty surrounding this matter until this Court issues a final directive. For that reason this issue is worthy of writ consideration. In fact, the Nevada Supreme Court has previously decided a writ petition challenging the denial of a motion to dismiss involving the important issue of ERISA preemption. *See W. Cab. Co. v. Eighth Judicial Dist. Court of State in & for Cty. Of Clark*, 133 Nev. 65, 68, 390 P.3d 662, 667 (2017).[3] But the

[3] Plaintiffs concede that in *Western Cab* this Court substantively ruled on a writ petition challenging a district court's denial of a defendant's motion to dismiss a plaintiff's claims based on ERISA preemption. Answer at fn. 4. However, Plaintiffs' argument that ERISA preemption was a minor, incidental issue in *Western Cab.* This is incorrect. The Court devoted substantial attention to whether the Minimum Wage Amendment ("MWA") was preempted by ERISA. *W. Cab Co.*, 133 Nev. 68-74, 390 P.3d 667-672. So the Court has considered ERISA preemption a sufficiently important issue to address on a writ. Regardless, Defendants' writ stands on its own merits.

Court has not addressed the exact issue presented here; namely, ERISA preemption in the context of an out-of-network medical provider's claims against an insurer/claim administrator. This narrow but important legal issue concerns a matter of significant public policy, and its resolution will promote judicial economy. This issue is being litigated in state courts around the country, and the Nevada district courts require guidance here. Addressing this Petition will also provide needed guidance to numerous Nevada medical providers and insurers. Thus, this case falls within this Court's prior holdings that "judicial economy," the "need for clarification" in the law, and the need for similarly situated parties to become aware of the parameters of the law "as soon as possible" constitute other sound grounds for this Court to resolve important issues pursuant to its original jurisdiction to issue writs of mandamus and/or prohibition. *MountainView Hosp. Inc. v. Dist. Ct.*, 128 Nev. 180, 185, 273 P.3d 861, 864 (2012) ("judicial economy"); *Rolf Jensen & Assoc., Inc. v. Eighth Judicial Dist. Ct.*, 128 Nev. 441, 444, 282 P.3d 743, 746 (2012) ("need for clarification"); *Ashokan v. State Dept. of Ins. Co.*, 109 Nev. 662, 667, 856 P.2d 244, 247 (1993) (need to know the "parameters" of the law).

B. ERISA preemption applies to any and all state claims where the conduct arose out of an ERISA plan

Plaintiffs seek damages stemming from purported underpayments of plan benefits for medical services rendered by Plaintiffs to plan members. Although

Plaintiffs incorrectly state otherwise, whether ERISA applies to an out-of-network medical provider's claims against an insurer/plan administrator for additional reimbursement is a question that remains unaddressed by this Court. Again, this important issue of law is being litigated around the country and needs to be addressed in Nevada.

Plaintiffs contend that the Petition is based on the false premise that their claims implicate ERISA. That is not a false premise underlying the Petition; it is the precise subject of the Petition and the unsettled question that the Court should address. Contrary to Plaintiffs' assertion, federal courts have not determined that ERISA does not preempt an out-of-network provider's claims against an insurer/plan administrator. Such generalizations do not reflect the nuance and the careful analysis that governs ERISA preemption, which is expansive in scope.

The federal preemption provisions in ERISA are known for their breadth. In particular, Congress mandated that under § 514 of ERISA any and all state law claims which "relate to" an ERISA plan are preempted. The U.S. Supreme Court has noted that in order to determine whether a claim is preempted by ERISA, the appropriate inquiry is whether the conduct challenged by each claim arose out of the administration of an ERISA plan. *Shaw v. Delta Airlines. Inc.* 463 U.S. 85, 97, 103 (1983); *Ingersoll-Rand Company v. McClendon*, 498 U.S. 133 (1990); *Scott v. Gulf Oil Corp.* 754 F.2d 1499, 1504 (9th Cir. 1985). As set forth in the Petition,

Plaintiffs' state law claims are undisputedly based upon services they provided to patients who had employee benefit plans governed by ERISA. *See e.g.*, Petition at pp. 22-42. Accordingly, Plaintiffs' state law claims are preempted by ERISA.

C. The Court need not resolve any disputed facts for purposes of this writ

There are no critical issues of disputed facts that are implicated by this Petition. This writ challenges the denial of a motion to dismiss and factual issues that were not contested. There was no dispute over factual issues at the district court level that would need to be resolved by this Court despite Plaintiffs disingenuous assertion otherwise. Answer at pp. 15-16. Plaintiffs' Answer does not dispute that over 90% of their claims were for services provided to members of ERISA-governed plans (a key fact supporting Defendants' conflict preemption arguments), nor do they dispute the existence or validity of assignments of benefits from Defendants' plan members (a key fact supporting Defendants' complete preemption arguments). Plaintiffs waived any arguments they did not raise at the district court level, and should not be permitted to dispute facts they previously failed to contest for purposes of evading writ review now. *See e.g., Valley Health Sys., LLC v. Eighth Judicial Dist. Court of State ex rel. Cty. Of Clark*, 127 Nev. 167, 252 P.3d 676 (2011).

D. ERISA preemption immediately impacts this case; it should not be delayed until after a trial and appeal

Plaintiffs fail to appreciate that availability of remedy by appeal is not a jurisdictional bar to granting a writ. *See La Gue v. Second Judicial Dist. Ct.,* 68 Nev. 131, 133, 229 P.2d 162 (1951); *Ashokan, supra,* 109 Nev. at 667 (writ entertained "despite the availability of an adequate legal remedy"); *Business Computer Rentals, supra,* 114 Nev. at 67) (consideration of writ petition warranted despite "alternative avenues of relief" that could be pursued). The circumstances in this case require urgency given the early stages of this litigation.[4] The facts of this case provide a unique opportunity to define the

[4] Plaintiffs' Answer disputes that this litigation is in its early stages and points to (1) the fact that Defendants served their first discovery requests on June 28, 2019 and (2) the current December 30, 2020 fact discovery cut-off. Answer at pp. 17-18. This is highly misleading for a number of reasons. First, the initial discovery served by Defendants was only focused on proving up key facts related to ERISA preemption (i.e. the existence of the ERISA plans and the assignments of benefits Plaintiffs received). RPA 001-009. Defendants did not serve additional non-ERISA related discovery until August 12, 2020, after their motion to dismiss had been denied. **6 PA 696-719**. As to Plaintiffs, they did not serve *any* written discovery until December 9, 2019, nearly 8 months after suit was filed. **6 PA 679-695** (Plaintiffs' First Set of Requests for Production).

Plaintiffs' citation to the fact discovery cut-off is also misleading as there is no question a significant discovery extension will be required. On November 9, 2020, the District Court entered an order requiring Defendants to produce 2,000 administrative records per month until all 22,153 administrative records have been produced. **6 PA 727-737**. Based on this order alone, a discovery extension of at least 9 months will be necessary unless the Parties can reach an agreement to narrow the scope of the Court's production order. Further, no depositions or expert disclosures have taken place. Indeed, Plaintiffs cite to an outdated October 8, 2020 scheduling order. RPA 019-025. This order was superseded by a November 3, 2020 scheduling order which set a trial date of August 2, 2021. **6 PA 720-726**. However, even that trial date may be pushed given the ongoing suspension of jury trials in Clark County. **6 PA 738-746** (Administrative Order 20-24 suspending jury trials until Jan. 11, 2021). In sum, this case is at an early enough stage that writ relief is in the interests of judicial economy and efficiency.

precise breadth of ERISA. It is an appropriate subject for writ relief and the Court's discretionary intervention is warranted.

II. Plaintiffs' Claims are Subject to Conflict Preemption Under ERISA

Although Plaintiffs' Answer contains a substantial number of string citations referencing supposedly helpful case law, **none** of the decisions cited allow Plaintiffs to circumvent ERISA conflict preemption under facts similar to this litigation.

Plaintiffs' Answer does accurately identify instances wherein certain plaintiff-providers have avoided preemption by anchoring their rate of payment claims to an obligation independent of the ERISA plans, in the form of: (i) a written provider agreement, (ii) an oral promise, and (iii) a state insurance statute requiring payment to an out-of-network provider. Answer at pp. 28-35. However, it is undisputed that Plaintiffs: (i) lack a written contract, (ii) do not allege any oral rate of payment promises, and (iii) do not allege that a Nevada rate of payment statute exists. *See generally* Compl. 2 PA 91-139; *see also* Petition at pp. 37-38. Thus, the only obligations Defendants owe to Plaintiffs, if any, flow from their role in administering Plaintiffs' patient's health plans based on the payment methodology in such plans, which the Court must reference to resolve this dispute. Plaintiffs' claims therefore "relate to" ERISA plans.

A. Plaintiffs' claims unquestionably "relate to" an ERISA plan

Plaintiffs' claims are subject to dismissal as conflict preempted because Plaintiffs are seeking additional benefit reimbursement under ERISA-governed plans and therefore their state law claims unquestionably "relate to" the plans. While there *are* cases where state common law and statutory claims have escaped conflict preemption, which Plaintiffs' rely on, there is a stark difference between those cases and the case at hand because they rested on agreements and duties independent of ERISA plans, and thus the claims did not "relate to" the plans. Answer at 30-34.

Plaintiffs' Answer largely relies on *Morris B. Silver M.D., Inc. v. Int'l Longshore & Warehouse etc*. for the proposition that third party provider claims are independent of ERISA plans; however, that case is readily distinguishable. Specifically, in *Morris B. Silver*, a California court found that a provider's quasi-contract claim was not conflict preempted. 2 Cal. App. 5th 793, 796, 206 Cal. Rptr. 3d 461, 463 (Ct. App. 2016). Importantly, and clearly distinct from this matter, the provider was suing based on an *oral promise* by the plan administrator to pay specified amounts. *Id.* at 806, 206 Cal. Rptr. 3d at 472 ("The gravamen of Silver's causes of action . . . is that the Plan orally agreed to pay Silver for health care services in the specified amounts, authorized the provision of those services and then failed to pay as agreed."). Thus, there was no need to reference the

ERISA plan. The insurer could be liable for the oral promise even if the patient was not a member of the insurer's plans. Here, Plaintiffs do not allege that Defendants made any oral promise to them regarding the rate of payment.

Plaintiffs also look to *Glastein v. Aetna, Inc.*, an unpublished case from the District of New Jersey that expressly acknowledged its holding was "at odds with several recent decisions in the District of New Jersey," 2018 WL 4562467, at *3. (D.N.J. Sept. 24, 2018), to support their contention that the lack of a written or oral contract does not mean a court would have to consult the ERISA plans to resolve their claims. At the outset, *Glastein* involved an alleged written contract, contrary to Plaintiffs' argument. The plaintiff in *Glastein* brought a breach of contract claim, among others, because "Plaintiff [surgeon] had contacted Defendant [insurer] prior to the surgery, and Defendant sent Plaintiff a written authorization for the surgery." *Id.* at *1. The *Glastein* court even referenced another case brought by the same surgeon, which *was* preempted because the surgeon "based his claim on an authorization for surgery that was explicitly not a guarantee of payment." *Id.* at *3 (citing *Glastein v. Horizon Blue Cross Blue Shield of America*, 2018 WL 3849904 (D.N.J. Aug. 13, 2018). In other words, the *Glastein* case only escaped preemption based on a prior guarantee of payment which, the plaintiff alleged, constituted a contract. *Glastein* is thereby not analogous to this case as

Plaintiffs admit that they lack a written contract or oral promise.[5]

Moreover, *Glastein* has subsequently been forcefully disagreed with. For example, the court in *Atlantic Shore Surgical Associates v. United Healthcare/Oxford* expressly rejected *Glastein* in holding that a plaintiff's common law claims seeking to obtain "usual, customary, and reasonable" rates of reimbursement without regard to plan terms were preempted under ERISA § 514(a). 2019 WL 1382103, at *3-4 (D.N.J. Jan. 23, 2019). The court reasoned that:

> Plaintiff is disputing the reimbursement for a medical procedure that was performed on a patient pursuant to an ERISA plan. Accordingly, Plaintiff is asserting quintessential ERISA claims ... It is Plaintiff's dispute with this out-of-network reimbursement payment, which is set forth in the terms of the Plan, that underlies its claims. The Court thus cannot analyze Plaintiff's claims without referencing the Plan.

[5] Plaintiffs' other case law citations also turn on the existence of a written contract or oral promise to provide coverage which render them immaterial to this action. *Memorial Hosp. System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 238 (5th Cir. 1990) (coverage was verified orally and relied upon prior to care being provided); *Emergency Physicians of St. Clare's v. United Health Care*, No. 14-404(ES)(MAH), 2014 WL 7404563, at *1,6 (D. N.J. Dec. 29, 2014) (coverage was undisputed and reimbursement made pursuant to a participation agreement); *The Meadows v. Employers Health Ins.*, 47 F.3d 1006 (9th Cir. 1995) (insurer/plan administrator made direct representations to the provider confirming coverage, when in fact the individuals were not covered. This allowed the provider to maintain its independent state law claims because they related to the direct misrepresentations made by the insurer, rather than the ERISA plan); *In Re Managed Care Litig.*, 135 F. Supp. 2d 1253, 1268 (S.D. Fla 2001) (no conflict preemption of providers' contract claims because the plaintiffs had written provider agreements with the defendant insurers that governed the rate of payment).

Id. at *4 (internal quotations and citation omitted). So too, here. And courts' conflicting views of *Glastein* presage like disagreements between the district courts of this state and counsels in favor of hearing this Petition on the merits.

Finally, Plaintiffs rely on *Gobeille v. Liberty Mut. Ins. Co.* to support their argument that conflict preemption is limited in scope. Answer at 30. However, *Gobeille* only reaffirms ERISA's broad scope. There, the U.S. Supreme Court analyzed its prior precedent and explained two situations in which ERISA preempts a state law: (i) where a state law has a "reference to" an ERISA plan, or (ii) where "a state law . . . has an impermissible 'connection with' ERISA plans." *Gobeille*, 136 S. Ct. at 943. The Supreme Court confirmed that, "[w]hen considered together, these formulations ensure that ERISA's express pre-emption clause receives the broad scope Congress intended while avoiding the clause's susceptibility to limitless application." *Id.* Plaintiffs are, at bottom, seeking to modify the rights and obligations set forth in ERISA-governed benefit plans.

Plaintiffs further contend that Ninth Circuit Court precedent recognizing Section 514(a) as one of the "broadest preemption clauses ever enacted by Congress" is now "outdated." Answer at 29. In support of this argument, Plaintiffs cite to this Court's decision in *W. Cab Co. v. Eighth Judicial Dist. Court of State in & for Cty. of Clark,* 133 Nev. 65, 70, 390 P.3d 662, 669 (2017), and the United States Supreme Court's decision in *Egelhoff v. Egelhoff ex rel. Breiner*, 532

U.S. 141, 146 (2001). For multiple reasons, Plaintiffs' argument is wrong.

First, this Court's decision in *W. Cab Co.* merely references Supreme Court precedent set forth in the *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* case ("*Travelers*"), it does not make any affirmative holding regarding the scope of ERISA in the context of an out-of-network provider's state law claims against an insurer. 133 Nev. at 70, 390 P.3d at 669. Second, Plaintiffs' citation to *Egelhoff v. Egelhoff* is also a mere reference to the *Travelers* decision. 532 U.S. 141, 146 (2001). Although the Supreme Court's decision in *Travelers* was critical of the ambiguity in the term "relates to," the Court did not attempt to redefine the purpose or preemptive scope of ERISA. Rather, *Travelers* reaffirmed that the provisions of ERISA "'are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans.'" *Travelers*, 514 U.S. 645, 657 (1995) (quoting 120 Cong. Rec. 29,933 (1974) (statement of Sen. Williams)). Regardless, as noted *supra*, *Gobielle*, which post-dates each of the cited cases, reaffirmed the expansive scope of ERISA § 514.

Further, a recent case from the District of Arizona with nearly identical claims to this case asserted by affiliates of Plaintiffs, *Emergency Grp. of Arizona Prof'l Corp. v. United Healthcare Inc.*, reaffirmed the expansive scope of the ERISA scheme in a parallel case where healthcare providers asserted state law

claims for alleged underpayment of out-of-network billed services. 2020 WL 1451464, at *7 (D. Ariz. Mar. 25, 2020).[6] Specifically, the *Emergency Grp. of Arizona* Court held that "[i]f put into place, Plaintiffs' theory would undermine Congress' policy objective by allowing the development of a patchwork of inconsistent litigation in state courts across the country." *Id.* at *7. Here, Plaintiffs have not and cannot demonstrate that they are suing on a basis independent of the controlling ERISA plans. As set forth more fully in the Petition, at bottom, Plaintiffs' claims seek to force Defendants to pay an inflated "usual and customary rate" without regard to the specific benefit rates established by the terms of each controlling health plan, and without any of the plans having ever agreed to pay anything other than what their terms permit. Petition at pp. 24-29. Because ERISA requires that a health plan "specify the basis on which payments are made to and from the plan," 29 U.S.C. § 1102(b)(4), and that the fiduciary (i.e. Defendants here) follow the terms of the plan, 29 U.S.C. § 1104(a)(1)(D), Plaintiffs' claims seek nothing less than a court order requiring Defendants to violate the payment terms of the plans which would violate their duties under ERISA. Therefore, Plaintiffs' claims "relate to" ERISA plans and are conflict preempted.

[6] Case currently on appeal.

III. Plaintiffs' State Law Claims are Completely Preempted by ERISA

As with the issue of conflict preemption, Plaintiffs' Answer contains numerous string citations referencing supposedly helpful but wholly inapposite case law related to complete preemption. Again, **none** of the cases cited by Plaintiffs recognize the avoidance of complete preemption under facts similar to those alleged in Plaintiffs' Complaint.

A. State courts, just like federal courts, regularly dismiss state law claims on the basis of complete preemption under ERISA

Plaintiffs argue, and the District Court incorrectly found, that only federal courts can dismiss state law claims on the basis of complete preemption. Answer at 22-23. However, the Nevada Supreme Court has already rejected this argument in *Marcoz*. *Marcoz v. Summa Corp*., 106 Nev. 737, 749, 801 P.2d 1346, 1354 (1990) (dismissing state law wrongful discharge claim on the basis of ERISA complete preemption). Plaintiffs' Answer falsely alleges that *Marcoz* does not contemplate complete preemption when, in fact, the decision specifically approves of the lower court's reliance on 29 U.S.C. § 1132 in dismissing state law claims. ("Here, the district court primarily based its decision on its interpretation of 29 U.S.C. §§ 1144(a), 1140, **and 1132**"). *Id.* at 742. As Plaintiffs are undoubtedly aware, 29 U.S.C. § 1132 is the codified version of ERISA Section 502 and governs complete preemption. Importantly, the *Marcoz* decision also analyzes § 1132 and its effect on state law causes of action, which this Court would not have done if it

did not take complete preemption under § 1132 into account when rendering its decision. *Id.* at 743-44.

In the end, this Court affirmed the district court's decision in *Marcoz* in all respects, including its application of § 1132 to hold the at-issue state law claims were completely preempted. *Id.* at 749. Indeed, why would this Court state that "Marcoz attempts to avoid **complete preemption** . . . [but] Marcoz has not stated a viable cause of action" if state courts were prohibited from using the doctrine of complete preemption to dismiss state law claims? *Id.* (emphasis added). Other state courts are in accord. *See e.g.*, *Ambulatory Infusion Therapy Specialist, Inc. v. N. Am. Adm'rs, Inc.*, 262 S.W.3d 107, 114 (Tex. App. 2008) ("in such instances of complete preemption, a state law claim may be re-characterized as an action to recover benefits under ERISA, and the state courts will have jurisdiction over that claim, although the claim may be subject to removal to federal court as a claim 'arising under' federal law.").

The cases cited by Plaintiffs do not support the conclusion they offer this Court. For example, in *Autonation*, the Court never stated that complete preemption may not be used to dismiss claims. *Autonation Inc. v. United Healthcare Ins. Co.*, 423 F. Supp. 2d 1265, 1269 (S.D. Fla. 2006). Rather, the court declined to address the issue of complete preemption because the plaintiff's

claims were clearly conflict preempted. *Id.*[7]

Finally, although Plaintiffs look to the Nevada federal district court's remand order for support here,[8] a federal district court in Arizona, dealing with Plaintiffs' affiliates' nearly identical state law claims, reached the opposite conclusion in *Emergency Grp. of Arizona Prof'l Corp. v. United Healthcare Inc.*, finding the plaintiffs' state law claims subject to dismissal "in [their] entirety under conflict and complete preemption." 2020 WL 1451464, at *7. Moreover, the Nevada federal district court's ruling on complete preemption is not binding on this Court. As the Ninth Circuit cogently held: "The federal court's ruling on 'complete preemption' has no preclusive effect on the state court's consideration of the substantive preemption defense. This is, of course, particularly appropriate because the jurisdictional decision of lack of complete preemption is insulated by section 1447(d) from appellate review." *Whitman v. Raley's Inc*., 886 F.2d 1177, 1181 (9th Cir. 1989).

So long as the two-part test set forth by the U.S. Supreme Court in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004) is satisfied for a given state law claim, complete preemption applies and the claim must be dismissed. Plaintiffs' other

[7] Plaintiffs also cite to *Mid-Town Surgical Ctr., L.L.P. v. Humana Health Plan of Texas, Inc.*, however, that case involved the verification and pre-certification of coverage by the issuer of the plan prior to any services being rendered to its members. 16 F. Supp. 3d 767, 772 (S.D. Tex. 2014). The facts here are inapposite.

[8] 1 PA 85-90.

arguments and case law in regard to the complete preemption issue is an attempt to distract this Court from focusing on whether the *Davila* elements have been met here, which they clearly have. The application of the *Davila* test, as discussed *infra*, renders Plaintiffs' claims completely preempted, and vacation of the District Court's order is the appropriate remedy here.

B. Element 1 of the *Davila Test* is met

The first prong of the *Davila* test is met here: Plaintiffs could have brought these claims under ERISA because they have received assignments of benefits from Defendants' plan members that allow them to stand in the plan members' shoes to bring ERISA benefit claims. Petition at pp. 12-13. Plaintiffs do not contest that Defendants have established that over 90% of Plaintiffs' claims/requests for payment to Defendants were for services provided to members of employee benefit plans governed by ERISA. *Id.* Plaintiffs also do not contest that, for all of the claims that they are asserting in this litigation, they received an assignment of benefits. Plaintiffs therefore have standing to bring a claim under ERISA § 502(a)(1)(B), ERISA's civil enforcement statute, and thus the first element of the *Davila* test is met. *Misic v. Bldg. Serv. Employees Health & Welfare Tr.*, 789 F.2d 1374, 1377-79 (9th Cir. 1986) (finding that provider's acceptance of an assignment of benefits from patient gave him the right to assert a statutory ERISA claim against the plan administrator because he now stood in the shoes of

the plan member.); *In Re Managed Care Litig*., 298 F. Supp. 2d 1259, 1291-92 (S.D. Fla. 2003) (same).[9]

Despite this, Plaintiffs argue that the "rate of payment" claims they are asserting do not implicate ERISA plans. Answer at 26-27. However, Plaintiffs' focus on "rate of payment" vs. "right to payment" arises from a superficial analysis of the law.[10] Regardless of what type of claim is at issue, a court's focus is always on Davila's two part test: whether the provider **could have brought the claim under ERISA** and whether the provider **can anchor that claim to a legal duty independent of the ERISA plans**. In all of the so-called "rate of payment" cases that Plaintiffs rely on, the provider avoided complete preemption by either: (i) showing that it lacked an assignment of benefits and thus the ERISA plan was undisputedly not implicated, or (ii) citing to an express written contract governing the rate of payment, a state insurance statute requiring payment to out-of-network providers, or an oral promise by the plan administrator/insurer that it would pay the

[9] Plaintiffs cite to the *California Spine* case (Answer at p. 25) which is inapposite. *California Spine & Neurosurgery Inst. v. Bos. Sci. Corp*., 2019 WL 1974901, at *1 (N.D. Cal. May 3, 2019). In *California Spine*, complete preemption did not apply because the defendant failed to bring forth evidence demonstrating that the plaintiff-provider was an assignee of its patients' benefits. *Id.* Here, Defendants *have* brought forth evidence proving that Plaintiffs received assignments (Petition at pp. 13-14) and it is undisputed that Plaintiffs are assignees and have standing (the derivative right) to assert ERISA claims.

[10] Plaintiffs attempt to use their "rate of payment" argument to defeat both conflict and complete preemption. Thus, although the argument is discussed here in the context of complete preemption, it is inapplicable to conflict preemption for the same reasons.

provider at a particular rate. Answer at pp. 25-28. But it is undisputed that none of these facts are present here.

In cases similar to this one, out-of-network rate of payment claims have been found to be completely preempted because the provider received an assignment of benefits. For example, in *Torrent & Ramos* (cited in the Petition at pp. 34, 38 but never addressed in Plaintiffs' Answer) the Court found that an out-of-network provider's implied-in-fact contract and unjust enrichment rate of payment claims were completely preempted. *Torrent & Ramos M.D., P.A. v. Neighborhood Health Partnerships, Inc*., 2004 WL 7320735, at *4 (S.D. Fla. July 1, 2004). There, the provider argued that preemption should not apply since the HMO had already deemed the claims payable and thus only the rate of payment was at issue. *Id.* at *2-3. The court rejected this "rate of payment" argument, stating:

> this is simply a suit for benefits under an ERISA plan where a provider rendered certain emergency services to an ERISA [plan member], submitted claim forms to the various ERISA plans, and failed to receive the payment it expected. Pathologists' attempt to recast its claim as one of implied contract does not change this reality.

Id. at *4 (emphasis added). Like the plaintiff in *Torrent & Ramos*, Plaintiffs received assignments of benefits from their patients and cannot "recast" their ERISA reimbursement claim as an implied-in-fact contract claim, unjust

enrichment claim, or anything else. The first element of the *Davila* test is met.[11]

C. Element 2 of the *Davila* Test is met

The second element of the *Davila* Test is also met: Plaintiffs have failed to allege any facts that give rise to a legal duty independent of ERISA. Plaintiffs, by their own admission, and "[a]t all relevant times, . . . [did not have] a written 'network' agreement governing rates of reimbursement" from Defendants. Compl. at ¶ 20, 2 PA 97. Plaintiffs further admit that the Health Care Providers are a "non-participating" or "out-of-network" providers. *Id.* Plaintiffs attempt to bridge this analytical gap by claiming that an implied-in-fact contract exists, and contend that this implied-in-fact contract gives it a legal right to proceed with its state law claims. Answer at 27.

Notably, Plaintiffs fail to cite a single Nevada state insurance statute that requires payment to out-of-network providers. *See generally,* Plaintiffs'

[11] The *Misic* case cited by Plaintiffs also has nearly identical facts and supports Defendants' position. *Misic v. Bldg. Serv. Employees Health & Welfare Tr.*, 789 F.2d 1374 (9th Cir. 1986). ***Misic* was a so-called "rate of payment" case** and the Court found complete preemption was appropriate. In *Misic*, just as Plaintiffs allege here, the insurer/administrator paid a portion of the amounts billed by the medical provider but not the entire amount. *Id.* at 1376 ("The trust paid a portion of the amount billed, but less than the full 80%."). The Court found that the terms of the ERISA plan (requiring that the plan member be reimbursed at 80% of the usual and customary cost of medical services) were the only thing that governed the rate of payment and thus complete preemption applied. *Id.* The result should be the same here as the ERISA plans at issue do require a particular rate of payment to plan members for services from out-of-network providers like Plaintiffs.

Complaint. Plaintiffs do cite to the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd and NRS 439B.410. Compl. at ¶ 18, 2 PA 96. However, these statutes only relate to requirements that hospitals provide emergency services to patients regardless of the patients' ability to pay. These statutes do not require payment to out-of-network providers. In fact, these statutes establish that Plaintiffs provided care in order to comply with federal and Nevada law, and were not induced to do so by any assurance by Defendants or any other insurer.

Plaintiffs also allege that the "Health Care Providers were entitled to and expected to be paid at rates in accordance with the standards established under Nevada law." *Id.* at ¶ 195, 2 PA 124. However, Plaintiffs' allegation is implausible and vague for a simple reason: no such statute exists in Nevada. Plaintiffs' Complaint is also devoid of any allegation of an oral representation by Defendants that they would pay Plaintiffs a particular rate for their services. *See generally id*. Rather, the only allegation is that Defendants' past conduct of paying for certain medical services that Plaintiffs provided to Defendants' plan members created an implied-in-fact contract. *Id.* at ¶¶ 196-199, 2 PA 124-125.

The above admissions and omissions demonstrate that there is no legal duty independent of ERISA implicated by the Complaint. In their Answer, Plaintiffs attempt to distinguish the *N. Cypress Med. Ctr. Operating Co., Ltd. v. Cigna*

Healthcare case by arguing that state law claims are not preempted when they are based on independent legal duties. Answer at 36; 781 F.3d 182, 201 (5th Cir. 2015). Defendants agree. Plaintiffs simply fail to identify a legal duty here other than the terms of the ERISA plans themselves.

As discussed in more detail below, all of the cases that Plaintiffs cite in support of their argument that element 2 of the *Davila* test is not met involved situations where an independent duty was created by (1) a written provider agreement, (2) an oral promise by the insurer to pay the provider a particular rate or (3) a state insurance statute requiring a particular rate of payment. Since none of these facts are alleged here, the case law cited by Plaintiffs is unpersuasive.

1. Plaintiffs' reliance on cases where (a) an express written provider agreement exists or (b) where an oral promise to pay a particular rate was made, is misplaced.

When a plaintiff-provider has a separate written agreement with the defendant-insurer (often called a "provider agreement") that governs the rate of reimbursement owed to that medical provider, the second element of the *Davila* test is often not met.[12] The reason is that the provider agreement creates legal

[12] Plaintiffs' Answer offers the following cases which are all distinguishable: *Blue Cross of California v. Anesthesia Care Assocs. Med. Grp., Inc*., 187 F.3d 1045, 1052 (9th Cir. 1999) (express written provider agreement with the insurer created duties independent of the employee benefit plan); *Lone Star OB/GYN Assocs. v. Aetna Health Inc*., 579 F.3d 525, 530 (5th Cir. 2009) (same); *Connecticut State Dental Ass'n v. Anthem Health Plans, Inc*., 591 F.3d 1337, 1353 (11th Cir. 2009) (same); *CardioNet, Inc. v. Cigna Health Corp.*, 751 F.3d 165, 168 (3d Cir. 2014)

duties independent of the ERISA-governed plans: the insurer has agreed to pay under the terms of the contract and would be liable even if the ERISA plan were ignored. Here, Plaintiffs admit that they are out-of-network providers and that "[t]here is no written agreement between Defendants and the Health Care Providers for the healthcare claims at issue in this litigation." Compl. at ¶ 20, 2 PA 97. Thus, the only legal duties owed by Defendants (if any) flow from the rights Plaintiffs have as the assignees of Defendants' plan members. Since those rights are directly based on and related to ERISA-governed plans, element 2 of the *Davila* test is met.

Similarly, legal duties independent of those owed under an ERISA plan can also sometimes be created by oral representations to pay a particular rate such as those that occurred in the *Marin* case that Plaintiffs rely on. *Marin Gen. Hosp. v. Modesto & Empire Traction Co*., 581 F.3d 941, 950-51 (9th Cir. 2009). In *Marin*, the plan administrator offered during a phone call to pay 90% of the billed medical expenses even though this was more than the rate of payment called for in the ERISA plan. *Id.* at 943-44. The ERISA plan could be wholly ignored and the claim adjudicated as if it did not exist, because the oral representation created the duty. Thus, the court held that the provider's claims were not preempted by ERISA.

(same); *Montefiore Med. Ctr. v. Teamsters Local* 272, 642 F.3d 321, 326 (2d Cir. 2011) (same).

Here, in contrast to *Marin*, Plaintiffs' Complaint does not allege that Defendants ever made any oral representations that they would reimburse Plaintiffs at a particular rate (or at all for that matter). Absent the plans, the providers have conferred no alleged benefit on the Defendants; Defendants receive no benefit for conferral of care on third parties. And if the patients turn out not to be plan members, Defendants would owe nothing to Plaintiffs, even under Plaintiffs' own theories. Thus, Plaintiffs' only right to reimbursement (if any) flows from the assignment it received from Defendants' plan members and its claims are subject to complete preemption.

2. Cases where a legal duty independent of the ERISA plan is created by a state insurance statute requiring payment to out-of-network providers

State statutes mandating that insurers pay out-of-network providers a particular rate of payment have also sometimes been found to create a legal duty independent of ERISA that will allow a provider's claims to avoid complete preemption.[13] However, no such state insurance statute exists in Nevada.[14]

[13] *Garber v. United Healthcare Corp.*, 2016 WL 1734089, at *5 (E.D.N.Y. May 2, 2016) (rates of reimbursement were set by New York "Fair Database" established in October 2009 "as part of the settlement of an investigation by then New York State Attorney General, Andrew Cuomo, into the health insurance industry's methods for determining out-of-network reimbursement."); *Med. & Chirurgical Faculty of State of Maryland v. Aetna U.S. Healthcare, Inc*., 221 F. Supp. 2d 618, 619, 621 (D. Md. 2002) (citing "Maryland statutes that require HMOs to pay non-

Because there is no legal duty independent of ERISA in this case, element 2 of the *Davila* test is met and Plaintiffs' claims should be dismissed as completely preempted.

IV. PLAINTIFFS HAVE FAILED TO STATE VIABLE CLAIMS UNDER NRCP 12(B)(5)

To the extent any of Plaintiffs' claims escape both conflict and complete preemption, which they do not, the claims should nevertheless be dismissed pursuant to NRCP 12(b)(5).

A. Plaintiffs' implied-in-fact contract claim should be dismissed

Plaintiffs' Answer focuses on the incorrect notion that it has properly stated a claim for "Breach of Implied In Fact Contract" under Nevada law. Answer at 38-40. Plaintiffs offer *Nevada Ass'n Servs., Inc. v. First Am. Title Ins. Co.*, for the proposition that "through a course of dealing. . . [parties] can manifest[] an intent to be bound and agreed to material terms of an implied contract." 2012 WL 3096706, at *3 (D. Nev. July 30, 2012). But Nevada law requires that both parties demonstrate that they: (1) intended to contract, (2) exchanged bargained-for

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contracting physicians according to certain formulas" to find that provider-plaintiff's claims were not preempted by ERISA).

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

promises, and (3) the terms of the bargain are sufficiently clear. *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 379-80, 283 P.3d 250, 256 (2012). Plaintiffs fail to allege these elements, which is demonstrated by paragraph ¶ 197 of their Complaint:

> 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.

Compl. ¶ 197, 2 PA 124. There is no allegation that the Defendants "intended to contract" with Plaintiffs, no allegation that promises were exchanged between the Parties, and no allegation defining the terms of those supposed promises. Plaintiffs' claim consists only of conclusory statements.

The fact that Plaintiffs can only rely on the aforementioned paragraph to support their claim is telling—as it evinces that Plaintiffs' claim is based on what "Defendants pa[id] for other substantially identical claims also submitted by the Health Care Providers." In other words, Plaintiffs' claim is based on consideration from previously submitted claims. Under Nevada law, "[p]ast consideration is the legal equivalent to no consideration." *Smith v. Recrion Corp*., 91 Nev. 666, 669, 541 P.2d 663, 665 (1975).

Plaintiffs' attempt to distinguish *Recrion* based on the existence of the

Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd, and NRS 439B.410, is misplaced. Answer at pp. 39-40. To the extent that Plaintiffs contend *Recrion* is inapposite because it involved services that were unsolicited, this is nonsensical. The existence of these statutes does not imply that Defendants *solicited* services from Plaintiffs, the statutory provisions only establish requirements *that hospitals provide* emergency services to *patients* regardless of the patients' ability to pay. The statutes relied on by Plaintiffs do not require payment by *insurers* to out-of-network providers, nor do they contain provisions setting forth a required rate of payment. Accordingly, there is no mandate that Defendants pay Plaintiffs at any specific rate for these services.

Plaintiffs have failed to satisfy any of the elements for an implied-in-fact contract. At a minimum, it cannot be disputed that the terms of any alleged contract were not "sufficiently clear." This claim should be dismissed.

B. Plaintiffs' claim for tortious breach should be dismissed

Defendants agree that *Martin v. Sears, Roebuck and Co.* sets forth the appropriate elements to establish a valid claim for "tortious breach of the implied covenant of good faith and fair dealing" under Nevada law. Answer at 41; 111 Nev. 923, 929, 899 P.2d 551, 555 (1995). Specifically, Plaintiffs must establish: (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. *Id.*

As to the first element under *Martin*, there must exist a valid contract between Plaintiffs and Defendants to give rise to the implied covenant of good faith and fair dealing. *A.C. Shaw Const., Inc. v. Washoe Cty*., 105 Nev. 913, 914, 784 P.2d 9, 10 (1989). Because Plaintiffs have failed to allege an enforceable implied-in-fact contract as demonstrated *supra*, the claim should fail at the outset of the analysis. Even assuming, however, that an implied-in-fact contract somehow exists, this claim still fails. Nevada has only recognized this cause of action in two discrete circumstances: (1) a suit by an insured against its insurer where an insurer acts in bad faith in denying coverage, and (2) bad faith wrongful discharge by an employer where the employee has a special relationship of trust, reliance and dependency with the employer. *U.S. Fid. & Guar. Co. v. Peterson*, 91 Nev. 617, 620, 540 P.2d 1070, 1071 (1975) (recognizing bad faith tort in insurance context); *D'Angelo v. Gardner*, 107 Nev. 704, 717, 819 P.2d 206, 215 (1991) (recognizing bad faith tort in employment context).

Plaintiffs nevertheless contend that "a special relationship exists between United and the Health Care Providers," such that Defendants "wield[] a disparate level of power over whether the Health Care Providers get paid for its services." Answer at 43. This is a conclusory allegation that is defeated by the other

allegations in the Complaint. Plaintiffs, by their own admission, are a sophisticated "professional practice group of emergency medicine physicians" that run major emergency rooms across the Las Vegas Valley. *See* Compl. at ¶¶ 3-5, 17, 2 PA 94, 96. Further, no Nevada Court has ever recognized a special relationship between an out-of-network provider and a plan administrator. While Plaintiffs argue that this does not foreclose the recognition of such a relationship, it is nonetheless still true that Nevada law has ***never*** recognized this tort as arising from contracts between sophisticated parties in the commercial realm, and the Nevada Supreme Court has not signified that it will broaden the tort to cover such circumstances in the future.

Finally, Plaintiffs have failed to set forth that the parties' dynamic amounts to a "special relationship" within the purview of Nevada law. Plaintiffs' Answer offers *Ins. Co. of the W. v. Gibson Tile Co.* as support for what constitutes a "special relationship," but that case indicates that the Nevada Supreme Court intended the term to be narrowly construed. Answer at 41; 122 Nev. 455, 134 P.3d 698 (2006). In particular, the Court cautioned that "**an action in tort for breach of the covenant arises only 'in rare and exceptional cases,**' . . . in which one party holds 'vastly superior bargaining power.'" *Id.* at 461–62, 702. Plaintiffs' allegations do not demonstrate "rare and exceptional" circumstances such that it should be allowed to proceed with this claim. Pursuant to Plaintiffs' own cited

authority, this claim should be dismissed.

C. Plaintiffs' claim for unjust enrichment should be dismissed

Plaintiffs cite to *Topaz Mut. Co. v. Marsh* for the proposition that a "benefit in [an] unjust enrichment claim can be 'indirect.'" Answer at 43. Defendants do not disagree with this general statement, but it is entirely irrelevant here, where Defendants did not receive *any* benefit, direct or indirect, from Plaintiffs' treatment of the patients at issue. Specifically, in *Topaz*, the defendants received money from the plaintiff and used it to forestall a foreclosure on a property. *Topaz Mut. Co. v. Marsh*, 108 Nev. 845, 856, 839 P.2d 606, 613 (1992). Here, Plaintiffs have not provided any services to Defendants.

Defendants' Petition relied on numerous decisions holding that in situations such as this no benefit indirectly or otherwise is bestowed to, or retained by a defendant-insurer. Petition at p. 48. Plaintiffs' Answer is unsuccessful in trying to distinguish the on-point decisions.

First, Plaintiffs argue that *Peacock Med. Lab, LLC v. UnitedHealth Grp., Inc.*, 2015 WL 2198470, at *5 (S.D. Fla. May 11, 2015) is distinguishable because "Florida law requires that the benefit conferred be 'direct' [so] any indirect benefit would not be actionable under Florida law." Answer at 45. While it is true that Florida law does require a direct benefit, the case law sets forth that *all* "benefits of healthcare treatment, [both direct and indirect,] flow to patients, not insurance

companies." *Adventist Health Sys./Sunbelt Inc. v. Med. Sav. Ins. Co.*, 2004 WL 6225293, at *6 (M.D. Fla. Mar. 8, 2004). These cases do not draw a distinction to say that there were indirect benefits that were otherwise "[in]actionable under Florida law." Answer at 45.

Next, Plaintiffs attempt to distinguish *Encompass Office Sols., Inc. v. Ingenix, Inc.*, 775 F. Supp. 2d 938, 966 (E.D. Tex. 2011) on the basis that it did not arise in "the context of emergency medical services." Answer at 45. This is an aimless argument; the case still set forth that quasi-contractual causes of action should be dismissed because the benefit of medical treatment flows only to the patient.

While Plaintiffs argue that *Joseph M. Still Burn Centers, Inc. v. AmFed Nat. Ins. Co.*, 702 F. Supp. 2d 1371, 1377 (S.D. Ga. 2010) is distinguishable because "plaintiff was already paid reimbursement rates set forth in Mississippi's and Georgia's workers' compensation fee schedules," this is similar to the present matter where Plaintiffs were likewise already reimbursed under their patients' health plans. And while Plaintiffs argue that the court in *Cedars Sinai Med. Ctr. v. Mid-W. Nat. Life Ins. Co.*, 118 F. Supp. 2d 1002, 1013 (C.D. Cal. 2000) supposedly issued an inconsistent ruling in a later unpublished case, the *Cedars Sinai* ruling was decided on different grounds and has not been overturned or abrogated.

Finally, regarding *Travelers Indem. Co. of Connecticut v. Losco Grp., Inc*., 150 F. Supp. 2d 556, 563 (S.D.N.Y. 2001), Plaintiffs incorrectly argue that New York law imposes a requirement that "more than a benefit received, plaintiff must show services were performed at the behest of the defendant." Answer at p. 45. While this was an argument by one of the *parties*, the *Travelers* court never actually signaled that it was adopting this position, nor did it acknowledge that it had any bearing on the ultimate holding. The common sense holding simply acknowledged that "insurance compan[ies] derive[] no benefit from [medical] services; indeed, what the insurer gets is a ripened obligation to pay money to the insured—which hardly can be called a benefit." *Id.* at 563. Plaintiffs next cite to a number of cases for the proposition that insurers receive benefits in the form of having their obligations to plan members discharged (Answer at pp. 43-44) but these cases are inapposite.[15]

[15] *See Bell v. Blue Cross of California*, 131 Cal.App.4th 211 (2005) (dealt with California Department of Managed Health Care's jurisdiction and did not otherwise set forth that insurers receive benefit from provision of medical services); *El Paso Healthcare System, Ltd. v. Molina Healthcare of New Mexico*, 683 F.Supp.2d 454 (W.D. Tex. 2010) (involved Managed Care Organizations ("MCO") under Medicaid Program; an MCO might be unjustly enriched when another entity provides services the MCO was obligated to provide); *Appalachian Reg'l Healthcare v. Coventry Health & Life Ins. Co.*, 2013 WL 1314154, at *1 (E.D. Ky. Mar. 28, 2013) (same); *River Park Hosp., Inc. v. BlueCross BlueShield of Tennessee, Inc.*, 173 S.W.3d 43 (Tenn. Ct. App. 2002) (same); *New York City Health & Hosps. Corp. v. Wellcare of New York, Inc.*, 35 Misc. 3d 250, 255, 937 N.Y.S.2d 540, 544 (Sup. Ct. 2011) (same); *Fisher v. Blue Cross Blue Shield of Texas*, 2011 WL 3417097 (N.D. Tex. Aug. 3, 2011) (relies on holding in *El Paso v. Molina*, which is grounded in reasoning based on obligations of MCO); *Forest Ambulatory Surgical Assocs., L.P. v. United Healthcare Ins. Co.*, 2013 WL 11323600, at *10 (C.D. Cal. Mar. 12, 2013) ("Plaintiff's quantum meruit claim is based on Plaintiff's right to reimbursement from Defendant for services rendered

Here, there has been no legally recognizable benefit bestowed to, or retained by, Defendants. Nor have Plaintiffs' alleged that Defendants have appreciated any purported benefit. Plaintiffs' unjust enrichment claim must be dismissed.

D. Plaintiffs' Unfair Trade Practices claim should be dismissed

In defense of their Unfair Trade Practices Claim, Plaintiffs attempt to distinguish this Court's recognition in *Gunny v. Allstate* that there is no private right of action under Nevada's Unfair Insurance Practices Act to bring claims against insurers in favor of third-party claimants like Plaintiffs. 108 Nev. 344, 346, 830 P.2d 1335, 1336 (1992). In doing so, Plaintiffs argue that "the absence of a contract between Gunny and the insurer makes this case distinguishable." Answer at 46. While Plaintiffs agree that *Gunny* bars third party claimants from bringing this claim absent a direct contractual relationship with the insurer, they seek to use their implied-in-fact contract allegation to supply the needed contract and, as discussed at length *supra*, Plaintiff's implied-in-fact contract claim fails. Further, Plaintiffs do not refute the applicability of *Tweet v. Webster*, 614 F. Supp. 1190 (D. Nev. 1985) or *Crystal Bay Gen. Imp. Dist. v. Aetna Cas. & Sur. Co*., 713 F. Supp. 1371, 1376 (D. Nev. 1989), which provide "that the Act created no private right of action in favor of third party claimants against [] insurer[s]." Plaintiffs are nothing

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[and therefore] arises from Plaintiff's status as a beneficiary of its patients . . . [and] is preempted by ERISA").

more than a "third party claimant" with no contractual relationship with Defendants.

E. Plaintiffs' Deceptive Trade Practices claim should be dismissed

In their Petition, Defendants demonstrated that a "victim" as defined in the *Igbinovia v. State*,[16] *Winnemucca Farms, Inc. v. Eckersell*[17] and *Weaver v. Aetna Life Ins. Co*.[18] cases only confers standing on individuals who were "passive" victims of a deceptive trade practice and did not "voluntarily" participate in a scheme that allegedly caused them harm. Petition at pp. 50-51.

Plaintiffs, in response, did not disagree that the definition of "victim" set forth in *Igbinovia v. State*, *Winnemucca Farms, Inc. v. Eckersell*, and *Weaver v. Aetna Life Ins. Co*., is applicable to claims brought under NRS 41.600(1). Instead, Plaintiffs contend that they still qualify as a victim under these holdings. Answer at 48-49. Plaintiffs' position is nonsensical, however, because they admit to voluntarily participating in the negotiations and business interactions that led to their alleged harms. Compl. at ¶ 91, 2 PA 107. Therefore, because Plaintiffs were not passive victims of the alleged deceptive trade practice but rather actively negotiated and engaged with Defendants regarding a potential in-network provider

[16] 111 Nev. 699, 895 P.2d 1304 (1995).

[17] No. 3:05-CV-385-RAM, 2010 WL 1416881, at *7 (D. Nev. Mar. 31, 2010).

[18] No. 308-CV-00037-LRH-VPC, 2008 WL 4833035, at *5 (D. Nev. Nov. 4, 2008).

agreement, Plaintiffs lack standing to bring a Deceptive Trade Practices cause of action and this claim should be dismissed.

F. Plaintiffs' RICO claim should be dismissed

1. The Answer fails to address Defendants' core argument—that Plaintiffs cannot plead proximate cause

The crux of Plaintiffs' RICO claim is that the Defendants and various third parties made misrepresentations to Plaintiffs regarding their payment methodologies with the aim of reducing the rate of payment to Plaintiffs. Compl. at ¶ 265, 2 PA 134. Yet, Plaintiffs admit that they were required by state and federal law to treat Defendants' plan members regardless of "insurance status or ability to pay." *Id.* at ¶ 21, 2 PA 97. Thus, the Petition pointed out that it is impossible for Defendants' alleged misrepresentations about the rate of reimbursement to have been the proximate cause of Plaintiffs' damages. Petition at pp. 52-55.

In their Answer, Plaintiffs try to circumvent this glaring problem by citing to *Holmes, Takeda,* and *Mendoza* to argue that, because Plaintiffs' allegations allegedly meet the three factor *Holmes* test for proximate cause, Plaintiffs do not need to allege that Defendants' misrepresentations were the "but for" cause of Plaintiffs' injuries. Answer at 50-51. This is an incorrect statement of the law, as a court should not consider the three-factor causation test set forth by the U.S. Supreme Court in *Holmes* unless it first determines that a RICO plaintiff has

adequately alleged that the predicate RICO crimes are the "but for" cause of the plaintiff's injuries. *Holmes v. Sec. Inv'r Prot. Corp*., 503 U.S. 258, 269 (1992) (holding that even if a plaintiff had adequately alleged the "but for" element of causation, it would still have to satisfy the separate three-factor causation test to determine whether the connection between the predicate crime and the harm to plaintiff was too attenuated to permit a recovery); *Painters & Allied Trades Dist. Council 82 Health Care Fund v. Takeda Pharm. Co. Ltd*., 943 F.3d 1243, 1248, n.6 (9th Cir. 2019) (stating that the court would only address the three factor *Holmes* test because the defendant had not challenged the "but for" causation element of the civil RICO claim); *Mendoza v. Zirkle Fruit Co*., 301 F.3d 1163, 1171 (9th Cir. 2002) (only addressing three-factor test because the plaintiff had adequately alleged "but for" causation).

Here, the Court does not need to reach the three-factor *Holmes* test because Plaintiffs have failed to allege "but for" causation, including because they were legally obligated to provide emergency medical services regardless of the promises Defendants and Data iSight allegedly made regarding how the amount of reimbursement would be calculated. Compl. at ¶ 21, 2 PA 97.

Nor can Plaintiffs even satisfy the *Holmes* test because Plaintiffs admit that their damages flow from the state and federal laws that require them to provide emergency medical services even if they will not be compensated for those

services—not from Defendants' alleged misrepresentations about the rate of reimbursement. Plaintiffs have therefore failed to adequately allege causation and their RICO claim should be dismissed.[19]

2. Plaintiffs fail to allege the elements of reliance and intent to deceive for the two fraud based RICO predicate crimes

Plaintiffs do not dispute that to adequately allege a predicate RICO crime under NRS 207.360(28) (obtaining money by false pretenses) or NRS 207.360(35) (transaction involving fraud or deceit) a complaint must allege *reliance* by the plaintiff on the false statement. Answer at 52-53. But just as with the proximate cause issue, Plaintiffs' Answer does not engage with Defendants' argument that, because Plaintiffs have admitted in their Complaint that they were required by law to provide emergency medical services, Plaintiffs have by definition failed to allege that they relied to their detriment on Defendants' alleged false representations about how the rate of reimbursement would be calculated. Rather than address this issue, Plaintiffs simply argue that they can amend their Complaint. Answer at 53. However, any amendment would be futile because Plaintiffs cannot allege that they relied on Defendants' alleged false representations because they were mandated by state and federal law to render

[19] As addressed in the Petition, the District Court incorrectly held that proximate cause is a factual issue precluding dismissal at this stage in the litigation. The District Court's holding is in direct conflict with this Court's precedent. *Allum v. Valley Bank of Nevada*, 109 Nev. 280, 286, 849 P.2d 297, 301 (1993) (affirming dismissal as a matter of law because the plaintiff failed to plead proximate cause).

treatment to Defendants' plan members regardless of what Defendants allegedly said or promised. Plaintiffs' argument is therefore without merit.

Plaintiffs also ignore Defendants' argument that they have failed to plead "intent to deceive." *See* Answer at 52-53. Plaintiffs admit that Defendants provided advance notice to Plaintiffs that their out-of-network payment rates were expected to drop, which defeats any suggestion of deception. Compl. at ¶¶ 93-97, 104-106, 2 PA 107-108, 109. Therefore, because Plaintiffs have failed to plead the required elements of "reliance" and "intent to deceive" for the two fraud based RICO predicate crimes,[20] they have failed to properly allege two predicate RICO crimes as required by NRS 207.390 and the RICO claim as a whole should fail.

3. Plaintiffs cannot allege the predicate crime of involuntary servitude

Without providing any legal support whatsoever, Plaintiffs argue that the predicate crime of involuntary servitude is not limited to instances of physical coercion but can also include legal coercion. Answer at 54. However, even accepting this proposition as true, it was not Defendants' alleged misrepresentations that legally coerced Plaintiffs into allegedly providing emergency medical services. Rather, Plaintiffs admit that it was state and federal

[20] The alleged fraud based RICO predicate acts are (1) 207.360(28) (obtaining possession of money by false pretenses and (2) NRS 207.360(35) (transactions involving fraud or deceit that result in a loss to the person who relied on the false representation).

law that legally forced them to provide emergency medical services to Defendants' plan members, not the actions of Defendants. Compl. at ¶ 21, 2 PA 97. As such, this claim should be dismissed.

CONCLUSION

The relief sought by Defendants' Petition is warranted. Plaintiffs cannot demonstrate that their state law causes of action escape ERISA preemption or otherwise state a claim.

Dated: November 30, 2020

/s/ Colby L. Balkenbush
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VERIFICATION

1. I, the undersigned, declare as follows:

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

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

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

Dated: November 30, 2020

/s/ Colby L. Balkenbush

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CERTIFICATE OF COMPLIANCE

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

2. I further certify that Petitioners' brief exceeds the type-volume limitations of NRAP 21(d) because it contains 10,086 words and a reply in support of a petition may not exceed 7,000 words unless the Court grants leave to file a longer reply.

3. Petitioners are filing a motion to exceed word length contemporaneously with this reply.

4. I further certify that I have read this brief, and to the best of my knowledge, information, and belief, it is not frivolous or interposed for any improper purpose. I further certify that this brief complies with all applicable Nevada Rules of Appellate Procedure, and I understand that I may be subject to sanctions in the event that the accompanying reply is not in conformity with the requirements of the Nevada Rules of Appellate Procedure.

Dated: November 30, 2020

/s/ Colby L. Balkenbush
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CERTIFICATE OF SERVICE

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

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