Case Nos. 85525 & 85656

In the Supreme Court of Nevada

UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTH CARE SERVICES, INC.; UMR, INC.; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; and HEALTH PLAN OF NEVADA, INC., Appellants, *vs.* FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; and CRUM STEFANKO AND JONES, LTD., Respondents.	Case No. 85525
UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTH CARE SERVICES, INC.; UMR, INC.; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; and HEALTH PLAN OF NEVADA, INC., Petitioners, *vs.* THE EIGHTH JUDICIAL DISTRICT COURT of the State of Nevada, in and for the County of Clark; and the Honorable NANCY L. ALLF, District Judge, Respondents, *vs.* FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; and CRUM STEFANKO AND JONES, LTD., Real Parties in Interest.	Case No. 85656

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CERTIFICATE OF SERVICE

I certify that on April 18, 2023, I submitted the foregoing appendix for filing *via* the Court's eFlex electronic filing system.

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CERTIFICATE OF SERVICE

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

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DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: A-19-792978-B Dept. No.: 27 **PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS** Hearing Date: April 15, 2020 Hearing Time: 10:30 a.m.

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

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Emergency Medicine ("Ruby Crest" and collectively the "Health Care Providers") oppose the Motion to Dismiss (the "Motion") filed by 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, the "Removing Defendants" and together with UnitedHealth Group, Inc. ("United")).[1] This Opposition is based upon the record in this matter, the points and authorities that follow, the pleadings and papers on file in this action, and any argument of counsel entertained by the Court.

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION AND PROCEDURAL POSTURE

The Health Care Providers are professional emergency medicine service groups that staff the emergency departments at ten hospitals and other facilities throughout Nevada. **Exhibit 1**, First Amended Complaint (hereinafter "FAC") ¶¶ 3-5.[2] 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.

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. At all relevant times, United and the Health Care Providers have not had a written "network" agreement governing rates of reimbursement for emergency services rendered by the Health Care Providers to

[1] Defendants UnitedHealth Group, Inc. did not answer or otherwise respond to the operative pleading which is the First Amended Complaint. The Health Care Providers will seek appropriate relief from the Court.

[2] The Exhibits attached hereto are contained in the Appendix submitted concurrently herewith. The FAC is the operative pleading in this action. It was filed on January 7, 2020 while the case was pending in the United States District Court, District of Nevada (the "Federal District Court"), Case No. 2:19-cv-00832-JCM-VCF.

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United's Members. FAC ¶ 20. Nevertheless, in accordance with their legal and ethical obligations, the Health Care Providers have provided emergency care to United's Members. FAC ¶¶ 18, 22.

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*. 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. Thereafter, however, circumstances changed. 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; Compl. ¶ 20.

Due to the unilateral and self-serving reduction in United's rates of reimbursement, on April 15, 2019, Fremont brought suit in this Court. *See* Complaint, filed April 15, 2019 (hereinafter "Compl.") ¶¶ 2-9. The original Complaint made clear that the lawsuit involved only claims for reimbursement which United already had determined were payable and had paid, although at artificially reduced rates. Compl. ¶ 27. The original Complaint asserted seven state-law causes of action, including 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* Compl. *generally*. 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.

Having opted to violate Nevada law by reimbursing the Health Care Providers at unreasonably low rates, United now seeks impunity for its wrongdoing. It argues that the Health Care Providers cannot pursue their state law claims, because those claims are preempted by the federal ERISA statute which limits recovery of benefits to amounts allowed by the terms of the relevant ERISA plans (here, conveniently, such allowed amounts fall well below the reasonable

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value of the medical services rendered). In other words, United wields ERISA—a statute enacted to protect employee benefits—as a sword to ensure that such benefits remain insufficient to cover the reasonable costs of plan members' medical care and that emergency medical providers—who are required by law to render care—enjoy no legal recourse to challenge the unreasonable, arbitrarily determined rates. That position is not only shockingly inequitable, but contrary to the law. As explained in detail below, 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. At bottom, the Health Care Providers simply assert that legal obligations entirely separate from and independent of ERISA require United to reimburse the Health Care Providers for medical services rendered to United's members at reasonable market rates. Plaintiffs' legal claims do not seek recovery of ERISA benefits, do not rely upon any of ERISA's provisions, do not require analysis of or reference to ERISA plan terms, do not obstruct ERISA plan administration, and do not implicate any of ERISA's goals. That some of the claims for reimbursement happen to fall under health plans regulated by ERISA is utterly immaterial to the issues at stake in this action. Plaintiffs' claims are not preempted.

II. STATEMENT OF RELEVANT FACTS

The Health Care Providers are professional practice groups of emergency medicine physicians and healthcare providers that provides emergency medicine services to patients presenting to the emergency departments at hospitals and other facilities in Nevada staffed by the Health Care Providers. FAC ¶ 14; Compl ¶ 2. The Health Care Providers 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. FAC ¶ 18; Compl. ¶ 15; NRS 439B.410. These patients therefore include those with insurance issued, administered and/or underwritten by United's Members. FAC ¶ 18; Compl. ¶ 15.

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; Compl. ¶¶ 3-9.

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United provides, either directly or through arrangements with providers such as hospitals and Fremont, healthcare benefits to its members. FAC ¶ 19; Compl. ¶ 16. There is no written agreement between United and the Health Care Providers for the healthcare claims at issue in this litigation; Fremont is therefore designated as "non-participating" or "out-of-network" for all of the claims at issue. FAC ¶ 20; Compl. ¶ 17.

Despite not participating in United's "provider network" for the period in dispute, the Health Care Providers have continued to provide emergency medicine treatment, as required by law, to the Members who seek emergency medical services. FAC ¶ 59; Compl. ¶ 22. United is obligated, as a matter of Nevada law, to reimburse the Health Care Providers at the usual and customary rate for emergency services they provided to United's Members, or alternatively for the reasonable value of the services provided. FAC ¶ 62; Compl. ¶ 57. 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; Compl. ¶¶ 19-20. United paid some of the claims for emergency services rendered by the Health Care Providers at far below the usual and customary rates. Yet, United 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. FAC ¶ 57; Compl. ¶ 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. Thus, 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. Rather, the questions to be answered in this case are whether United paid the claim at rates that complied with applicable state law – namely the usual and customary rate (i.e. the billed rate) or, alternatively, at the reasonable value of services rendered. The answer to these questions does not require the jury to ever read or refer to an ERISA plan. Instead, these are straightforward questions of Nevada law.

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On April 15, 2019, Fremont filed the Complaint against the Removing Defendants. *See generally* Compl. On May 14, 2019, the Removing Defendants filed its Notice of Removal with this Court, contending that the state law claims asserted are completely preempted by ERISA. (ECF No. 1). On May 21, 2019, United 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.[3]

On May 24, 2019, Fremont filed a Motion to Remand (ECF No. 5) because this case, which only involves questions of the proper rate of payment, and not the right to payment, is not completely preempted by ERISA.[4] With the Court's permission, the Health Care Providers filed their First Amended Complaint (the "Am. Comp.") on January 7, 2020.[5] Given the procedural posture of the action, the Court directed the Health Care Providers to file a renewed motion to remand, which they did on January 18, 2020 (ECF No. 49). After completed briefing, the Federal District Court granted the Renewed Motion to Remand, expressly *rejecting* United's argument that the Health Care Providers' claims were completely preempted by ERISA, the very arguments that United reasserts here. *See* Notice of Entry of Remand Order.

III. APPLICABLE LEGAL STANDARDS ON A MOTION TO DISMISS

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.*,

[3] As mentioned in the Introduction herein, the instant Motion is largely repurposed from the earlier filing, especially with respect to the inapplicable complete preemption analysis therein.

[4] As the Health Care Providers set forth in the Amended Motion to Remand, binding Ninth Circuit precedent makes clear that disputes concerning **rates of payment** -- which is the exact dispute at issue here -- do not fall within ERISA's scope and are not subject to complete preemption. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.,* 581 F.3d 941 (9th Cir. 2009); *see also California Spine & Neurosurgery Inst.*, 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.").

[5] The Health Care Providers served UnitedHealth Group, Inc. on January 15, 2020. *See* Summons Returned Executed (ECF No. 67).

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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).

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). 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)).

Importantly, 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 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). 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 (emphasis added). A review of the FAC demonstrates that dismissal is not warranted, and the Court should, respectfully, deny Defendant's Motion.

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IV. THE HEALTH CARE PROVIDERS' CLAIMS ARE NOT SUBJECT TO EITHER COMPLETE ERISA PREEMPTION OR CONFLICT PREEMPTION

A. Overview of ERISA

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). "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). "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 (2016).

B. ERISA Complete Preemption and Conflict Preemption Explained

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). 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).

1. Conflict Preemption

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). 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

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over insurance, banking, and securities. *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); *Gobeille*, 136 S. Ct. at 943. Section 514, however, does not confer federal jurisdiction. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 945 (9th Cir. 2009). 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)).

2. Complete Preemption

Separately, ERISA completely preempts state law only to the extent that the state law "duplicates, supplements, or supplants the ERISA civil enforcement remedy." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004). Section 502 (codified at 29 U.S.C. § 1132) sets forth "a comprehensive scheme of civil remedies to enforce ERISA's provisions." *Rudel*, 937 F.3d at 1269–70. 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.

C. This Action Is Not Subject to Conflict Preemption

1. The Proper Section 514(a) Analysis

The proper analysis starts with a presumption that ERISA does not supplant state law claims. Generally speaking, 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. v. Anesthesia Care Assocs. Med. Group, Inc.*, 187 F.3d 1045, 1052 (9th Cir. 1999). 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

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ERISA plans, meaning a state law that governs a central matter of plan administration or interferes with nationally uniform plan administration." *Id.*

The Health Care Providers' state-law claims do not fall within either of the *Gobeille* categories. Here, the Health Care Providers allege that they and United have an implied-in-fact contract, 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. The Health Care Providers have not pled claims for ERISA benefits. "[The Health Care Providers are] the master[s] of [their] complaint and ha[ve] chosen to plead [their] claims based on the existence of an implied contract." *N. Jersey Brain & Spine Ctr. v. Aetna Life Ins. Co.*, 2017 WL 659012, at *5 (D.N.J. Feb. 17, 2017), R&R adopted by 2017 WL 1055957 (D.N.J. Mar. 20, 2017). As the court aptly concluded in *Emergency Case Physicians of St. Clare's v. United Health Care*, "the fact that there is no contract between the parties in this case, if true, would not convert Plaintiff's claims for additional reimbursements into claims for coverage or the denial of benefits." 2014 WL 7404563, at *6 (D.N.J. Dec. 29, 2014).

In *Glastein v. Aetna, Inc.*, a district court determined that an out-of-network healthcare provider's analogous state law claims against an ERISA plan administrator were not conflict preempted. 2018 WL 4562467, at *2-3 (D.N.J. Sept. 24, 2018). The *Glastein* court's analysis is well-reasoned and instructive:

> The state laws at issue here…neither 'refer to' nor have an 'impermissible connection with' an ERISA plan….[T]he Complaint does not claim that Plaintiff was a contracting party to an ERISA plan. It does not allege that payment is due to him according to the terms of an ERISA plan, or even that any relevant ERISA plan provides reimbursement rates for the out-of-network services provided. To the contrary, the Complaint states that Plaintiff is entitled to recover $209,000 because that amount 'represents reasonable and normal charges' under an implied-in-fact contract. The Complaint's factual assertions . . . do nothing to suggest that the claims brought in this case will require examination of an ERISA plan. The state laws here therefore do not 'refer to' an ERISA plan.
>
> Second, these laws do not have an 'impermissible connection with' an ERISA plan. The central purpose of ERISA is to protect plan participants and beneficiaries….As several Circuit Courts have held, claims brought by a provider against an insurance company do not implicate ERISA's goals of protecting participants and beneficiaries. Such claims therefore do not have an 'impermissible connection with' an ERISA plan, and are not preempted.

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Id. (citations omitted).

The Ninth Circuit has also 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;[6] *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").

The *Morris B. Silver M.D., Inc.*, case is instructive. In that case, the California court utilized a two-part test to determine whether a third-party provider's state-law quasi-contract claims (like those asserted by the Health Care Provider's here) were subject to ERISA's conflict preemption. The two-part test considers: (1) whether the state law claims address areas of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan; and (2) the claims directly affect the relationship among the traditional ERISA entities—the employer, the plan and its fiduciaries, and the participants and beneficiaries. *Id.,* 2 Cal. App. 5th at 804, 206 Cal. Rptr. 3d at 470; *see also The Meadows*, 47 F.3d at 1009. Employing this test, the *Morris B. Silver, M.D.* court held that third-party provider state-law claims are not conflict preempted. As the court explained, third-party providers are not parties to the bargain "struck

[6] In *Providence*, the Ninth Circuit found a contract claim did not have the requisite "connection with" or "reference to" an ERISA plan. The court determined that the plaintiff "is simply attempting, through contract law, to enforce the reimbursement provision. Adjudication of its claim does not require interpreting the plan or dictate any sort of distribution of benefits." *Id.* Similarly, in *Summit Estate, Inc.*, 2017 WL 4517111 at *15, the court held that claims for breach of express contract, breach of implied contract, and negligent failure to disclose did not fall under either of the two categories; therefore they were not preempted by Section 514(a). Under the "reference to" prong, the court recognized that state law contract and tort laws do not "act exclusively upon ERISA plans." *Id.* Nor is "the existence of ERISA plans...essential to [the laws'] operation." *Id.* Instead, the court ruled that contract and tort law "are laws of general application, and do not focus exclusively (or, for that matter, even primarily) upon ERISA plan administration." *Id.* (quoting *In re Anthem, Inc. Data Breach Litig.*, 2016 WL 3029783, at *49 (N.D. Cal. May 27, 2016)); *see also Viad Corp.*, 2016 WL 6436827, at *3. In *Viad*, the plaintiff did not sue as an assignee of an ERISA plan participant or beneficiary, instead suing in its own right pursuant to an independent contract. As a result, the Court concluded plaintiffs' claims were not preempted.

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in ERISA" between plaintiffs and employers; accordingly, the court could not "believe that Congress intended the preemptive scope of ERISA to shield welfare plan fiduciaries from the consequences of their acts toward non-ERISA health care providers when a cause of action based on such conduct would not relate to the terms or conditions of a welfare plan, nor affect—or affect only tangentially—the ongoing administration of the plan." *Morris B. Silver M.D., Inc.*, 206 Cal. Rptr. 3d at 471.

And, the *Morris B. Silver M.D., Inc.* decision is just one of many similar cases, finding that 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).[7]

[7] United cites to *Pilot Life Ins. v. Dedeaux,* 481 U.S. 41, 57, 107 S. Ct. 1549, 1558 (1987) for the proposition that claims of tortious breach of contract and fraud in the inducement are expressly preempted, without actually even considering the facts of that case. Indeed, many of the above cases rejected reliance on *Pilot Life* because it "does not address the circumstances unique to third-party provider claims." In *Pilot Life*, the plaintiff was an insured who sought to recover against the insurer for claims arising directly from his plan – specifically, the insurer's failure to provide coverage. Of course, because such claims arose directly from his rights under the subject plan, the court held that such claims were expressly preempted. The Health Care Providers' position is entirely consistent with this decision. They, though, are not seeking to recover against United for any claims arising under their plans with their insured. Rather, the claims asserted in the Operative Pleading have no connection to the plans. The plans could say that emergency services will not be covered or they could say that emergency services will be covered 100%. Under either case, such terms would not form the basis for the Health care Providers' claims because the Health care Providers bring their claims as separate, independent claims relating to the relationship between United and the Health Care Providers. The claims all rely on

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At its core, 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.[8] Accordingly, the Health Care Providers' state-law claims are not conflict preempted. *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) (collecting cases);[9] *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 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"). As a result, the Motion should be denied in its entirety.

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independent statutory and common law to address whether a certain rate of payment is appropriate – not any one benefit plan. Thus, because nothing about the benefit plans needs to be considered in order to fully adjudicate each of the claims at issue, the claims asserted do not "relate to" any ERISA benefit plans and cannot be expressly preempted.

[8] United argues 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. The Court need not address this contradiction, as other courts have rejected United's argument out of hand, 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*, 2018 WL 4562467, at *3 n.4 (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).

[9] The cases are: *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)).

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2. United's Motion Overstates the Scope of ERISA Conflict Preemption

In the face of this controlling law, United relies on outdated and 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." Motion at 7:17-20. United is mistaken.

The 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 v. Travelers Insurance Co.*, 514 U.S. 645, 115 S. Ct. 1671 (1995), the court clarified that ***the "starting presumption" is that Congress does not intend to supplant state law***. *Id.* at 654, 115 S.Ct. 1671; *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.

United's Motion overlooks this more circumspect interpretation. Indeed, even the cases upon which United relies recognize that the Supreme Court has "cautioned against an 'uncritical literalism' that would make pre-emption turn on "infinite connections." *Egelhoff v. Egelhoff ex rel. Breiner*, 121 S. Ct. 1322, 1327 (2001). As the *Egelhoff* Court noted:

> 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."

Id. at 1327 (emphasis added). The Court should decline to entertain United's outdated analysis.

United also relies on legal authority that is inapplicable because it addresses complete preemption under § 502(a) of ERISA; involve claims expressly seeking ERISA benefits and/or

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brought directly by plan members rather than third-party medical providers.[10] Because the Health Care Providers are pursuing the instant lawsuit in their own capacity, the Health Care Providers' claims are not preempted. The Court or jury will never 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.

United essentially argues 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, as if the mere existence of an ERISA plan renders any state law claims the Health Care Providers wish to pursue against United preempted. As the case law above makes clear, that is wholly irrelevant. Otherwise, every state law claim arising out of a medical provider's rendition of services to persons covered by an ERISA Plan would *always* "relate to" ERISA. But that is not the test, and indeed, courts have rejected this very argument. *See In re Managed Care Litig.*, 2011 WL 1595153, at *5 (S.D. Fla. Mar. 31, 2011).

In *In re Managed Care*, a defendant health insurer sought the dismissal of a plaintiff's claims on the grounds that they were defensively preempted by ERISA Section 514(a). *Id.* at *5. The health insurer contended (as United does here) that the provider's rate of payment claims "related to" ERISA because the provider had to "first establish the appropriate level of coverage which necessitates reference to the ERISA plans." *Id.* at *5. The court rejected that argument, stating that "while . . . Plaintiffs' claims exist only because Defendant has ERISA plans, the claims themselves do not implicate the plans." *Id.* (citing *Pascack Valley Hosp. Inc. v. Local 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393, 402-04 (3d Cir. 2004)). Similarly, here, even assuming that the Health Care Providers' claims exist only because United's Members have ERISA plans, that has no bearing on whether the Health Care Providers' claims "relate to"

[10] *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) (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).

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ERISA. As the *In re Managed Care* court held, the Health Care Providers' claims themselves would have to "implicate the plans." *Id.*

Further, United's attempt to distinguish self-funded plans from other employee-sponsored plans is misleading and unavailing. With regard to self-funded plans, the analysis of whether a state law affecting the ERISA plan is defensively preempted simply begins and ends with a determination of whether a law "relates to" ERISA. Self-funded ERISA plans are only shielded from state laws (insurance or otherwise) that "*relate to*" ERISA.[11] *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).

Finally, no less critical in terms of the Court's adjudication of a Rule 12(b)(5) motion, the existence of an ERISA plan is a question of fact. *Ellington v. Metropolitan Life Ins. Co.*, 696 F. Supp. 1237, 1240 (S.D. Ind. 1988); *see also Credit Managers Ass'n v. Kennesaw Life & Acc. Ins.*, 809 F.2d 617, 625 (9th Cir. 1987). Therefore, to the extent such a determination on a Rule 12(b)(5) motion to dismiss is not proper in light of recognized pleading standards because whether an oral agreement exists is one of fact.

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[11] The only relevance of whether an ERISA plan is "self-funded" is that, with regard to plans that are ***not*** self-funded, state laws that "regulate[] insurance, banking, or securities" are ***still not preempted*** even if they "relate to" ERISA. *See FMC Corp.*, 498 U.S. at 58, 61 ("[ERISA's preemption clause] establishes as an area of exclusive federal concern the subject of every state law that 'relates to' an employee benefit plan governed by ERISA. The saving clause returns to the States the power to enforce those state laws that 'regulate insurance,' except as provided in the deemer clause. . . . We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the saving clause.") (internal bracketing omitted); *see also* 29 U.S.C. § 1144(b)(2)(A) ("Except as provided in [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."). Thus, under the ERISA "savings clause," ***even if***, the Health Care Providers' claims did "relate to" ERISA, which they clearly do not, the Health Care Providers' statutory claims still ***would not be preempted*** with respect to any claims relating to any non-self-funded ERISA plans, because such statutes are ones that "regulate[] insurance, banking, or securities" and are exempted from ERISA preemption by the "savings clause."

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D. Plaintiffs' State Law Claims Are Not Completely Preempted

1. Complete Preemption Does Not Provide a Basis for Dismissal of State Court Claims

As a threshold issue, United's discussion of complete preemption is misplaced because 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).");[12] *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);[13] *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."). Because complete preemption is not a defense to a state law claim, it cannot serve as the foundation of an argument in a Rule 12(b)(5).

In any event, the Federal District Court addressed this precise issue in the motion to remand, aptly concluding—in accord with the overwhelming weight of authority—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. The Court should follow this highly persuasive opinion. [14]

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

[13] As the Ninth Circuit has explained, 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)." *Id.*

[14] The Health Care Providers attach their full briefing submitted to the Federal District Court on this issue and incorporate those arguments in full herein. **Exhibit 2**, Amended Motion for Remand; and **Exhibit 3**, Reply in Support of Amended Motion For Remand.

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2. The FAC is Not Completely Preempted

Even if the Court is inclined to engage in a complete preemption analysis, it will undoubtedly determine, like the Federal District Court, that the Health Care Providers' claims are not completely preempted. *See* Ex. 2 and 3.

In *Davila*, the Supreme Court established a two-part framework governing complete ERISA preemption. Under *Davila*, complete preemption obtains 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).

a. Davila Prong 1

Davila Prong 1 looks to whether the plaintiff "could have brought [the] claim under ERISA § 502(a)(1)(B)." *Marin*, 581 F.3d at 947. To satisfy this element, two requirements must be met: the asserted claims must fall within the scope of ERISA and the plaintiff must have standing to sue under ERISA. *Conn. Dental*, 591 F.3d at 1350. Regarding the first requirement, multiple appellate courts have held that claims which challenge the ***rates*** of reimbursement paid for covered healthcare services, rather than the right to reimbursement for such services, do not fall within the scope of § 502(a)(1)(B). *Id.* at 1349-50; *Lone Star*, 579 F.3d at 531; *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. v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1051 (9th Cir. 1999) (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.").[15]

[15] 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.

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Here, the Health Care Providers explicitly plead that they challenge only rates of reimbursement on claims which Defendants have adjudicated as payable and actually paid, not the right to reimbursement for those claims. 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."); 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). Here, as in *Blue Cross, Marin*, and their progeny, the Health Care Providers assert claims based upon contractual and quasi-contractual legal obligations independent of any ERISA plans. For this reason, the Court should deny the Motion.

b. Davila Prong 2

Davila Prong 2 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). Courts routinely hold that claims predicated upon duties imposed by state common and statutory law do not satisfy *Davila* Prong 2. *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

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preemption. Plaintiffs' claims do not derive from their plans or require 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). As such, Davila Prong 2 is unsatisfied, providing yet another basis to deny the Motion.

V. The Amended Complaint States Viable Claims for Relief

A. The Health Care Providers Stated a Claim for Breach of Implied In Fact Contract Claim

The Health Care Providers have pled detailed factual allegations about the parties' conduct, understanding, and course of dealing from which a jury could conclude an implied contract arose.[16] 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. *Smith*, 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."). 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

[16] 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)); *Smith v. Recrion Corp.*, 541 P.2d 663, 664 (Nev. 1975) (recognizing the elements of breach of express and implied contract claims are the same).

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examination of the facts and circumstance." *Id*.

The Health Care Providers have alleged a claim for breach of implied in fact contract against United based on the parties' course of dealing over thousands of claims. United contends that this claim fails because there is no allegation that United intended to contract with Fremont, that promises were exchanged or what the terms of the promises were; however, this argument ignores the explicit allegations from the Amended Complaint. Fremont alleges that:

> 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.***

FAC ¶ 197; *see also* Compl. ¶ 38 (emphasis added). This course of conduct clearly supports the existence of an implied contract, based on an exchange of consideration, and a breach by United that has caused damage to the Health Care Providers. Moreover, the Health Care Providers' allegations that both parties, throughout the course of conduct, understood United's legal obligation to pay, only further supports the assertion that an implied contract was formed.

United also argues that payments for past services cannot constitute a promise by United to pay for future services and cites to *Recrion Corp*. to support this proposition. United misunderstands the allegations presented by Fremont. Under Nevada law, the Health Care Providers are required to provide emergency medical services and, in exchange, United is required to pay for such services. *See Williams v. EDCare Mgmt., Inc.*, No. CIV. A. 1:08-CV-278, 2008 WL 4755744, at *5 (E.D. Tex. Oct. 28, 2008) (remanding state law claims that alleged violation of federal regulations as an element of those claims); *see also* Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd; NRS 439B.410. *Recrion Corp*. is distinguishable for this reason. As United highlighted, the services provided in *Recrion Corp*. were *unsolicited*. Here, Nevada law mandates that the Health Care Providers provide these services to United's insureds, a key distinction from *Recrion Corp*. Of course, if the Health Care Providers provided these services to United's Members without any obligation to do so,

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this may not form the basis for an implied in fact agreement. However, United has always understood that if its Members encounter an emergency situation, the Health Care Providers will provide the necessary medical services and, in exchange United will be required to pay for such services. An implied in fact contract exists here, and United has breached this contract, as expressly alleged in the Complaint. Because the Health Care Providers have stated a cognizable claim for breach of implied contract, United's Motion to Dismiss must be denied.

B. The Health Care Providers Have Stated a Claim for Tortious Breach of Implied Covenant of Good Faith and Fair Dealing

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). 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). 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).

Contrary to United's conclusory statements, Nevada has never limited the application of a claim for tortious breach of implied covenant of good faith and fair dealing to two instances; rather, Nevada has recognized that this claim is viable in *at least* two scenarios. Simply because a Nevada court has not faced the facts alleged herein does not mean that Nevada has foreclosed the possibility of asserting this claim under the facts alleged. Under the applicable pleading standard and with the facts alleged, this claim is viable.

Moreover, *Aluevich v. Harrah's* does not stand for the proposition that "the Nevada Supreme Court has refused to expand this tort to contracts between sophisticated parties in the commercial realm" as argued by United. Motion at 19:11-12. Rather, in *Aluevich v. Harrah's*,

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the Nevada Supreme Court held that "[t]he relationship between appellant and respondent was that of lessee and lessor. We do not find, in the present case, the special element of reliance which prompted this court in *Peterson* to recognize a cause of action in tort for the breach of an implied covenant of good faith and fair dealing." 99 Nev. 215, 218, 660 P.2d 986, 987 (1983). The *Aluevich* did not make a blanket statement, as United implies, that this claim for relief could not apply to sophisticated parties in the commercial realm. In fact, the *Aluevich* court cited to *U.S. Fidelity v. Peterson*, 91 Nev. 617, 540 P.2d 1070 (1975), a case involving insurance agreements, and noted that "an implied covenant of good faith and fair dealing has mainly been implied in contractual relations which involve a special element of reliance such as that found in partnership, **insurance** and franchise **agreements**." *Id.* at 217. While *Peterson* involved a dispute between an insurer and an insured, neither *Peterson* nor *Aluevich* forecloses the possibility that a special element of reliance can exist between the Health Care Providers and United. The type of relationship at issue here is one that undoubtedly gives rise to a relationship in which Fremont relies on United. The Health Care Providers performed millions of dollars in services to United's Members with the expectation that United would pay for these services. Because the Health Care Providers are obligated to provide these services under Nevada law, United sits in a superior position over Fremont, wielding a disparate level of power over whether the Health Care Providers get paid for its services and therefore, the facts alleged in the Operative Pleading fall squarely within the scope of a claim of tortious breach of implied covenant of good faith and fair dealing.

Finally, United appears to contend, without any support, that a higher pleading standard is required for a claim of tortious breach of implied covenant of good faith and fair dealing. No such obligation exists. The Health Care Providers have satisfied its pleading requirements under *Iqbal* and *Twombly* and, at this stage in litigation, the Health Care Providers have articulated a special relationship exists between United and the Health Care Providers. Because the Health Care Providers have adequately pled this claim, the Court should reject United's effort to litigate the facts at this juncture.

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C. The Health Care Providers Stated an Alternative Claim for Unjust Enrichment

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). The Health Care Providers' 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. *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…").[17]

[17] *See also 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 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).

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To support its position, United cites to a handful of cases from Florida, Texas, New York, Georgia and California which are readily distinguishable. *See e.g. Adventist Health Sys./Sunbelt Inc. v. Med. Sav. Ins. Co.*, No. 6:03-CV-1121-ORL-19, 2004 WL 6225293, at *6 (M.D. Fla. Mar. 8, 2004) (noting that Florida law requires that the benefit conferred be "direct, not indirect or attenuated" thus any indirect benefit would not be actionable under Florida law); *Peacock Med. Lab, LLC v. UnitedHealth Grp., Inc.*, No. 14-81271-CV, 2015 WL 2198470, at *5 (S.D. Fla. May 11, 2015) (same); *Encompass Office Sols., Inc. v. Ingenix, Inc.*, 775 F. Supp. 2d 938, 966 (E.D. Tex. 2011) (addressing payment for equipment and nursing staff not in the context of emergency medical services); *Electrostim Med. Servs., Inc. v. Health Care Serv. Corp.*, 962 F. Supp. 2d 887, 898 (S.D. Tex. 2013), *aff'd in part, rev'd in part*, 614 F. App'x 731 (5th Cir. 2015) (concerning payments relating to the sale of a medical device, not in the context of emergency medical services); *Travelers Indem. Co. of Connecticut v. Losco Grp., Inc.*, 150 F. Supp. 2d 556, 562–63 (S.D.N.Y. 2001) (under New York law, claim of quantum meruit requires more than a benefit received, plaintiff must show services were performed at the behest of the defendant); *Joseph M. Still Burn Centers, Inc. v. AmFed Nat. Ins. Co.*, 702 F. Supp. 2d 1371, 1377 (S.D. Ga. 2010) (plaintiff was already paid reimbursement rates set forth in Mississippi's and Georgia's workers' compensation fee schedules); *Cedars Sinai Med. Ctr. v. Mid-W. Nat. Life Ins. Co.*, 118 F. Supp. 2d 1002, 1013 (C.D. Cal. 2000) (since this decision, the same court has concluded in *Forest Ambulatory Surgical Associates v. United Healthcare Ins. Co.,* that a claim for quantum meruit can survive dismissal upon "establish[ing] that Defendants received the benefit of having their obligations to the [policyholders] discharged.").

Thus, 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. United's grounds for dismissal therefore fail because 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.

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D. The Health Care Providers Stated a Claim for Violation of NRS 686A.020 and 686A.310

United cites to *Gunny v. Allstate Ins. C*o. 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. *Gunny* does not reach this blanket conclusion, rather the *Gunny* court emphasized that Gunny did not have a contractual relationship with the insurer. *Gunny v. Allstate Ins. Co.*, 108 Nev. 344, 346, 830 P.2d 1335, 1336 (1992). Thus, while the *Gunny* court did find that Gunny could not assert a private action against the insurer under NRS 686A.310, the absence of a contract between Gunny and the insurer makes this case distinguishable. Here, the Health Care Providers do have an implied in fact contract with United and, consequently, a claim asserted by a medical services provider under NRS 686A.020 and 686A.310 should be deemed actionable. Notably, 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."). 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 686A.170 to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance." Thus, based on the plain language of NRS 686A.310 and 686A.020 and the specific holding in *Gunny*, there is no express prohibition barring the Health Care Providers from asserting this claim. Accordingly, dismissal on this basis would be improper.

E. The Health Care Providers Stated a Claim for Violation of Nevada's Prompt Pay Statutes

United did not challenge the Health Care Providers' claim for violation of Nevada's prompt pay statutes under Rule 12(b)(5); consequently, this claim is not subject to dismissal on this basis.

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F. The Health Care Providers Stated a Claim for Violation of Nevada's Deceptive Trade Practices Act

1. The Health Care Providers Have Pled This Claim with Particularity Even Though Such Is Not Required Under Nevada Law

In its Motion to Dismiss, United relies entirely on an unpublished and federal district court decision in asserting that a claim for violation of Nevada's Deceptive Trade Practices Act ("DTPA") must be pled with particularity. *See* Motion at 27:17-28:1. However, the Nevada Supreme Court has held, in a published decision, 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). Thus, by analogy, such claims should not need to be pled with the particularity required for fraud claims and, based on the statements made in *Betsinger,* when faced with this question, the Nevada Supreme Court would not likely require a heightened pleading standard for a violation of the DTPA.

Even if this Court were to require that this claim be subject to heightened pleading standards, the Health Care Providers pled its claim for violation of DTPA with particularity. To support its claim, the Health Care Providers allege:

> 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

Am. Comp. ¶ 246; *see also* ¶¶ 25, 57, 65; *see also* Compl. at ¶¶ 19-20, 25-26 & 87. The Health Care Providers adequately allege that the UH Parties knowingly made a false representation by paying the Health Care Providers for emergency medical services at artificially reduced rates, thereby representing that, through their actions, these payments represent usual and customary rates and a reasonable value for services rendered when such rates are not usual and customary or reasonable. These representations commenced in July 2017 and have continued to present

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date. Accordingly, the Health Care Providers have adequately alleged this part of the DTPA claim.

Next, the Health Care Providers allege that the UH Parties violated "a state or federal statute or regulation relating to the sale or lease of goods or services." The Health Care Providers sufficiently alleges this claim as the UH Parties have 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. Compl. at ¶¶ 69-71,77-80. The Health Care Providers expressly states that the UH Parties began to violate these provisions in July 2017 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 have sufficiently alleged this portion of the DTPA claim.

The Health Care Providers also properly alleges that the DPTA has been violated by the UH Parties' use of "coercion, duress or intimidation in a transaction." 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; Compl. at ¶ 87. Further, as is detailed above, 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.

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FAC ¶ 65; Compl. at ¶ 26. Based on the foregoing, the Health Care Providers have alleged who engaged in these bad acts (the United entities) when such parties engaged in these acts (From 2017 to present, FAC ¶ 90; Compl. ¶ 26) and the scope of the bad acts alleged (improperly lowering amounts paid to leverage negotiations) (FAC ¶ 65; Compl. at ¶ 26).

Finally, the Health Care Providers properly allege that the UH Parties have knowingly misrepresented the "legal rights, obligations or remedies of a party to a transaction." FAC ¶ 244; Compl. ¶ 85. Specifically, the Health Care Providers assert that by paying claims at artificially reduced rates, the UH Parties are representing that these claims are being paid at usual and customary and reasonable rates when such a representation is clearly inaccurate. This conduct commenced in July 2017 and continues to present date and each of the UH Parties have engaged in these bad acts. Accordingly, the Health Care Providers have sufficiently alleged this aspect of its claim for violation of DTPA.

While United argues that it is improper to lump all the parties together in the Health Care Providers' allegations, this is not a situation in which only one party engaged in the improper acts. Rather, each of the UH Parties has improperly engaged in artificially reducing the rates paid to Fremont for an ulterior purpose. Thus, it is certainly 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. As is detailed herein, the Health Care Providers have satisfied the heightened pleading standard required for claims based on violation of DTPA.

2. The Health Care Providers are "Victims" Under NRS 41.600 and Have Standing

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, it is clear that the legislature did not intend to limit the scope of this term. However, even under *Igbinovia's* definition of "victim" limiting it to passive victims who suffered a loss that was "unexpected and occurs without voluntary

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participation of the person suffering the harm or loss," Fremont qualifies as a victim. *See Igbinovia v. State*, 111 Nev. 699, 706, 895 P.2d 1304, 1308 (1995). As is detailed in the Operative Pleading, the Health Care Providers 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."). The provision of services to United's Members was not voluntary and the loss Fremont has 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 Health Care Providers are not an active participant in United's fraudulent conduct and should be deemed "victims" under NRS 41.600(1) even if the definition of "victim" is limited in the way United proposes.

Furthermore, contrary to United's arguments, while one court has found that business competitors cannot be victims under Nevada law, the Ninth Circuit has reached a contrary conclusion, finding that 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). Thus, United's passing reference to *Rebel Oil Co*. for the proposition that business competitors are not "victims" should be disregarded.

Based on the foregoing, the Health Care Providers would undoubtedly be treated as victims of consumer fraud, even if this Court accepts the narrow definition of "victim" forwarded by United because the Health Care Providers have never been an active participant in United fraud.

G. The Health Care Providers Have Stated a Claim for Declaratory Relief

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.

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VI. CONCLUSION

Based on the foregoing, the Health Care Providers respectfully request that the Motion to Dismiss be denied in its entirety.

DATED this 26th day of March, 2020.

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By: */s/ Kristen T. Gallagher*

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 26th day of March, 2020, I caused a true and correct copy of the foregoing **PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

Defendants.

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

APPENDIX OF EXHIBITS IN SUPPORT OF PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS

Hearing Date: April 15, 2020
Hearing Time: 10:30 a.m.

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Plaintiffs hereby submit its Appendix in Support of Plaintiffs' Opposition to Defendants' Motion to Dismiss as follows:

Exhibit Description	Exhibit No.	Bates No.
First Amended Complaint	1	001-048
Amended Motion to Remand	2	049-088
Reply in Support of Amended Motion to Remand	3	089-122

DATED this 26th day of March, 2020.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 26th day of March, 2020, I caused a true and correct copy of the foregoing **APPENDIX OF EXHIBITS IN SUPPORT OF PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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EXHIBIT 1

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EXHIBIT 1

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832-JAD-VCF **FIRST AMENDED COMPLAINT** **Jury Trial Demanded**

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

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

NATURE OF THIS ACTION

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

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

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

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PARTIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

JURISDICTION AND VENUE

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

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

FACTS COMMON TO ALL CAUSES OF ACTION

The Health Care Providers Provide Necessary Emergency Care to Patients

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

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

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

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

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

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

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

24. The uhc.com website state:

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

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

25. Relevant to this action:

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

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

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

The Relationship Between the Health Care Providers and Defendants

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Defendants Paid the Health Care Providers Unreasonable Rates

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Defendants' Prior Manipulation of Reimbursement Rates

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Defendants' Current Schemes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Defendants' and Data iSight's Activities Constitute Racketeering Activity

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

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

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

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

The Enterprise and Scheme

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

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

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

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

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

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

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

The Enterprise's False Statements: Transparency

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(emphasis added).

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

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

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

155. These statements are false.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Enterprise's False Statements: Geographic Adjustment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Enterprise's Predicate Acts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FIRST CLAIM FOR RELIEF

(Breach of Implied-in-Fact Contract)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECOND CLAIM FOR RELIEF

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

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

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

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

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

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

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

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

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

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

THIRD CLAIM FOR RELIEF

(Alternative Claim for Unjust Enrichment)

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

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

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

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

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

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

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

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

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

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

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

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

FOURTH CLAIM FOR RELIEF

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

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

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

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

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

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

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

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

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

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

FIFTH CLAIM FOR RELIEF

(Violations of Nevada Prompt Pay Statutes & Regulations)

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

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

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

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

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

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

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

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

SIXTH CLAIM FOR RELIEF

(Consumer Fraud & Deceptive Trade Practices Acts)

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

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

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

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

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

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

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

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

SEVENTH CLAIM FOR RELIEF

(Declaratory Judgment)

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

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

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

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

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

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

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

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

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

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

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

EIGHTH CLAIM FOR RELIEF

(Violation of NRS 207.350 *et seq.*)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REQUEST FOR RELIEF

WHEREFORE, the Health Care Providers request the following relief:

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

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

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

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

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

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

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

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

I. Reasonable attorneys' fees and court costs;

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

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

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JURY DEMAND

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

DATED this 7th day of January, 2020.

McDONALD CARANO LLP

By: /s/ *Pat Lundvall*

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CERTIFICATE OF SERVICE

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

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

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EXHIBIT 2

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EXHIBIT 2

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832-JAD-VCF **AMENDED MOTION TO REMAND**

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") (collectively, the "Health Care Providers") move the Court to

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remand this action to the Eighth Judicial District Court for Clark County, Nevada. In addition, pursuant to 28 U.S.C. § 1447(c), the Health Care Providers also ask that the Court award them their reasonable attorneys' fees and costs attributable to the improper removal.

This Amended Motion to Remand is submitted at the request of the Court, and based upon the record in this matter, the points and authorities that follow, the exhibits attached hereto, and any argument of counsel entertained by the Court.

MEMORANDUM OF POINTS AND AUTHORITIES

PRELIMINARY STATEMENT

The Health Care Providers initiated this action in Nevada state court, and Nevada state court is where it belongs. The Health Care Providers assert claims arising exclusively under Nevada state law. As such, given the absence of complete diversity between the Parties, there is no basis for federal subject-matter jurisdiction. But rather than defend against the Health Care Providers' claims in the proper forum, Defendants have improperly removed. They argue that the doctrine of "complete preemption" under ERISA § 502(a)[1] transforms the Health Care Providers' state law claims into federal claims, thus creating federal question jurisdiction pursuant to 28 U.S.C. § 1331.

Defendants' position is meritless for multiple reasons. First, federal courts across the country, at both the district and appellate levels, are virtually unanimous in distinguishing between claims challenging the rates of reimbursement paid for healthcare services rendered to ERISA plan beneficiaries and claims challenging the right-to-payment for such services. Only right-to-payment claims are completely preempted. Rate-of-payment claims, like those asserted here, are not preempted and are routinely remanded to state court. Additionally, a healthcare provider's lack of standing to pursue ERISA benefits and assertion of claims predicated upon legal duties independent of an ERISA plan (such as contractual, quasi-contractual, tort, or statutory duties), factors which are present in this case, are both independently fatal to complete preemption.

[1] "ERISA" is the Employee Retirement Income Security Act of 1974, Pub. L. 93-406, 88 Stat. 829. Section 502(a) is codified at 29 U.S.C. § 1132(a).

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United has conceded that the overwhelming weight of authority prohibits complete preemption under ERISA where there exists a written, oral or quasi contract between the provider and the insurer which gives rise to the claims at issue. *See* Ex. 1, January 6, 2020 Hearing Tr. at 37:2-4 ("If it's a rate of payment case based on a -- a contract or a quasi contract, then it's outside of ERISA."). Notwithstanding that concession, United argues that the claims asserted here are preempted because an implied in fact agreement is different than a written, oral or quasi contract. Nevada law compels a different conclusion. Nevada courts uniformly agree that 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."). There is no question that implied in fact 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.

As shown below, in cases such as this—where a healthcare provider asserts state law causes of action challenging the rates of reimbursement allowed by an ERISA plan for claims which the plan has determined to be covered and payable, and the defendant removes on the basis of complete preemption—remand is essentially automatic. The Court should follow this well-established authority and grant the Amended Motion.

SUMMARY OF ALLEGATIONS & PROCEDURAL HISTORY

The Health Care Providers are professional emergency medicine service groups that staff the emergency departments at ten hospitals and other facilities throughout Nevada. *See* First Amended

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Complaint (ECF No. 40) (hereinafter "Am. Compl.") ¶¶ 3-5. Defendants ("United") are large health insurance companies and claims administrators. Am. Compl. ¶¶ 6-13. United provides healthcare benefits to its members ("United's Members"), including coverage for emergency care. Am. Compl. ¶¶ 19, 33.

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. Am. Compl. ¶ 18; *see also* Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd; NRS 439B.410. At all relevant times, United and the Health Care Providers have not had a written "network" agreement governing rates of reimbursement for emergency services rendered by the Health Care Providers to United's Members. Am. Compl. ¶ 20. Nevertheless, in accordance with their legal and ethical obligations, the Health Care Providers have provided emergency care to United's Members. Am. Compl. ¶¶ 18, 22.

The Health Care Providers have submitted claims to United seeking reimbursement for this emergency care. Am. Compl. ¶¶ 25-26, 40. United, in turn, has paid the Health Care Providers. *Id.* Over the period of 2008 through 2017, United paid the Health Care Providers at a range of 75-90% of the Health Care Providers' billed charges. Am. Compl. ¶ 53. 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. Am. Compl. ¶¶ 54, 189-206, 216-226. Thereafter, however, circumstances changed. 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 usual and customary rates. Am. Compl. ¶ 55.

Not satisfied with the reduced rates of reimbursement, on April 15, 2019, Fremont brought suit in the Eighth Judicial District Court for Clark County, Nevada. *See* Original Complaint (ECF No. 1-1) (hereinafter "Compl.") ¶¶ 2-9. The Original Complaint made clear that the lawsuit involved only claims for reimbursement which United already had determined were payable and had paid, albeit at artificially reduced rates. Compl. ¶ 27. The Original Complaint asserted seven state-law causes of action, including breach of implied-in-fact contract, tortious breach of the implied

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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* Compl. *generally*. 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.

Although the basis for federal subject-matter jurisdiction was facially lacking, on May 14, 2019, Defendants filed a Notice of Removal with this Court, contending that the asserted state-law claims are completely preempted by ERISA because they "relate to" an employee benefit plan. *See* Notice of Removal (ECF No. 1) at ¶¶ 2-12. Fremont timely moved to remand. *See* Motion to Remand (ECF No. 5). The Motion to Remand was denied without prejudice on January 6, 2020, in light of the anticipated filing of the First Amended Complaint.

On January 7, 2020, with the Court's permission, the Health Care Providers filed the First Amended Complaint. *See* Am. Compl. In this amended pleading, the Health Care Providers added additional parties (two plaintiffs and one defendant), as well as an additional state statutory cause of action (violation of NRS 207.350 *et seq.* (Nevada RICO)). Am. Compl. ¶¶ 3-13, 261-73. The Original Complaint featured claims arising exclusively under Nevada state statutory and common law, and the First Amended Complaint has not changed this.

Because there is no basis for federal subject-matter jurisdiction, the Health Care Providers seek remand to Nevada state court.

LEGAL STANDARD

"Under 28 U.S.C. § 1441, a defendant may remove an action filed in state court to federal court if the federal court would have original subject matter jurisdiction over the action." *Moore-Thomas v. Alaska Airlines, Inc.*, 553 F.3d 1241, 1243 (9th Cir. 2009). And "[f]ederal courts have original jurisdiction over 'all civil actions arising under the Constitution, laws, or treaties of the United States.'" *Id.* (citing 28 U.S.C. § 1331). In general, "[a]n action arises under federal law only if federal law 'creates the cause of action' or 'a substantial question of federal law is a necessary element'" of the plaintiff's state law claim. *Coeur d'Alene Tribe v. Hawks*, 933 F.3d

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1052, 1055 (9th Cir. 2019) (citing *Morongo Band of Mission Indians v. Cal. State Bd. of Equalization*, 858 F.2d 1376, 1383 (9th Cir. 1988)). The Ninth Circuit "has long and consistently held that [such] federal-law element must appear on the face of plaintiff's well-pleaded complaint." *Morongo*, 858 F.2d at 1383 (citing *Franchise Tax Bd. v. Construction Laborers Vacation Tr.*, 463 U.S. 1, 9-10 (1983)). "This means that a plaintiff may not establish federal jurisdiction by asserting in its complaint that the defendant will raise a federal-law defense to the plaintiff's claim, or by including in its complaint allegations of federal-law questions that are not essential to its claim[.]" *Id*. (citing *Franchise Tax Bd*., 463 U.S. at 13-14).

Further, "[t]he removal statute is strictly construed, and any doubt about the right of removal requires resolution in favor of remand." *Moore-Thomas v. Alaska Airlines, Inc*., 553 F.3d 1241, 1244 (9th Cir. 2009) (citing *Gaus v. Miles, Inc*., 980 F.2d 564, 566 (9th Cir.1992)). "The presumption against removal means that the defendant always has the burden of establishing that removal is proper." *Id.* (internal quotations omitted). *See also Hansen v. Group Health Coop*., 902 F.3d 1051, 1057 (9th Cir. 2018) ("The removing defendant bears the burden of overcoming the strong presumption against removal jurisdiction.") (citation omitted). And so, "[i]f a district court determines at any time that less than a preponderance of the evidence supports the right of removal, it must remand the action to the state court." *Id*. (citing *Geographic Expeditions, Inc. v. Estate of Lhotka ex rel. Lhotka*, 599 F.3d 1102, 1107 (9th Cir. 2010)).

Finally, Plaintiffs are the "master[s]" of their complaints and may choose to litigate in state court by pleading only state law causes of action, even where a federal cause of action would otherwise be available. *See Hansen*, 902 F.3d at 1056; *ARCO Envtl. Remediation, L.L.C. v. Dep't of Health & Envtl. Quality of Montana*, 213 F.3d 1108, 1114 (9th Cir. 2000) ("As the master of the complaint, a plaintiff may defeat removal by choosing not to plead independent federal claims"). Removal based on federal-question jurisdiction is reviewed under the longstanding well-pleaded complaint rule, which "provides that an action 'aris[es] under' federal law 'only when a federal question is presented on the face of the plaintiff's properly pleaded complaint.'" *Hansen*, 902 F.3d at 1057 (citing *Caterpillar Inc. v. Williams*, 482 U.S. 386, 398–99 (1987)). Thus, "a defendant cannot remove on the basis of a federal defense." *Id*. (citation omitted).

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ARGUMENT

I. ONLY COMPLETE ERISA PREEMPTION YIELDS FEDERAL SUBJECT-MATTER JURISDICTION

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). These two forms of preemption are doctrinally distinct. Complete preemption occurs where "Congress intended the scope of a federal law to be so broad as to entirely replace any state-law claim." *Marin Gen. Hosp. v. Modesto & Empire Traction Co*., 581 F.3d 941, 945 (9th Cir. 2009) (internal citation and quotation marks omitted). Complete preemption is a "rare" doctrine, by which a "state-created cause of action can be deemed to arise under federal law[,]" regardless of whether a plaintiff, as "the master of [its] complaint," intentionally "cho[se] not to plead independent federal claims." *ARCO*, 213 F.3d at 1114. As such, complete preemption operates as an exception to the well-pleaded complaint rule. *Marin*, 581 F.3d at 945. "Even if the only claim in a complaint is a state law claim, if that claim is one that is 'completely preempted' by federal law, federal subject matter jurisdiction exists and removal is appropriate." *Toumajian v. Frailey*, 135 F.3d 648, 653 (9th Cir. 1998).

"Unlike complete preemption, preemption that stems from a conflict between federal and state law is a defense to a state law cause of action and, therefore, does not confer federal jurisdiction over the case." *ARCO*, 213 F.3d at 1114. Accordingly, conflict preemption is not a basis for removal to federal court. *Toumajian*, 135 F.3d at 654. If a claim is conflict preempted, "[t]he district court lacks power to do anything but remand the case to the state court where the preemption issue can be addressed and resolved." *Id*. 655.

ERISA contains an express preemption provision—§ 514(a)—which directs that "this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." 29 U.S.C. § 1144(a). ERISA conflict preemption arises from this language. *See Conn. Dental*, 591 F.3d at 1344. Separately, complete preemption is derived from ERISA's civil enforcement provision—§ 502(a)—in which Congress enacted a "comprehensive scheme of civil remedies to enforce ERISA's provisions." *Cleghorn v. Blue*

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Shield of Cal., 408 F.3d 1222, 1225 (9th Cir. 2005). These doctrines are not coextensive in reach. "Complete preemption is narrower than [conflict] ERISA preemption . . . . Therefore, a state-law claim may be defensively preempted under § 514(a) but not completely preempted under § 502(a)." *Conn. Dental*, 591 F.3d at 1344 (internal brackets omitted).

Defendants contend that "state law claims that ***relate to*** an employee welfare benefit plan are properly removed to federal court even where the complaint does not facially state an ERISA cause of action." Notice of Removal ¶ 11 (emphasis added). That is a blatant misstatement of the law. The Ninth Circuit has expressly held that "the question whether a law or claim 'relates to' an ERISA plan is not the test for complete preemption under § 502(a)(1)(B). Rather it is the test for conflict preemption under § 514(a)." *Marin*, 581 F.3d at 949. And "conflict preemption under § 514(a) does not provide a basis for federal question jurisdiction . . . ." *Id.* Because only complete preemption—not conflict preemption—yields federal subject-matter jurisdiction, Defendants must establish that that the Health Care Providers' claims are completely preempted in order to avoid remand. Conflict preemption is irrelevant in this context.

II. PLAINTIFFS' CLAIMS ARE NOT COMPLETELY PREEMPTED

In *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), the Supreme Court established a two-part framework governing complete ERISA preemption. Under *Davila*, complete preemption obtains 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.[2] *McCulloch Orthopaedic Surgical Servs., PLLC v. Aetna Inc.*, 857 F.3d 141, 146 (2d Cir. 2017). Multiple federal circuits, including the Ninth Circuit, have analyzed and applied this framework. *See Marin*, 581 F.3d at 946; *Pascack Valley Hosp., Inc. v. Local 464A Welfare Reimbursement*

[2] A number of courts have further disaggregated the first *Davila* prong into two subparts. *See, e.g., Montefiore Med. Ctr. v. Teamsters Local 272*, 642 F.3d 321, 328 (2d Cir.2011); *Conn Dental*, 591 F.3d at 1350 (citing *Marin*, 581 F.3d at 947-49); *Comprehensive Spine Care P.A. v. Oxford Health Ins. Inc.*, 2018 WL 6445593, at *2 (D.N.J. Dec. 10, 2018). These courts find that *Davila* Prong 1 is satisfied only where: (1) the plaintiff is the type of party who could bring a claim pursuant to ERISA § 502(a)(1)(B), *i.e.*, the plaintiff must have ERISA standing; and (2) the actual claim asserted by the plaintiff can be construed as a colorable claim for ERISA benefits, *i.e.* the claim falls within the scope of § 502(a)(1)(B). *Id.*

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Plan, 388 F.3d 393, 399 (3d Cir. 2004); *Lone Star OB/GYN Assocs. v. Aetna Health Inc.*, 579 F.3d 525, 529 (5th Cir. 2009); *Franciscan Skemp Healthcare, Inc. v. Cent. States Joint Bd. Health and Welfare Tr. Fund*, 538 F.3d 594, 598 (7th Cir. 2008); *Conn. Dental*, 591 F.3d at 1345; *Montefiore*, 642 F.3d at 328. As shown below, neither *Davila* prong is satisfied here.

A. *Davila* Prong 1

Davila Prong 1 looks to whether the plaintiff "could have brought [the] claim under ERISA § 502(a)(1)(B)." *Marin*, 581 F.3d at 947. To satisfy this element, two requirements must be met: the asserted claims must fall within the scope of ERISA and the plaintiff must have standing to sue under ERISA. *Conn. Dental*, 591 F.3d at 1350. Regarding the first requirement, multiple appellate courts have held that claims which challenge the rates of reimbursement paid for covered healthcare services, rather than the right to reimbursement for such services, do not fall within the scope of § 502(a)(1)(B). *Id.* at 1349-50; *Lone Star*, 579 F.3d at 531; *Montefiore*, 642 F.3d at 325; *CardioNet Inc. v. Cigna Health Corp.*, 751 F.3d 165, 177-78 (3d Cir. 2014). This crucial distinction between rate-of-payment and right-to-payment claims finds its genesis in a Ninth Circuit decision called *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1051 (9th Cir. 1999) (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."). 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, the Health Care Providers explicitly plead that they challenge only rates of reimbursement on claims which Defendants have adjudicated as payable and actually paid, not the right to reimbursement for those claims. Am. Compl. ¶¶ 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."). As such, the claims asserted in this action do not fall within the scope of ERISA, and the Court should grant the Amended Motion for this reason alone. Indeed, federal district courts routinely remand cases removed based upon complete ERISA preemption where the plaintiff

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challenges only rates of reimbursement. *See, e.g., 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).

The cases cited by Defendants in the Notice of Removal (ECF No. 1) are inapposite because they all concern disputes over the right to payment/coverage under a health plan, rather than the rate of payment, as is the case here. In *Tingey v. Pixley-Richards W., Inc*., the plaintiff was an *employee* bringing suit for claims concerning the employer's and insurer's termination of health insurance coverage, squarely within the scope of ERISA because the claims arose out of an employee welfare benefit plan. *Tingey v. Pixley-Richards W., Inc*., 953 F.2d 1124, 1133 (9th Cir. 1992). Similarly, in *Misic v. Bldg. Serb. Employees Health & Welfare Tr*., the insurer was being sued for failure to cover a claim based on the amount that was expressly required to be paid under the health plan when the beneficiary's rights were assigned to the medical provider. *Misic v. Bldg. Serv. Employees Health & Welfare Tr*., 789 F.2d 1374, 1376 (9th Cir. 1986). In *Gables*, the claims concerned an alleged wrongful denial of *coverage* under the health care plan. *Gables Ins. Recovery, Inc. v. Blue Cross & Blue Shield of Fla., Inc*., 813 F.3d 1333, 1338 (11th Cir. 2015). Finally, in *Cleghorn*, an employee bringing claims against the insurer asserted claims based on his health plan's denial of coverage. *Cleghorn v. Blue Shield of California*, 408 F.3d 1222, 1223–24 (9th Cir. 2005). This case is distinct from all the cases cited by Defendants because this is a rate of payment case, not a right to payment case, as in *Cleghorn*, *Gables*, *Misic* and *Tingey*.

Defendants have also indicated (ECF Doc. No. 38) that they will rely upon a recent decision called *Hill Country Emergency Med. Assocs., P.A. et al. v. UnitedHealthCare Ins. Co. et al.*, No. 1:19-CV-00548-RP (W.D. Tex. Dec. 10, 2019), in which a district court in the Western

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District of Texas held that an out-of-network healthcare provider's rate-of-payment claims were completely preempted. The *Hill Country* Court premised this conclusion upon its reading of the Fifth Circuit's decision in *Lone Star* to hold that the right-to-payment / rate-of-payment distinction applies only to claims brought by in-network providers. *See* Petition in *Hill Country Emergency Medical Associates et al. vs. UnitedHealthcare Insurance Company et al.* (Ex. 2) at 6-7. But that reflects a misreading of *Lone Star*, which, while addressing claims by an in-network provider, in no way so limits its recognition of the distinction in out of network cases. *Lone Star*, 579 F.3d at 530-32. *Hill Country* is an extreme outlier, standing in stark contrast to the multitude of cases in which district courts have remanded rate-of-payment disputes brought by out-of-network providers. *See, e.g., Garber*, 2016 WL 1734089, at *3-5; *Long Island Thoracic Surgery*, 2019 WL 5060495, at *2; *Premier Inpatient*, 371 F. Supp. 3d at 1068-74; *Gulf-to-Bay*, 2018 WL 3640405, at *3; *Hialeah*, 258 F. Supp. 3d at 1327-30; *Comprehensive Spine*, 2018 WL 6445593, at *2; *N. Jersey Brain & Spine Ctr. v. United Healthcare Ins. Co.*, 2019 WL 6317390, at *5 (D.N.J. Nov. 25, 2019), R&R adopted, 2019 WL 6721652.

In addition, *Hill Country* is distinguishable because the factual allegations and legal theories in that case were different: the *Hill Country* plaintiffs asserted claims based upon assignments of benefits and did not allege the existence of any contract. Ex. 2 at 2, 5. Here, the Health Care Providers have alleged the existence of an implied-in-fact agreement and have expressly stated that they are not pursuing any claims under an assignment of benefit theory. As the Ninth Circuit explained in *Marin,* such a claim "does not stem from the ERISA plan, and the [provider] is therefore not suing as an assignee of an ERISA plan participant or beneficiary . . . it is suing in its own right pursuant to an independent obligation." 581 F.3d at 948.

Davila Prong 1 is unsatisfied for the additional reason that the Health Care Providers lack ERISA standing. Section 502(a)(1)(B) confers standing to bring a benefits-due action upon plan "participant[s]" and "beneficiar[ies]." 29 U.S.C. § 1132(a)(1)(B). The Health Care Providers are neither. Defendants assert that the Health Care Providers enjoy derivative standing because they received assignments of benefits from their patients. Notice of Removal ¶ 13. Putting aside that Defendants have not even attempted to demonstrate the existence, scope, or legal effectiveness of

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such assignments, the Health Care Providers have explicitly pled that they pursue claims based upon duties owed directly to them, not derivative claims based upon duties owed to their patients. Am. Compl. at 1 n.1. The law is clear that the existence of an assignment does not convert a healthcare provider's claims based upon legal obligations independent of an ERISA plan into claims for ERISA benefits. *See Blue Cross*, 187 F.3d at 1052 ("[W]e find no basis to conclude that the mere fact of assignment converts the Providers' claims into claims to recover benefits under the terms of an ERISA plan.").

Marin is highly instructive. In that case, the healthcare provider plaintiff asserted state law claims for breach of an implied-in-fact contract, breach of oral contract, negligent misrepresentation, quantum meruit, and estoppel. 581 F.3d at 944. The defendant removed based upon complete ERISA preemption, arguing that the first *Davila* prong was satisfied because the provider allegedly had standing to pursue claims under an assignment of benefits. *Id.* at 949. The Ninth Circuit disagreed, concluding that because the provider had asserted claims based upon a purported oral contract with the defendant, the relevant legal obligation "does not stem from the ERISA plan, and the [provider] is therefore not suing as an assignee of an ERISA plan participant or beneficiary . . . it is suing in its own right pursuant to an independent obligation." *Id.* at 948. The Ninth Circuit considered and squarely rejected the argument that United makes here: that because the provider plaintiff allegedly obtained an assignment of benefits, it was prevented from seeking relief under state law:

> Second, defendants argue that because the Hospital was assigned the patient's rights to payment under his ERISA plan, it was prevented from seeking additional payment under state law. That is, they argue that because the Hospital could have brought a suit under § 502(a)(1)(B) for payments owed to the patient by virtue of the terms of the ERISA plan, this is the *only* suit the Hospital could bring. This argument is inconsistent with our analysis in *Blue Cross.* There we concluded that, even though the Providers had received an assignment of the patient's medical rights and hence could have brought a suit under ERISA, there was "no basis to conclude that the mere fact of assignment converts the Providers' claims [in this case] into claims to recover benefits under the terms of an ERISA plan." 187 F.3d at 1052.
>
> We conclude that the Hospital's state-law claims based on its alleged oral contract with [defendant] were not brought, and could not have been brought, under § 502(a)(1)(B). Therefore, the Hospital's state-law claims do not satisfy the first prong of *Davila.*

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Id. at 949. In other words, that the plaintiff could have but chose not to assert a derivative claim for ERISA benefits did not foreclose it from instead asserting non-ERISA claims based on separate legal obligations owed to it directly. *See also Bay Area Surgical Mgmt., LLC v. United Healthcare Ins. Co.*, 2012 WL 3235999, at *4 (N.D. Cal. Aug. 6, 2012) (no ERISA standing where causes of action "arise from the alleged oral contract between [plaintiff] and United"); *N. Jersey Brain & Spine Ctr. v. Aetna Life Ins. Co.*, 2017 WL 659012, at *4-5 (D.N.J. Feb. 17, 2017) (no ERISA standing where "[plaintiff] is not seeking relief as an assignee of an ERISA plan's benefits, but pursuing recovery under the terms of an implied contract between it and Aetna.").

Here, as in *Blue Cross*, *Marin*, and their progeny, the Health Care Providers assert claims based upon contractual and quasi-contractual legal obligations independent of any ERISA plans. Assignments of benefits, to the extent they exist and are effective, would not convert the claims pled into claims for ERISA benefits. For this reason, the Court should grant the Amended Motion.

B. *Davila* Prong 2

Davila Prong 2 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). Courts routinely hold that claims predicated upon duties imposed by state common and statutory law do not satisfy *Davila* Prong 2. *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 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

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"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).

Once again, *Marin* is analogous. The *Marin* Court held that legal and equitable claims asserted by a healthcare provider plaintiff based upon a purported contract that was never reduced to writing—similar to the claims alleged in this action—were supported by an independent legal duty because they were "in no way based on an obligation under an ERISA plan" and "would exist whether or not an ERISA plan existed." 581 F.3d at 950. Here too, the Health Care Providers' claims are based upon obligations imposed by Nevada state law and in no way depend upon the existence of an ERISA plan. And importantly, United has already conceded the point, acknowledging that contractual or quasi-contractual claims for reimbursement do not give rise to complete ERISA preemption. *See* January 6, 2020 Hearing Tr. at 37:2-4.

As such, *Davila* Prong 2 is unsatisfied, providing yet another fatal flaw in Defendants' complete preemption argument.

III. COSTS AND FEES

Should the Court grant this Motion, it should award the Health Care Providers their reasonable fees and costs incurred as a result of the improper removal, pursuant to 28 U.S.C. § 1447(c). In applying § 1447(c), this Court has explained that fees are appropriate if the removal was not objectively reasonable based on the relevant case law. *See J.M. Woodworth Risk Retention Grp., Inc. v. Uni-Ter Underwriting Mgmt. Corp*, 2014 WL 6065820, at *1 (D. Nev. Nov. 12, 2014). Here, United did not have an objectively reasonable basis for removal. Voluminous case law, in the Ninth Circuit and beyond, demonstrated that removal was improper because rate-of-payment disputes are not completely preempted by ERISA. But United chose to disregard this precedent and remove nonetheless. Accordingly, the Health Care Providers are entitled to recover its attorneys' fees and costs incurred in filing the original Motion and this Amended Motion.

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CONCLUSION

For all the foregoing reasons, the Court should grant the Amended Motion, remand this action to the Eighth Judicial District Court for Clark County, Nevada, and award the Health Care Providers their reasonable costs and attorney's fees pursuant to 28 U.S.C. § 1447(c).

DATED this 15th day of January, 2020.

McDONALD CARANO LLP

By: /s/ Kristen T. Gallagher

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 15th day of January, 2020, I caused a true and correct copy of the foregoing **AMENDED MOTION TO REMAND** to be served via the U.S. District Court's Notice of Electronic Filing system ("NEF") in the above-captioned case, upon the following:

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INDEX OF EXHIBITS

Description	Exhibit No.
Transcript of Hearing on January 6, 2020 (relevant portions)	1
Petition in *Hill Country Emergency Medical Associates et al. vs. UnitedHealthcare Insurance Company et al.*	2

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EXHIBIT 1

Transcript of Hearing on January 6, 2020

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EXHIBIT 1

TRANSCRIBED FROM DIGITAL RECORDING

IN THE UNITED STATES DISTRICT COURT

FOR THE 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, et al., Defendants.	Case No. 2:19-cv-00832-JAD-VCF Las Vegas, Nevada January 6, 2020 Courtroom 3D Recording method: Liberty/CRD 2:50 p.m. - 3:58 p.m. MOTION HEARING

ORIGINAL

TRANSCRIPT OF PROCEEDINGS
BEFORE THE HONORABLE CAM FERENBACH
UNITED STATES DISTRICT COURT MAGISTRATE JUDGE

(Appearances contained on page 2.)

Recorded by: Jerry Ries

Transcribed by: Amber M. McClane, RPR, CRR, CCR #914
United States District Court
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Proceedings recorded by electronic sound recording.
Transcript produced by mechanical stenography and computer.

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something to do with whether the dispute is coverage or rate of payment? Does that make a difference?

MR. ROBERTS: Yes.

THE COURT: Okay.

MR. ROBERTS: Yes. And that may be more detail than we need to go in now --

THE COURT: Okay.

MR. ROBERTS: -- but I -- I --

THE COURT: That's probably what I told Ms. Lundvall I didn't want to hear about.

MR. ROBERTS: Yes, you did. And I don't know that the Court needs to address it, but they -- they do make clear in -- in their reply brief --

THE COURT: Right.

MR. ROBERTS: -- that they acknowledge this is only about the rate of payment.

THE COURT: Rate of payment. Right. Yeah.

MR. ROBERTS: And we paid them something, but it's just not satisfactory to them.

THE COURT: And that way -- that -- you know, if that's accepted, then it's outside of ERISA. If it's truly and only a rate of payment case, then it's -- it's not ERISA. No?

MR. ROBERTS: I don't -- I think that's a little bit too broad.

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THE COURT: Too broad? Okay.

MR. ROBERTS: If it's a rate of payment case based on a -- a contract or a quasi contract, then it's outside of ERISA.

THE COURT: Okay.

MR. ROBERTS: But if there is no contract except the ERISA contract, I don't believe it is outside of ERISA.

THE COURT: Okay. So -- so the -- then the question is, is there a contract or a quasi contract.

MR. ROBERTS: Correct.

THE COURT: Aah. Okay. Okay. Thank you.

MR. ROBERTS: And -- and for that very issue, this Court in the order on the motion to stay, Document 25 --

THE COURT: Right. And I was looking at that just before I came in here.

MR. ROBERTS: Yes.

THE COURT: I said, gosh, I entered an order in this case. I better read what I had to say. Okay.

MR. ROBERTS: And I think --

THE COURT: That's Number 25; right?

MR. ROBERTS: Yes.

THE COURT: Yeah.

MR. ROBERTS: And -- and the Court took a preliminary peek at these issues and determined that it was unlikely that the case would be remanded --

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Thank you very much.

MS. LUNDVALL: Thank you, Your Honor.

MR. ROBERTS: Thank you, Your Honor.

MS. GALLAGHER: Thank you.

(Proceedings adjourned at 3:58 p.m.)

* * *

I, AMBER M. McCLANE, court-appointed transcriber, certify that the foregoing is a correct transcript transcribed from the official electronic sound recording of the proceedings in the above-entitled matter.

/s/ Amber M. McClane 1/15/2020

AMBER MCCLANE, RPR, CRR, CCR #914 Date

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EXHIBIT 2

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Petition in *Hill Country Emergency Medical Associates et al. vs. UnitedHealthcare Insurance Company et al.*

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EXHIBIT 2

CAUSE NO. D-1-GN-19-002050

Hill Country Emergency Medical Associates, P.A., Longhorn Emergency Medicine Associates, P.A., Central Texas Emergency Associates, P.A., and Emergency Associates of Central Texas, P.A.,	§	IN THE DISTRICT COURT
Plaintiffs,	§	
v.	§	201ST JUDICIAL DISTRICT
UnitedHealthCare Insurance Company and UnitedHealthCare of Texas, Inc.,	§	
Defendants.	§	TRAVIS COUNTY, TEXAS

PLAINTIFFS' ORIGINAL PETITION

TO THE HONORABLE COURT:

COME NOW Plaintiffs Hill Country Emergency Medical Associates, P.A., Longhorn Emergency Medicine Associates, P.A., Central Texas Emergency Associates, P.A., and Emergency Associates of Central Texas, P.A., by and through undersigned counsel, file this Original Petition against Defendants UnitedHealthCare Insurance Company and UnitedHealthCare of Texas, Inc. (collectively, "The Insurance Companies"), and would show the Court as follows:

INTRODUCTION

1. Plaintiffs Hill Country Emergency Medical Associates, P.A., Longhorn Emergency Medicine Associates, P.A., Central Texas Emergency Associates, P.A., and Emergency Associates of Central Texas, P.A. (collectively, the "Plaintiff Doctors") are four groups of physicians who provide emergency care to thousands of citizens of central Texas. Unlike most other physicians,

who generally have the ability to choose the patients that they treat, these doctors do not. By necessity and under compulsion of federal and state law, Plaintiff Doctors are obligated to treat all patients who require emergency services. In recognition of the nature and critical importance of these services, Texas law requires health insurers to compensate emergency medicine physicians at usual and customary rates, whether or not the doctors are part of the insurers' preferred provider networks. Reasonable compensation is essential to permit Plaintiff Doctors to continue to provide high-quality emergency services and to attract and retain physicians who are willing to work long hours under great stress in order to perform life-saving medical services in otherwise underserved areas of Texas.

2. The Insurance Companies historically have compensated Plaintiff Doctors at more reasonable rates, as required under Texas statutes. In recent years, however, the Insurance Companies began slashing the rates at which they paid Plaintiff Doctors for their emergency services. The Insurance Companies began paying some of the claims for emergency services rendered by Plaintiff Doctors at far below the usual and customary rates—substantially below the historic levels for the same services and significantly below the rates at which the Insurance Companies continued to pay other substantially identical claims.

3. One explanation for this disparity is that the Insurance Companies are reimbursing Plaintiff Doctors for services provided to members of the plans they fully underwrite at significantly lower rates than they are reimbursing Plaintiff Doctors for services provided to members of the employer-funded plans for which the Insurance Companies only provide administrative services.

4. This action seeks damages for the Insurance Companies' violations of Texas law and to compel the Insurance Companies to abide by Texas law with respect to payment of future claims.

PARTIES

5. Plaintiff Hill Country Emergency Medical Associates, P.A. is a Texas professional association that provides physician staffing to emergency departments, primarily in Central Texas.

6. Plaintiff Longhorn Emergency Medicine Associates, P.A. is a Texas professional association that provides physician staffing to emergency departments, primarily in Central Texas.

7. Plaintiff Central Texas Emergency Associates, P.A. is a Texas professional association that provides physician staffing to emergency departments, primarily in Central Texas.

8. Plaintiff Emergency Associates of Central Texas, P.A. is a Texas professional association that provides physician staffing to emergency departments, primarily in Central Texas

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9. Defendant UnitedHealthCare Insurance Company is a corporation organized under the laws of the State of Connecticut doing business in Texas. UnitedHealthCare Insurance Company is licensed by the Texas Department of Insurance as a life, health or accident insurance company, and underwrites or administers preferred provider benefit plans and other health insurance products in the State of Texas. It may be served through its agent for service of process, C T Corporation System, 350 North Paul Street, Dallas, TX 75201.

10. Defendant UnitedHealthCare of Texas, Inc. is a corporation organized under the laws of the State of Texas with a principal office in Plano, Texas. UnitedHealthCare of Texas, Inc. is licensed by the Texas Department of Insurance as a basic health maintenance organization ("HMO"). It may be served through its agent for service of process C T Corporation System, 1999 Bryan St., Suite 900, Dallas, TX 75201-3136.

DISCOVERY CONTROL PLAN AND CLAIM FOR RELIEF

11. This case will be governed by Level 3 discovery pursuant to Rule 190.4 of the Texas Rules of Civil Procedure. Plaintiff doctors seek monetary relief in excess of $1,000,000.00.

JURISDICTION & VENUE

12. This Court has subject-matter jurisdiction because this dispute involves an amount in controversy in excess of this Court's minimum jurisdictional requirements.

13. Venue is proper in Travis County, Texas pursuant to Section 15.002(a)(1) of the Texas Civil Practice & Remedies Code because a substantial part of the events or omissions giving rise to Plaintiff Doctors' claims occurred in Travis County, Texas.

14. The Insurance Companies are subject to personal jurisdiction in this state pursuant to Tex. Civ. Prac. & Rem. Code § 17.042(1) because they have entered into contracts to provide insurance to Texas residents and conduct business in this State.

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FACTS

The Plaintiffs Provide Necessary Emergency Care

15. This is an action for damages stemming from the Insurance Companies' failure to properly reimburse Plaintiff Doctors for emergency services provided to members of the Insurance Companies' health plans.[1]

[1] Plaintiff Doctors 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). Thus, there is no basis to remove this lawsuit to federal court under federal question jurisdiction. Plaintiff Doctors also do not assert any claims relating to the Insurance Companies' Managed Medicare business. As explained below, upon entry of an appearance by counsel for the Insurance Companies, Plaintiff Doctors will serve, via encrypted transmission, a list of the individual healthcare claims at issue in this litigation. To the extent that list contains any healthcare claims relating to Managed Medicare, FEHBA, or Managed Medicaid business, Plaintiff Doctors will remove them upon notice by the Insurance Companies.

16. Plaintiff Doctors are emergency medicine physicians who staff emergency departments 24 hours a day, 7 days a week. Plaintiff Doctors provide emergency department coverage at 25 Texas emergency departments.

17. As providers of emergency medical care, Plaintiff Doctors have made a commitment to providing emergency medical services to all patients, regardless of insurance coverage or ability to pay, including to patients with insurance coverage issued or underwritten by the Insurance Companies.

18. This philosophy is echoed in the federal Emergency Medical Treatment and Labor Act ("EMTALA") and Texas law, which require emergency room physicians to evaluate, stabilize, and treat all patients, regardless of their insurance status or ability to pay. *See* EMTALA, 42 U.S.C. § 1395dd; Tex. Health & Safety Code Ann. §§ 311.022–.024; Tex. Health & Safety Code Ann. §§ 241.027–.028, 241.055–.056.

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19. EMTALA is one of the central sources of patient protection in the United States healthcare system.

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20. However, EMTALA also places a financial burden on emergency medicine physicians, many of whom also adhere to grueling schedules and live in or commute to far-flung locations in order to ensure patients' access to emergency care.

21. Emergency medicine physicians represent 4% of physicians in this country but provide 67% of unreimbursed care.

22. On average, an emergency medicine physician provides almost $140,000 of charity care every year, and a third of emergency physicians provide more than 30 hours of charity care each week.

23. Almost 1 in 5 emergency patients has no ability to pay, and 3 out of 4 emergency room visits are reimbursed below cost.

24. In recognition of the challenges unique to the practice of emergency medicine, the Texas Legislature explicitly requires insurers and HMOs to reimburse healthcare providers of emergency services at either the usual and customary rate or an agreed rate. Tex. Ins. Code § 1271.155 (HMO plans); Tex. Ins. Code § 1301.0053 (POS plans); § 1301.155 (PPO plans).

25. The usual and customary rate is the general prevailing cost of a service within a geographic area.

26. These provisions are imperative to ensuring that emergency medicine physicians remain able to offer high quality services to Texas residents. They account for the expenses associated with emergency medicine physicians' education and continued training and incentivize emergency medicine physicians to move to underserved areas, ensuring that emergency medical services are available across the state.

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The Insurance Companies Underpaid the Plaintiffs for Emergency Services

27. The Insurance Companies operate an HMO under Chapter 843 of the Texas Insurance Code and as an insurer under Chapter 1301 of the Texas Insurance Code. The Insurance Companies provide, either directly or through arrangements with providers such as hospitals and Plaintiff Doctors, healthcare benefits to their subscribers.

28. In spite of the essential role emergency medicine physicians such as Plaintiff Doctors play in the United States healthcare system, the Insurance Companies have refused to offer sustainable provider contracts to Plaintiff Doctors.

29. Because there is no contract between the Insurance Companies and any of Plaintiff Doctors for the healthcare claims at issue in this litigation, Plaintiff Doctors are designated as "non-participating" or "out-of-network" for all of the claims at issue in this litigation.

30. Because Plaintiff Doctors did not participate in the Insurance Companies' provider network, there was no agreed rate. The Insurance Companies are therefore obligated to reimburse Plaintiff Doctors at the usual and customary rate for emergency services Plaintiff Doctors provided to their patients.

31. Despite not participating in the Insurance Companies' provider network for the time at issue, Plaintiff Doctors regularly provide emergency services to the Insurance Companies' health plan enrollees.

32. From January 2016 to September 2018, Plaintiff Doctors have provided emergency medical services to thousands of the Insurance Companies' health plan enrollees.

33. The Insurance Companies' members have received a wide variety of emergency services (in some instances, life-saving services) from Plaintiff Doctors, including treatment of conditions ranging from cardiac arrest, to broken limbs, to burns, to diabetic ketoacidosis and shock, to gastric distress and obstetrical distress.

34. In recent years, the Insurance Companies dramatically decreased the reimbursements to Plaintiff Doctors for services provided to certain of their members.

35. Despite the Insurance Companies' obligation under the Texas Insurance Code, these new reimbursement levels were significantly less than the usual and customary rate for the services provided.

36. From January 2016 to September 2018, Plaintiff Doctors have identified more than 7,000 emergency service claims that the Insurance Companies paid at unacceptably low rates, in violation of the above-referenced sections of the Texas Insurance Code.

37. On average, the Insurance Companies allowed approximately 150% of the Medicare allowable amount for these claims.

38. The total underpayment amount for these claims is in excess of $5.7 million.

39. As stated in ¶ 34, the Insurance Companies are reimbursing Plaintiff Doctors at unacceptably low rates for services provided to some of their members. They continue to reimburse Plaintiff Doctors at more reasonable rates for services provided to other of their members. The result is that the Insurance Companies are reimbursing Plaintiff Doctors at drastically different rates for essentially the same services, provided at the same facility, to different members.

40. Upon information and belief, the Insurance Companies generally are paying the lower reimbursement rates for services provided to their fully insured members and the higher reimbursement rates for services provided to members of their administrative services only or self-insured plans.

41. Put differently, when their own money is at stake, rather than the money of one of their employer clients, the Insurance Companies pay the lower rate.

42. The Insurance Companies have failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of these claims.

43. For each of the healthcare claims at issue, the Insurance Companies determined the claim to be payable; however, they paid at an arbitrarily reduced rate. Thus, the claims at issue involve no questions of whether the claim is payable; rather, they involve only the issue of whether the Insurance Companies paid the claim at the required usual and customary rate. (They did not.)

44. Plaintiff Doctors bring this action to collect damages due to the Insurance Companies' failure to comply with Texas law and to compel the Insurance Companies to pay them the usual and customary rate for the emergency services that Plaintiff Doctors provided to their members.

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

CAUSES OF ACTION

COUNT I – Violation of the Texas Insurance Code

46. The foregoing paragraphs are incorporated by reference.

47. Defendant UnitedHealthCare of Texas, Inc. is an HMO under the Texas Insurance Code. Defendant UnitedHealthCare Insurance Company is a life, health, and accident insurer under the Texas Insurance Code, and is an insurer under Chapter 1301 of the Texas Insurance Code. Plaintiff Doctors are out-of-network providers who have provided emergency care to enrollees of the Insurance Companies' plans. Section 1271.155 of the Texas Insurance Code requires an HMO to pay for emergency care provided by out-of-network providers such as Plaintiff Doctors at the usual and customary rate or at an agreed rate. Sections 1301.0053 and 1301.155 impose the same requirement on an insurer that offers preferred provider benefit plans.[2] There is no agreed rate between the parties for emergency care that has been rendered by Plaintiff Doctors to the Insurance Companies' members; therefore the Insurance Companies are obligated to pay Plaintiff Doctors at the usual and customary rate.

48. The Insurance Companies have failed to fulfill those obligations under the Texas Insurance Code by failing to pay for emergency care at the usual and customary rate on the claims

[2] Texas Department of Insurance regulations impose the same requirement, and further specify the appropriate manner in which the usual and customary rate should be calculated. *See* 28 Tex. Admin. Code §§ 11.1611(e), (f)(1) (HMO plan regulations); § 3.3708(a)(1) (PPO plans). Additionally, the Texas Department of Insurance has specifically regulated that an HMO is obligated to reimburse a non-participating hospital-based physician at the usual and customary rate if he or she treats patients at a participating hospital. 28 Tex. Admin. Code § 11.1611(a). The Insurance Companies also have violated those regulations.

submitted by Plaintiff Doctors for emergency care.[3] Plaintiff Doctors are entitled to recover the difference between the amount the Insurance Companies have paid for emergency services that Plaintiff Doctors rendered to the Insurance Companies' enrollees and the usual and customary rate.

COUNT II – Violation of Section 541.060 of the Texas Insurance Code

49. The foregoing paragraphs are incorporated by reference.

50. Section 541.060 of the Texas Insurance Code prohibits an insurer from engaging in an unfair settlement practice "with respect to a claim by an insured." Here, Plaintiff Doctors satisfy this requirement by virtue of having received an assignment of the insured's benefits from each patient and filing claims for such benefits with the Insurance Companies as the insured's assignee. Further, as a "person" that sustained actual damages—the difference between the usual and customary rate and the amount that the Insurance Companies paid—Plaintiff Doctors are specifically authorized by Section 541.151 of the Texas Insurance Code to bring an action against the Insurance Companies for their violations of Section 541.060.

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51. One prohibited unfair claim settlement practice is "failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of: (A) a claim with respect to which the insurer's liability has become reasonably clear." Tex. Ins. Code § 541.060(a)(2)(A). As detailed in the preceding paragraphs, the Insurance Companies have failed to comply with Sections 1271.155, 1301.0053, and 1301.155 of the Texas Insurance Code by failing to pay Plaintiff Doctors the usual and customary rate for emergency care provided to the Insurance Companies' members. By failing to pay Plaintiff Doctors the usual and customary rate, as required by Texas

[3] A list of the specific healthcare claims that the Insurance Companies have underpaid will be provided to the Insurance Companies by secure encrypted transmission upon entry of an appearance. The Insurance Companies' systemic underpayment of the doctors' claims is ongoing, and the doctors reserve the right to add additional healthcare claims as those claims are identified or accrue.

law, the Insurance Companies have violated Section 541.060(a)(2)(A) and committed an unfair settlement practice.

52. Plaintiff Doctors are therefore entitled to recover the difference between the amount the Insurance Companies paid for emergency care Plaintiff Doctors rendered to their members and the usual and customary rate, plus court costs and attorneys' fees. Tex. Ins. Code § 541.152(a). Because the Insurance Companies knowingly failed to pay Plaintiff Doctors the usual and customary rate for emergency care rendered to their enrollees, they are liable for a penalty equal to three times Plaintiff Doctors' damages—that is, the difference between the amount the Insurance Companies paid for emergency care Plaintiff Doctors rendered to their plan members and the usual and customary rate. *See* Tex. Ins. Code § 541.152(b).

COUNT III – Violations of Texas Prompt Pay Statutes

53. The foregoing paragraphs are incorporated by reference.

54. The Texas Insurance Code requires an insurer or HMO to pay a healthcare provider's claim within 30 days of receipt of an electronically submitted clean claim. TEX. INS. CODE §§ 843.338, 1301.103. Though this requirement generally only applies to participating providers, the Texas Insurance Code extends this requirement to out-of-network providers of emergency services such as Plaintiff Doctors. TEX. INS. CODE §§ 843.351, 1301.069. Thus, for all electronically submitted claims, the Insurance Companies were obligated to pay Plaintiff Doctors the usual and customary rate within 30 days of receipt of the claim.

55. Despite this obligation, as alleged above, the Insurance Companies have failed to reimburse Plaintiff Doctors at the usual and customary rate within 30 days of the electronic submission of the claim. Indeed, the Insurance Companies failed to reimburse Plaintiff Doctors at the usual and customary rate ***at all***. Because the Insurance Companies have failed to reimburse

Plaintiff Doctors at the usual and customary rate within thirty days of submission of the claims as the Texas Insurance Code requires, the Insurance Companies are liable to Plaintiff Doctors for statutory penalties.

56. For all claims payable by plans that the Insurance Companies insure that they failed to pay at the usual and customary rate within 30 days, the Insurance Companies are liable to Plaintiff Doctors for penalties. TEX. INS. CODE §§ 843.342, 1301.137.

57. Plaintiff Doctors seek penalties payable to them for late-paid claims under these statutes.

58. Plaintiff Doctors are also entitled to recover their reasonable attorneys' fees.

COUNT IV - Quantum Meruit

59. The foregoing paragraphs are incorporated by reference.

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60. Plaintiff Doctors rendered valuable emergency services to the Insurance Companies' members.

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61. The Insurance Companies received the benefit of having its healthcare obligations to its plan members discharged and their enrollees received the benefit of the emergency care provided to them by Plaintiff Doctors.

62. As insurers, the Insurance Companies were reasonably aware that medical service providers, including Plaintiff Doctors, would expect to be paid by the Insurance Companies for the emergency services provided to their members. Indeed, as pleaded above, this obligation is codified in the Texas Insurance Code and accompanying regulations.

63. The Insurance Companies accepted the benefit of the services provided by Plaintiff Doctors to members of their health plans.

64. Therefore, Plaintiff Doctors are entitled to quantum meruit recovery for the value of the services provided. However, the Insurance Companies have arbitrarily and unilaterally reimbursed Plaintiff Doctors at amounts far lower than required.

65. As a result of the Insurance Companies' actions, Plaintiff Doctors have been damaged in the amount in excess of the minimum jurisdictional limits of this Court. Plaintiff Doctors sue for the damages caused by the Insurance Companies' conduct and are entitled to recover the difference between the amount the Insurance Companies paid for emergency care Plaintiff Doctors rendered to their members and the reasonable value of the service that Plaintiff Doctors rendered to the Insurance Companies by discharging their obligations to their plan members.

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COUNT V – Declaratory Judgment

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66. The foregoing paragraphs are incorporated by reference.

67. As set out above, Plaintiff Doctors provide emergency care to patients who present to emergency departments in Central Texas, including the Insurance Companies' insureds. Under Texas law, the Insurance Companies are required to pay Plaintiff Doctors the usual and customary rate for that emergency care. *See* TEX. INS. CODE § 1271.155; 28 TEX. ADMIN. CODE §§ 11.1611(a), (e), (f)(1). Instead of reimbursing Plaintiff Doctors at the usual and customary rate, the Insurance Companies have reimbursed Plaintiff Doctors at reduced rates with no relation to the usual and customary rate.

68. An actual, justiciable controversy therefore exists between the Parties regarding the rate of payment for Plaintiff Doctors' emergency care that is the usual and customary rate that the Texas Insurance Code requires the Insurance Companies to pay. Plaintiff Doctors therefore request a declaration that the rates that the jury determines to be the usual and customary rates for

the past healthcare claims asserted in the preceding Counts are the usual and customary rates that the Insurance Companies are required to pay to Plaintiff Doctors for the emergency care that Plaintiff Doctors provide to the Insurance Companies' insureds in the future.

69. Plaintiff Doctors are entitled to an award of attorney's fees pursuant to Tex. Civ. Prac. & Rem. Code § 37.009.

CONDITIONS PRECEDENT

70. All conditions precedent have been performed or have occurred.

ATTORNEYS FEES

71. Plaintiff Doctors retained the services of Waller Lansden Dortch & Davis, L.L.P. to bring and prosecute this lawsuit. Plaintiff Doctors are entitled to recover, and hereby seek, their attorneys' fees and expenses incurred in bringing and prosecuting this lawsuit, pursuant to Texas Civil Practice and Remedies Code §37.009, et seq., the above-referenced provisions of the Texas Insurance Code, and other applicable law.

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RULE 193.7 NOTICE

72. Pursuant to Rule 193.7 of the Texas Rules of Civil Procedure, Plaintiff Doctors hereby give notice to the Insurance Companies that Plaintiff Doctors intend to use all documents exchanged and produced between the parties (including, but not limited to, correspondence, pleadings, records, and discovery responses) during the trial of this matter.

RULE 194 REQUEST FOR DISCLOSURE AND DISCOVERY REQUESTS

73. Pursuant to Texas Rule of Civil Procedure 194, Plaintiff Doctors request that the Insurance Companies disclose, within 50 days of service of this request, the information or material described in Rule 194.2.

JURY DEMAND

74. Plaintiff Doctors hereby demand a trial by jury of the above-styled action pursuant to Texas Rule of Civil Procedure 216(a).

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs hereby request that Defendants UnitedHealthCare Insurance Company and UnitedHealthCare of Texas, Inc., be cited to appear and answer this Original Petition, and that upon final trial and determination thereof, judgment be entered in favor of Plaintiff Doctors awarding them the following relief:

A. The difference between the amount the Insurance Companies have already paid on the healthcare claims at issue and the usual and customary rate;

B. An award of penalties pursuant to Texas Insurance Code § 541.152;

C. Penalties due under Texas Insurance Code §§ 843.342, 1301.137

D. Quantum meruit recovery;

E. Declaratory judgment as requested above;

F. Reasonable attorneys' fees and court costs;

G. Prejudgment and postjudgment interest; and

H. Such other and further relief to which the Plaintiffs may be entitled.

Dated this 15th day of April, 2019.

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Respectfully submitted,

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EXHIBIT 3

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Attorneys for Plaintiffs

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-JCM-VCF **REPLY IN SUPPORT OF AMENDED MOTION TO REMAND**

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") (collectively, the "Health Care Providers") submit this Reply

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in support of its Amended Motion to Remand (ECF No. 49)

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Adjudication of the Amended Motion to Remand is straightforward: rate of payment cases are not completely preempted by ERISA Section 502(a). There is Ninth Circuit precedent binds the Court in this regard, as well as near-uniformity in result from other jurisdictions in cases with the same facts as the case at bar. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 949 (9th Cir. 2009); *see e.g. New Jersey Brain & Spine Ctr. v. United Healthcare Ins. Co.*, No. CV1815631SDWLDW, 2019 WL 6317390, at *5 (D.N.J. Nov. 25, 2019), report and recommendation adopted, No. 18-15631 (SDW) (LDW), 2019 WL 6721652 (D.N.J. Dec. 10, 2019); *Crescent City Surgical Ctr. v. United Healthcare of La., Inc.*, No. CV 19-12586, 2019 WL 6112706, at *1 (E.D. La. Nov. 18, 2019). And this outcome has been reached applying the two-prong test required by *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004).

II. LEGAL ARGUMENT

A. United's Attempts to Distinguish the Health Care Providers' Cases Must Be Rejected.

To claim the case at bar is ERISA-preempted United makes the unsupported argument that a provider can only maintain a rate of payment action if there is as a written provider agreement, oral agreement, or applicable statute. Opposition at 13:5-10. To reach that conclusion, United ignores the clear mandate of *Marin Gen. Hosp.* and the other legal authority finding rate of payment cases outside the scope of ERISA since they cannot satisfy either of the two-prong test set forth in *Davila*, 542 U.S. at 210. *See also Premier Inpatient Partners LLC v. Aetna Health & Life Ins. Co.*, 371 F. Supp. 3d 1056, 1073 (M.D. Fla. 2019) (the "rate of payment and right of payment distinction is dispositive..."); *Blue Cross of California v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1051 (9th Cir. 1999) (noting that ERISA did not preempt the state law claims because "[t]he dispute here is 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."); *Windisch v. Hometown Health Plan, Inc.*, No. 3:08-

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cv-00664-RJC-RAM, 2010 WL 786518, at *5 (D. Nev. Mar. 5, 2010) ("Plaintiff has affirmatively taken the position that he is only challenging Defendants' adjudication and payment of claims that have already been determined to be covered…ERISA does not preempt Plaintiff's claims because they do not require the Court to interpret ERISA plans.").

In support of its quest to bypass these cases and *Davila*, United tries to distinguish *Gulf-To-Bay*, in which it and its affiliate are parties, by arguing that a Florida statute created a legal duty independent of ERISA to pay out-of-network providers at a particular rate – which only concerns the second factor of the *Davila* test. This is an inaccurate reading of *Gulf-to-Bay* because that court did not even consider the second part of the *Davila* test:

> The **first part of the Davila test** is satisfied if two requirements are met: (1) **the plaintiff's claim must fall within the scope of ERISA;** and (2) the plaintiff must have standing to sue under ERISA. As to the first requirement of this part…the Eleventh Circuit has adopted a distinction between two types of claims: claims challenging the "rate of payment" pursuant to a provider-insurer agreement, and those challenging the "right to payment" under the terms of an ERISA beneficiary's plan….The Court finds unavailing UHIC's attempt to recast through an ERISA lens [plaintiff's] entitlement to full payment for services rendered. **Consequently, the Court finds that [plaintiff's] claims fall outside the scope of section 502(a) of ERISA, and no further analysis under *Davila* is necessary.**

Gulf-to-Bay Anesthesiology Assocs., LLC v. UnitedHealthcare of Fla., Inc., No. 8:18-CV-233-EAK-AAS, 2018 WL 3640405, at *3 (M.D. Fla. July 20, 2018) (emphasis added) (internal citations omitted). Because the *Gulf-to-Bay* dispute involved rate of payment, the claims did not fall within the scope of ERISA and, therefore, the ***first*** part of the *Davila* test could not be satisfied. There was no discussion about the second factor at all. Like *Gulf-to-Bay*, the Health Care Providers' claims are outside the scope of ERISA and *Davila's* first element is not satisfied.

The Health Care Providers have not asserted any claims relating to benefits that have been denied; their only claims are related to claims that United has already paid. First Amended Complaint ("Am. Compl.") at ¶ 43. Thus, this dispute does not involve any right to payment that could arise under an ERISA plan. It solely involves the rate of payment. *Id.*; *see* Reply in Support of Motion to Remand, Ex. A, Bristow Decl. ¶ 4 (ECF No. 26-1).

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There are numerous cases involving United or its affiliates where courts have rejected the same arguments United forwards here and some of these cases squarely underscore that courts have routinely remanded rate-of-payment cases involving implied-in-fact contracts. *See e.*g. *Gulf-to-Bay*, 2018 WL 3640405 at *3; *Low-T Physicians Serv., P.L.L.C. v. United Healthcare of Texas, Inc*., No. 4:18-CV-938-A, 2019 WL 935800, at *2 (N.D. Tex. Feb. 26, 2019); *Sobertec LLC v. UnitedHealth Grp., Inc.,* No. SACV191206JVSMRWX, 2019 WL 4201081, at *4 (C.D. Cal. Sept. 5, 2019) (claims for an implied-in-fact agreement not preempted by ERISA); *New Jersey Brain & Spine Ctr.*, 2019 WL 6317390, at *5; *Bay Area Surgical Mgmt., LLC. v. United Healthcare Ins. Co.*, No. C 12-01421 SI, 2012 WL 3235999, at *4 (N.D. Cal. Aug. 6, 2012) (oral contract and promises between provider and United not preempted by ERISA); *Regents for Univ. of California ex rel. its San Diego Med. Ctr. v. United Healthcare Ins. Co.*, No. 12-CV-0588 BEN BGS, 2012 WL 4471416, at *4 (S.D. Cal. Sept. 25, 2012) (claims including of breach of implied-in-fact contract and unjust enrichment not preempted under ERISA); *Temple Hosp. Corp. v. Gomez, United Healthcare Services, Inc*. No. 2:14-CV-01342-ODW, 2014 WL 953445, at *2 (C.D. Cal. Mar. 11, 2014) (claims of breach of oral contract, promissory estoppel, and implied equitable indemnity not preempted by ERISA); *Ghosh v. Aetna Health of Cal., Inc*., 2012 WL 4548173 (S.D. Cal. Oct. 2, 2012) (claims based on misappropriations, misrepresentations, and interference in his contractual relationship against, inter alia, United Healthcare of California relating to underpayment of provider claims not preempted by ERISA); *Crescent City Surgical Ctr*., 2019 WL 6112706 at *1 (claims of breach of contract, violations of the Louisiana Unfair Trade Practices Act, detrimental reliance, fraud, and negligent misrepresentation not preempted by ERISA).

B. Analysis Under Davila's Two Prongs Does Not Trigger Complete Preemption

Contrary to United's claims, the Health Care Providers do not substitute the *Davila* test for the rate of payment vs. right to payment test. Opposition at 11:4-7. Instead, the Health Care Providers note that many "rate of payment" decisions do not perform an extensive analysis of *Davila* because claims involving rate of payment fail to satisfy either prong of the *Davila* test. *See e.g. Premier Inpatient Partners LLC*, 371 F. Supp. 3d at 1073 ("The Eleventh Circuit has instructed that [] 'the 'rate of payment' and 'right of payment' distinction' is dispositive of whether a claimant

could have brought its claim under ERISA."). Federal courts in other jurisdictions likewise have determined that ERISA does not completely preempt claims based on statutory or other common law rate-payment obligations and two recent decisions involving United underscore this point. *New Jersey Brain & Spine Ctr.*, 2019 WL 6317390 at *5; *Crescent City Surgical Ctr.*, 2019 WL 6112706 at *1; *see also Coast Plaza Doctors Hosp. v. Ark. Blue Cross & Blue Shield*, No. CV 10-6927 DDP (JEMx), 2011 WL 3756052, at *4 (C.D. Cal. Aug. 25, 2011); *Med. & Chirurgical Faculty of Md. v. Aetna U.S. Healthcare, Inc.*, 221 F. Supp. 2d 618, 619 & n.1 (D. Md. 2002); *Emergency Servs. of Zephyrhills, P.A. v. Coventry Health Care of Fla., Inc.*, --- F. Supp. 3d ----, Case No. 16-25193, 2017 WL 6548019, at *5 (S.D. Fla. Apr. 5, 2017) (remanding out-of-network provider's claims for underpayment, breach of implied-in-fact contract and unjust enrichment where plaintiff alleged violation of Florida rate payment statute); *Lone Star OB/GYN Assocs. v. Aetna Health Inc.*, 579 F.3d 525, 53 (5th Cir. 2009) ("A claim that implicates the rate of payment as set out in the Provider Agreement, rather than the right to payment under the terms of the benefit plan, does not run afoul of *Davila* and is not preempted by ERISA.").[1]

As is detailed below, the existence of an assignment of benefits is of no consequence here and does not satisfy the first factor of *Davila*. That, alone, mandates that this matter be remanded. Further, United cannot fulfill its burden of establishing the second *Davila* factor because the Health Care Providers' claims are based upon independent statutory and common law duties which courts have repeatedly recognized do not satisfy the second *Davila* factor.

[1] In *New Jersey Brain & Spine Ctr.*, the court remanded a rate-of-payment case where plaintiff's claims were related to the amount of payment received and founded upon implied agreements and representations that allegedly arose in the course of dealings between the parties, and not claims seeking coverage under a given health plan. 2019 WL 6317390 at *5. "Where a plaintiff does not challenge the type, scope or provision of benefits under [an ERISA] healthcare plan, ***any disputes over the amount of reimbursement are not preempted by ERISA***." *Id.* (internal quotations omitted). The "growing trend" in that district is to remand this type of provider reimbursement claim. *Id.* at * 6. In *Crescent City Surgical Ctr.*, like the Health Care Providers here, that plaintiff could have brought derivative claims under an assignment of benefits, but specifically disavowed pursuing ERISA claims assigned by United's insured. Rather, that plaintiff, like here, elected to pursue claims that are solely based on United's breach of its agreement to pay certain amounts, independent of any coverage arrangement that United had with its insured. Both *New Jersey Brain & Spine Ctr.* and *Crescent City Surgical Ctr.* provide further support that rate-of-payment cases are not completely preempted by ERISA.

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1. The First *Davila* Factor[2]

Notwithstanding binding precedent directly on point, United makes the unsupported claim that the mere existence of an assignment of benefits converts a state law claim – not otherwise arising under an ERISA plan – into one that confers standing for purposes of the first *Davila* factor. *See e.g.* Opposition at 7:11-14. This argument must be rejected in light of the *Marin* decision.

The Ninth Circuit has unequivocally held that even when providers receive an assignment of benefits and *could* bring a suit under ERISA, the mere fact of an assignment does not convert a provider's claim into claims to recover benefits under an ERISA plan. *Marin Gen. Hosp.*, 581 F.3d at 949. Thus, so long as a provider's state law claim does not fall within § 502(a) (i.e. denial of payment/coverage, **the existence of the assignment is irrelevant to complete preemption if the provider asserts no claim under the assignment.** *Id.; see also Emergency Services of Zephyrhills, P.A.*, 281 F. Supp. 3d at 1347.

In *Marin Gen. Hosp.*, the Ninth Circuit considered whether the first element of the *Davila* test was satisfied where the provider could have asserted a claim under an assignment of benefits, but chose not to do so. The Ninth Circuit answered in the negative. The Ninth Circuit concluded:

> defendants argue that **because the Hospital was assigned the patient's rights to payment under his ERISA plan**, it was prevented from seeking additional payment under state law. That is, they argue that because **the Hospital could have brought a suit under § 502(a)(1)(B) for payments owed to the patient by virtue of the terms of the ERISA plan, this is the only suit the Hospital could bring**. This argument is inconsistent with our analysis in *Blue Cross*. There we concluded that, even though the Providers had received an assignment of the patient's medical rights and hence could have brought a suit under ERISA, **there was "no basis to conclude that the mere fact of assignment converts the Providers' claims [in this case] into claims to recover benefits under the terms of an ERISA plan."**
>
> We conclude that the Hospital's state-law claims based on its alleged oral contract with MBAMD were not brought, and could not have been brought, under § 502(a)(1)(B). **Therefore, the Hospital's state-law claims do not satisfy the first prong of *Davila***.

581 F.3d at 949 (internal citations omitted). This case forecloses all of United's arguments with

[2] This section addresses United's two separate sections making the same arguments – i.e. that the existence of an assignment of benefits converts state law claims based on independent duties into ERISA claims satisfying the first *Davila* factor. *Compare* Opposition at IV(C) *with* (IV)(D)(1).

respect to the first *Davila* factor. Because the Health Care Providers do not bring any claims as assignees of benefits, it cannot assert ERISA claims in this action and the first *Davila* factor is not satisfied, requiring remand. *Id.*; *see also Connecticut State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1347 (11th Cir. 2009) ("so long as the provider's state law claim does not fall within § 502(a), the existence of the assignment is irrelevant to complete preemption if the provider asserts no claim under the assignment.")

The cases cited by United in its Opposition are also inapplicable to the facts of this case. United erroneously argues that *Misic* is a "rate of payment" case in which the Court found that complete preemption applies. Opposition at 12:4-13. Rate of payment cases involve disputes between the provider and insurer based on an independent, implied or express agreement or course of conduct which does not relate to a benefit plan. The *Misic* case does not fall into this category and the Ninth Circuit itself has made clear that *Misic* is not a rate of payment case:

> **It is clear in *Misic* that the provider sought, as an assignee, to recover reimbursement due to his assignors under the terms of the benefit plan**; indeed, the terms of the benefit plan were the provider's only basis for his reimbursement claim… **The dispute here is 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.

Blue Cross of California v. Anesthesia Care Assocs. Med. Grp., Inc., 187 F.3d 1045, 1051 (9th Cir. 1999). There, the insurer was being sued for failure to *cover* a claim based on the amount that was **expressly required to be paid under the health plan when the beneficiary's rights were *assigned* to the medical provider.** *Misic v. Bldg. Serv. Employees Health & Welfare Tr.*, 789 F.2d 1374, 1376 (9th Cir. 1986). Here, the Health Care Providers have not asserted any claims as assignees, nor do they seek payment based on any provision of any health plan. *Misic* is not a rate of payment case and is inapposite.

United also tries to prove a negative by arguing that "in some of the cases Plaintiffs cite, complete preemption is not found because defendant fails to satisfy the first element of the *Davila* test due to a failure to bring forth sufficient evidence to demonstrate that an assignment of benefits occurred." Opposition at 13:26-28. The caselaw cited by the Health Care Providers in the Amended Motion to Remand does not support United's argument that where there is an

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assignment of benefits, an assignment always confers standing to bring a claim under ERISA. In fact, the court in *Med. & Chirurgical Faculty of State of Maryland* did not find that there were never any assignments as United suggests; instead, the Court found that, just as is the case here, the providers were not bringing their claims based on an assignment of benefits and therefore such claims could not be preempted. *Med. & Chirurgical Faculty of State of Maryland*, 221 F. Supp. at 621 ("Plaintiffs are asserting in this action an independent statutory right of health care providers to receive payment consistent with the statutory formulas, not the right to any benefits due to plan participants. It is undisputed that these statutory rights are not available to plan participants, and thus, could not be assigned by those participants."). Thus, the Court concluded that the rights asserted in the complaint by the plaintiff were not rights assigned by plan participants. *Id.*

In *California Spine*, the issue of an assignment of benefits was important because the claims raised were the type of claims that could be raised by a plan beneficiary if an assignment of benefits existed. In particular, the claims related to the following allegations:

> Defendant allegedly informed Plaintiff that the Patient had a deductible and a maximum out of pocket limit for healthcare of $6,000, of which $ 0 had been paid. Plaintiff was allegedly promised that Defendant would pay 80% of the UCR rate once the Patient met his or her deductible. Moreover, after the Patient met the maximum out of pocket limit, Plaintiff was allegedly promised that Defendant would pay 100% of the UCR rate.

California Spine & Neurosurgery Inst. v. Bos. Sci. Corp., No. 18-CV-07610-LHK, 2019 WL 1974901, at *1 (N.D. Cal. May 3, 2019) (internal citations omitted). Thus, the amount of payment to the provider was directly related to the plan and if an assignment of benefits existed, the provider would have a claim which squarely falls within ERISA.

The first *Davila* factor is not satisfied only because an assignment of benefits exists when the claims asserted are based on claims arising from an insurer's independent statutory and common law duties. Because United cannot establish the first *Davila* factor, this is dispositive.

2. The Second *Davila* Factor

In an attempt to argue that the second *Davila* factor is satisfied, United asserts the obscure argument that the only way for the second *Davila* factor not to be met would be if certain categories

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of circumstances applied, i.e. the existence of an express written contract, oral representation or statute. This argument ignores the decisions cited by the Health Care Providers which make clear that they are *not* limited to the categories identified by United. Essentially, United is attempting to create its own caselaw on this issue. **To be clear: no caselaw exists which finds that a party in a rate of payment case can avoid preemption *only if* one of the three foregoing categories is satisfied.** Rather, courts across various jurisdictions have repeatedly found that cases involving disputes over the rate of payment rather than the right to payment are not preempted by ERISA and neither of the *Davila* factors can be satisfied. *See e.g. Blue Cross of California v. Anesthesia Care Assocs. Med. Grp., Inc*., 187 F.3d 1045, 1051 (9th Cir. 1999) (claims not preempted where the dispute is over amount of payment rather than the right to payment)*; Lone Star OB/GYN Assocs.*, 579 F.3d at 53 ("A claim that implicates the rate of payment…does not run afoul of *Davila* and is not preempted by ERISA…we adopt the reasoning of the Third and Ninth Circuits, and that of a majority of district courts in this Circuit which have relied on this distinction between 'rate of payment' and 'right of payment.'"); *Med. & Chirurgical Faculty of State of Maryland*, 221 F. Supp. 2d at 619 ("Courts have, with near unanimity, found that independent state law claims of third party health care providers are not preempted by ERISA.").

United next argues that the existence of an express provider agreement somehow distinguishes certain cases from the case at hand. It does not because an implied-in-fact contract is on equal footing with an express written agreement. *Tucker v. Mayor, etc., of Virginia City*, 4 Nev. 20, 30 (1868) ("defendants are as completely bound by implied as by written contracts."); *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

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manifestation of assent; both types are based upon the expressed or apparent intention of the parties."). This attempt by United to denigrate the legal effect of an implied-in-fact contract is squarely contrary to Nevada law and must be rejected.

In order for United to meet its burden on the second *Davila* factor, it must establish that the claims asserted do not arise from legal duties independent of ERISA. *Davila*, 542 U.S. at 210. In other words, it must prove that the claims asserted are dependent on ERISA. The caselaw cited by the Health Care Providers which involves express provider agreements are examples of independent legal duties of an insurer to pay a certain rate to a provider. These independent legal duties may arise from a variety of circumstances as highlighted in the caselaw cited by the Health Care Providers, including express agreements, oral agreements, statutory duties and implied in law and implied in fact agreements. Simply because a case involves one of the foregoing does not mean the Court limited the second *Davila* factor to that one instance.

In fact, many of the decisions cited by the Health Care Providers do expressly state that claims for breach of implied agreements do not satisfy the second *Davila* factor because these also would be independent legal duties not relying on an ERISA plan. For example, United tries to distinguish *Connecticut State Dental* by arguing that it only concerned an express agreement. Opposition at n. 16. In *Hialeah Anesthesia Specialists, LLC v. Coventry Health Care of Fla*, the insurer tried to do the exact same thing as United by arguing "the use of the language "an agreement" [in *Connecticut State Dental*] necessarily means that the test applies only in cases arising from breach of an express provider agreement between an in-network provider and the insurer." 258 F. Supp. 3d 1323, 1329 (S.D. Fla. 2017). The court rejected this argument and explained:

> No part of *Connecticut State Dental* supports the proposition that an express written provider agreement ***must*** be present before the rate-of-payment/right-of-payment test can apply and that, in the absence of a written agreement, any claim for payment must be preempted. In the Court's view, *Connecticut State Dental* leaves the proverbial door sufficiently open that the test could come into play in a case like this one, involving allegations of an implied "agreement"—be it implied-in-fact or implied-in-law—between an out-of-network provider and an insurer.

Id. (emphasis in original). Courts in various jurisdictions have found that implied in fact and implied in law contracts involve independent legal duties such that the second *Davila* factor cannot

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be satisfied. *John Muir Health v. Cement Masons Health & Welfare Tr. Fund for N. California*, 69 F. Supp. 3d 1010, 1018 (N.D. Cal. 2014) (quantum meruit claim "based on an independent legal duty", failing to satisfy *Davila's* second prong); *Galileo Surgery Ctr., L.P. v. Aetna Health & Life Ins. Co.*, No. 2:14-CV-09738-ODW, 2015 WL 898525, at *1 (C.D. Cal. Mar. 3, 2015) (promissory estoppel and unjust enrichment not preempted by ERISA); *Coast Plaza Doctors Hosp.,* 2011 WL 3756052 at *4 (breach of implied in fact contract not preempted); *Med. & Chirurgical Faculty of State of Maryland*, 221 F. Supp. 2d at 619 (conversion and quantum meruit not preempted); *Emergency Servs. of Zephyrhills, P.A. v. Coventry Health Care of Fla., Inc.*, 281 F. Supp. 3d 1339, 1342 (S.D. Fla. 2017) (breach of implied-in-fact contract and unjust enrichment not preempted); *Orthopaedic Care Specialists, P.L. v. Blue Cross & Blue Shield of Fla., Inc.*, No. 12-81148-CIV, 2013 WL 12095594, at *2 (S.D. Fla. Mar. 5, 2013) (unjust enrichment/quantum meruit not preempted).

Furthermore, while some of these decisions are in states in which statutes require payments at certain rates, this distinction does not change the fact that the Health Care Providers have asserted claims completely independent of an ERISA plan. If United believes that the Health Care Providers lack a statutory or common law basis for bringing its claims, it is free to challenge these claims in state court. However, there is no question that the Health Care Providers claims are based on legal grounds independent of an ERISA plan and, for that reason alone, United cannot meet its burden of establishing that the second *Davila* factor is satisfied. Therefore, the Amended Motion to Remand must be granted.

Next, United contends that *Marin* is different than the case at hand because there are no oral representations alleged here while *Marin* concerned an oral representation. While *Marin* did involve an oral representation that a certain rate of payment would be made, the providers in that case also asserted claims, just as is the case here, for breach of implied contract, quantum meruit and estoppel. 581 F.3d at 943. In asserting its breach of implied contract claim, the provider plaintiff alleged:

> 30. **As a result of the custom and practice in the healthcare field, and prior dealings between the parties Hospital** and defendants understood that, because defendants authorized and made a representations of coverage

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> upon which Hospital reasonably relied, by providing medically necessary services, Hospital would be paid by defendants for such medical services, supplies and equipment provided to patient S.M. at a 10% discount from its total billings.

A true and correct copy of the Amended Complaint filed in *Marin Gen. Hosp.*, Case No. 07-cv-01027-SI, is attached hereto as **Exhibit 1** (emphasis added). This allegation is nearly identical to the allegations here. The Health Care Providers allege:

> 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.

Am. Compl. ¶ 197. The relevant facts of this case are nearly identical to the facts alleged in *Marin* and, just as was the case in *Marin,* this Court cannot find that the legal claims asserted by the Health Care Providers are dependent on ERISA. These claims are completely independent of ERISA and, therefore, the second *Davila* factor cannot be established, necessitating remand.

Finally, United relies heavily on two cases from Florida, both of which predate *Davila,* to rebut the binding *Marin* decision; however, even if *Marin* was not binding precedent, neither of these cases are applicable and United's reliance on these decisions should be rejected. In *In Re Managed Care Litig.*, the court evaluated unpaid claims by non-participating providers' who affirmatively alleged that they sought reimbursement as assignees. *In re Managed Care Litig.,* 298 F. Supp. 2d 1259, 1291 (S.D. Fla. 2003). Thus, the outcome there has no application to the facts before this Court. In *Torrent & Ramos*, an unpublished decision, the court's analysis relied entirely on a test which, since *Davila*, is no longer applicable when addressing complete preemption. *Torrent & Ramos, M.D., P.A. v. Neighborhood Health Partnerships, Inc.*, No. 04-20858-CIV, 2004 WL 7320735, at *2 (S.D. Fla. July 1, 2004) (discussing "superpreemption" under *Butero v. Royal Maccabees*); *see also Almont Ambulatory Surgery Ctr., LLC v. UnitedHealth Grp., Inc.*, 121 F. Supp. 3d 950, 964 (C.D. Cal. 2015) ("this Court follows and applies the Supreme Court's *Davila* test for complete preemption and, to the extent that the *Butero*

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analysis is inconsistent with *Davila*, it is not controlling."). Thus, none of the authority cited by United supports its tenuous position.

C. United's Other Legal Authority is Either Distinguishable or Irrelevant Because it Concerns Conflict Preemption, Not Complete Preemption

United cites to non-analogous cases in support of its contention that all of the Health Care Providers' claims are preempted,[3] but many of the cases cited turn on whether the claim is conflict preempted, not completely preempted. *Marin Gen. Hosp.*, 581 F.3d at 949. This is misleading because the question of whether a law or claim "relates to" an ERISA plan is not the test for complete preemption under § 502(a)(1)(B); rather, it is the test for conflict preemption under § 514(a). A defense of conflict preemption under § 514(a) does ***not*** provide a basis for federal question jurisdiction under either § 1331(a) or § 1441(a). Therefore the Court can disregard United's attempt to rely on cases that rely on a "relates to" analysis for a defense of conflict preemption.[4]

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[3] United relies on *Parlanti v. MGM Mirage*, No. 2:05-cv-1259-ECR-RJJ, 2006 WL 8442532, at *4 (D. Nev. Feb. 15, 2006) for the proposition that an implied-in-fact contract is completely preempted by ERISA, which is misleading. Opposition at 20:5-7. There, plaintiffs filed a lawsuit in connection with ***rights*** to benefits under a supplemental executive retirement plan ("SERP") given in connection with an employment contract. *Id.* at *1. The *Parlanti* court examined "the thrust" of plaintiffs' claims, determining that the state law causes of action related to allegations that they were entitled to benefits as stated in the SERP and that they were denied those benefits. *Id.* at *4. Next, in *Estate of Burgard v. Bank of Am., N.A.*, No. 2:15-cv-00833-RFB-PAL, 2017 WL 1273869, at *8 (D. Nev. Mar. 31, 2017), plaintiff sought recovery of benefits due under an ERISA plan and to enforce rights under the plan. This is not analogous to this rate of payment case. Nor is *Villescas v. CNA Ins. Companies*, 109 Nev. 1075, 1077, 864 P.2d 288, 290 (1993) analogous. There, an administrator of a decedent's estate brought suit against an insurance company under various theories of liability (breach of the covenant of good faith and fair dealing, breach of fiduciary duties, common law fraud, and breach of NRS 686A.310) for the alleged failure to pay all benefits under a long term disability policy. The court found conflict preemption existed, not complete preemption. And *Hill v. Opus Corp.*, 841 F. Supp. 2d 1070, 1085 (C.D. Cal. 2011) is different because plaintiffs' state law claims sought return of benefits purportedly due under the ERISA plan at issue there related to compensation and deferred compensation. In *Thrall v. Prudential Ins. Co. of Am.*, No. CV-N-050067-HDM-RAM, 2005 WL 8161321, at *1 (D. Nev. Aug. 11, 2005), a beneficiary of a decedent's accounts, retirement plans, and life insurance policies filed a lawsuit against defendants for failing to transfer the decedent's accounts, retirement plans, and life insurance policies to plaintiff. *Id.* The *Thrall* court found the beneficiaries' claims preempted because the claims asserted were for rights to benefits. Next, *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 274 (3d Cir. 2001) is a right to benefits case because it involved claims stemming from defendants' alleged failure to provide benefits due under an ERISA plan.

[4] *See e.g. Schoedinger v. United Healthcare of Midwest, Inc.*, 557 F.3d 872, 875 (8th Cir. 2009) (court dismissed claims for violation of prompt pay statutes based on conflict preemption under §

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III. COSTS AND FEES

Should the Court grant this Motion, it should also award the Health Care Providers their reasonable fees and costs incurred as a result of the improper removal, pursuant to 28 U.S.C. § 1447(c). In applying § 1447(c), this Court has explained that fees are appropriate if the removal was not objectively reasonable based on the relevant case law. *See J.M. Woodworth Risk Retention Grp., Inc. v. Uni-Ter Underwriting Mgmt. Corp*, 2014 WL 6065820, at *1 (D. Nev. Nov. 12, 2014). Voluminous case law, in the Ninth Circuit and beyond, demonstrated that removal was improper because rate-of-payment disputes are not completely preempted by ERISA.

IV. CONCLUSION

For all the foregoing reasons, the Court should grant the Amended Motion, remand this action to the Eighth Judicial District Court for Clark County, Nevada, and award the Health Care Providers their reasonable costs and attorneys' fees pursuant to 28 U.S.C. § 1447(c).

DATED this 5th day of February, 2020.

McDONALD CARANO LLP

By: /s/ *Kristen T. Gallagher*

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514(a)); *Productive MD, LLC v. Aetna Health, Inc.*, 969 F. Supp. 2d 901, 938 (M.D. Tenn. 2013), (court found conflict preemption, while noting that "[o]ther courts have found that particular prompt pay act claims are not preempted by ERISA under certain circumstances, typically where a provider sues pursuant to a separate contractual agreement with the insurer, not pursuant to a patient assignment."); *Am.'s Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1334 (11th Cir. 2014) (prompt pay statutes were preempted by ERISA § 514, not § 502(a)).

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 5th day of February, 2020, I caused a true and correct copy of the foregoing **REPLY IN SUPPORT OF AMENDED MOTION TO REMAND** to be served via the U.S. District Court's Notice of Electronic Filing system ("NEF") in the above-captioned case, upon the following:

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INDEX OF EXHIBITS

Description	Exhibit No.
Amended Complaint filed in *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*	1

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EXHIBIT 1

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Amended Complaint filed in Marin Gen. Hosp. v. Modesto & Empire Traction Co.

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EXHIBIT 1

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

MARIN GENERAL HOSPITAL, a non-profit California corporation, Plaintiff, vs. MODESTO & EMPIRE TRACTION COMPANY, a California corporation, MEDICAL BENEFITS AMINISTRATION OF MD., INC. a Maryland corporation,. RONALD J. WILSON, an individual, and DOES 1-50 inclusive, Defendants	Case No.: 3:07-cv-01027-SI FIRST AMENDED COMPLAINT FOR DAMAGES FOR: 1. BREACH OF ORAL CONTRACT; 2. NEGLIGENT MISREPRESENTATION; 3. QUANTUM MERUIT; AND 4. ESTOPPEL

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Plaintiff, MARIN GENERAL HOSPITAL ("Hospital") is informed and believes and thereon alleges as follows:[1]

PARTIES

1. **Hospital expressly disavows this action implicates any of the rights Hospital may have gained through an assignment of benefits from patient S.M. To the extent recovery on any of the claims asserted herein rely upon such an assignment, Hospital declines such recover in this action. Hospital elects to bring this suit specifically and exclusively on the basis of causes of action arising under the laws of the State of California.**

2. Hospital, a non-profit California corporation is a and at all times was, licensed by the State of California to conduct business as a health care provider in the County of Marin.

3. Defendant Modesto & Empire Traction Company ("Modesto"), is a for profit California corporation with its principal place of business in Modesto County, California. Modesto provides self- funded medical insurance to its employees, and/or officers, and their dependants.

4. Defendant Medical Benefits Administrators of MD, Inc. ("MBAMD") is a Maryland corporation, and has its principal place of business in Abington, Maryland. MBAMD administers member benefit plans on behalf of employers and organizations that provide self-funded medical insurance on behalf of their employees, officers, and/or members.

[1] Amendments to the original complaint are signified by **boldface** and ~~strikeouts~~.

5. Defendant Ronald J. Wilson ("Wilson") is an individual and at all relevant times herein mentioned was the Chief Executive Officer and Chairman of MBAMD.

6. There exists, and at all times herein mentioned there existed, a unity of interest and ownership between Wilson and MBAMD, such that any individuality and separateness between them have ceased and MBAMD is the alter ego of Wilson in that MBAMD is and, and at all times herein mentioned was, so inadequately capitalized that, compared with the business to be done by MBAMD and the risks of loss, its capitalization was trifling.

7. Adherence to the fiction of the separate existence of MBAMD as an entity distinct from Wilson would permit an abuse of the corporate privilege and would promote injustice in that Hospital is informed and beliefs and thereon alleges Wilson made loans to MBAMD and guaranteed certain of its obligations thereby enabling MBAMD to engage in business activities, without adequate financing and without capital stock, which invited the public generally and Hospital in particular to deal with MBAMD to Hospital's loss.

8. Modesto provided health care benefits to patient S.M - - whose name has been withheld for privacy purposes - - under a self-funded medical insurance plan.

9. Defendants at all relevant times transacted business either personally or through its agents and/or assigns within the State of California. The violations alleged in this complaint herein have been and are being carried out in California.

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10. Hospital is unaware of the true names and capacities, whether corporate, associate, individual, partnership or otherwise of Defendants DOES 1-50, inclusive, and therefore sues those defendants named DOE by such fictitious names. Hospital will seek leave of the Court to amend this Complaint to allege their true names and capacities when ascertained.

11. At all relevant times defendants, including the defendants named DOE, were and are the agents, employees, employers, joint venturers, representatives, alter egos, subsidiaries, and/or partners of one or more of the other defendants, and was, in performing the acts complained of herein, acting within the scope of such agency, employment, joint venture, or partnership authority, and/or is in some other way responsible for the acts of one or more of the other Defendants.

12. MBAMD was charge with administering health plan benefits to Modesto member S.M.

13. For all dates herein alleged defendants provided insurance coverage and thereby an obligation exists for reimbursement for medically necessary services, supplies and /or equipment provided S.M.

FACTUAL BACKGROUND

14. On or about April 19, 2004, S.M. was admitted to Hospital for a scheduled lumbar fusion procedure.

15. Hospital provided medical services, supplied, and/or equipment to S.M. from April 19, 2004 to April 24, 2004.

16. On or before April 19, 2004, patient S.M. was enrolled in Modesto's self-funded health plan.

17. Prior to S.M.'s admission, Hospital was advised of patient S.M.'s health insurance coverage through Modesto's self-funded health plan.

18. On or about April 8, 2004 Hospital contacted MBAMD, by telephone, which verified patient S.M.'s eligibility and coverage.

19. On or about April 8, 2004, defendants also authorized the care provided to patient S.M and issued the authorization number "CRW4098003LF" to Hospital.

20. Hospital, in reliance on defendants' verbal statements of coverage and authorization for the treatment of patient S.M., provided medical services, supplies, and /or equipment to patient S.M. with the understanding that defendants would pay Hospital's hospital bills at 90% of Hospital's total billed charges for said services, supplies and/or equipment.

21. Hospital timely and properly submitted a valid bill to defendants in the amount of $178,926.54.

22. On or about July 7, 2004 defendants issued a payment in the amount of $46,655.54, resulting in a balance still due and owing from defendants in the amount of $114,378.35 for the services provided to patient S.M. after application of a 10% discount.

23. Despite ~~requests~~ **written demands** to defendants that full

reimbursement to Hospital for the medical services, supplies and equipment provided to patient S.M, defendants refuse to pay Hospital the full amount due.

24. On or about December 8, 2004defendants issued to Hospital a final denial for the remaining balance for the services provided to patient S.M.

25. ~~Hospital has exhausted all of its administrative appeals~~. Hospital sent written demands to defendants to rectify the underpayment.

26. As a direct and proximate result of defendants' conduct, the medical bill for Hospital's provision of medical services, supplies, and equipment to patient S.M. from April 19, 2004 to April 24, 2004 remains underpaid by $114,378.35. Hospital thus has suffered damages in the amount of $114,378.35.

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FIRST CAUSE OF ACTION

(Breach of Implied Contract)

(Against all defendants)

27. Hospital incorporates by reference and re-alleges paragraphs 1 through **26** here as though set forth in full.

28. On or about April 8, 2004, Hospital informed defendants, that patient S.M. was scheduled for a lumbar fusion procedure at Hospital.

29. Defendants confirmed that patient S.M. health plan coverage and authorized the medical services, supplies, and equipment Hospital eventually provided to patient S.M.

30. As a result of the custom and practice in the healthcare field, and prior dealings between the parties Hospital and defendants understood that, because defendants authorized and made a representation of coverage upon which Hospital reasonably relied, by providing medically necessary services, Hospital would be paid by defendants for such medical services, supplies and equipment provided to patient S.M. at a 10% discount from its total billings.

31. Defendants, therefore, understood that Hospital's provision of medical services, supplies, and equipment to patient S.M. from April 19, 2004 to April 24, 2004 would require defendants to pay Hospital's bills at 90% of Hospital's total billed charges for said services, supplies and/or equipment for a total amount of $161,033.87.

32. Hospital timely submitted a bill to defendants. The total charges for the medical services, supplies, and equipment provided to patient S.M. amounted to $178,926.54.

33. On or about July 7, 2004, defendants issued a partial payment in the amount of $46,655.54.

34. Because defendants only paid the partial amount of $46,655.54 this claim has been underpaid, and the balance still due from Defendants amounts to $114,378.35.

35. Defendants acknowledged and accepted financial responsibility for the medical services, supplies, and equipment provided to patient S.M. by Hospital, and agreed to pay for those services, supplies and equipment.

36. Hospital has performed all conditions, covenants, and promises required on its part to be performed in accordance with the terms and conditions of this contract implied in fact at the rate agreed upon prior to patient S.M.'s hospitalization.

37. On or about December 8, 2004,defendants breached this implied agreement by issuing its final refusal to fully reimburse Hospital for the medical services, supplies and/or equipment provided to patient S.M. at the agreed upon rate.

38. As a direct and proximate result of defendants' breach of implied contract, Hospital has suffered damages in the amount of $114,378.35.

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SECOND CAUSE OF ACTION

(Breach of Oral Contract)

(Against all defendants)

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39. Hospital incorporates by reference and re-alleges paragraphs 1 through **26** here as though set forth in full.

40. On or about April 8, 2004, Hospital and defendants entered into an oral agreement whereby Hospital agreed to provided medically necessary services, supplies, and equipment to Defendant's enrollee (patient S.M.) in return for which Hospital agreed to pay Hospital's bills at 90% of Hospital's total billed charges for said services, supplies and/or equipment.

41. Hospital supplied medical services, supplies and equipment to Modesto's enrollee, patient S.M., from April 19, 2004 to April 24, 2004, and has

performed all conditions, covenants, and promises required on its part to be performed in accordance with the terms and conditions of this oral contract.

42. On or about December 8, 2004, defendants breached this oral agreement by issuing its final refusal to properly reimburse Hospital for the medical services, supplies and/or equipment provided to patient S.M.

43. As a direct and proximate result of defendants' breach of implied contract, Hospital has suffered damages in the amount of $114,378.35, after payments previously made by defendants are taken into account.

THIRD CAUSE OF ACTION

(Negligent Misrepresentation)

(Against all defendants)

44. Hospital incorporates by reference and re-alleges paragraphs 1 through **26** here as though set forth in full.

45. On or about April 8, 2004,defendants represented to Hospital that patient S.M., an enrollee under Modesto's self-funded health plan and that defendants would compensate Hospital for its provision of medical services, supplies and equipment to patient S.M. at 90% of Hospital's total billed charges for said services, supplies and/or equipment for a total amount of $161,033.87.

46. Defendants or their agents made those representations with the intention of inducing Hospital to act in reliance on these representations by providing services, supplies, and equipment to patient S.M. and in preventing Hospital from making other arrangements for payment.

47. When defendants or their agents made those representations to Hospital without reasonable grounds for believing them to be true.

48. On or about December 8, 2004, after the medical services, supplies and equipment were provided to patient S.M., defendants informed Hospital that they refused to issue any further payment to correct the underpayment of the claim.

49. At the time the representations were made by defendants, Hospital was ignorant of the falsity of defendants' representations and believed them to be true.

50. In reasonable reliance upon those representations, Hospital was induced to provide patient S.M. with medically necessary services, supplies, and equipment and refrain from making other arrangements to obtain payment.

51. As a direct and proximate result of its reliance Hospital has suffered damages in the sum of $114,378.35.

FOURTH CAUSE OF ACTION

(Quantum Meruit)

(Against all defendants)

52. Hospital incorporates by reference and re-alleges paragraphs 1 through **26** here as though set forth in full.

53. As a direct and proximate result of defendants' assurances and representations that patient S.M. had health plan coverage from which payment

would be made, Hospital rendered care to patient S.M. with a value of $178,926.54.

54. Hospital has requested full payment from defendants or their agents for the charges incurred for the medical services, supplies and equipment provided by Hospital Center to patient S.M.

55. Defendants or their agents have failed to pay fully for the medically necessary services, supplies and equipment provided to patient S.M., but to date defendants have only paid $46,655.54.

56. As a result of defendants or their agent's failure to perform according to the assurances and representations made to Hospital, Hospital has suffered damages in the amount of $132,271.00.

FIFTH CAUSE OF ACTION

(Estoppel)

(Against all defendants)

57. Hospital incorporates by reference and re-alleges paragraphs 1 through **26** here as though set forth in full.

58. Defendants or their agents represented to Hospital that patient S.M. had health plan coverage and that payment would be made for all hospital bills incurred at 90% of Hospital's total billed charges for said services, supplies and/or equipment for a total amount of $161,033.87 after applying the discount.

59. When promising, assuring and representing to Hospital that

patient S.M.. had a policy of health plan coverage that would reimburse Hospital for the medical services, supplied and /or equipment rendered to Modesto's plan enrollee, defendants knew, or should have known, that Hospital would be reasonably induced to rely on defendants' or their agent's promises, assurances and representations.

60. As a direct and proximate result of Defendants' or their agents making representations to Hospital that patient S.M. had health plan coverage and that payment would be made for the charges incurred, Hospital actually, reasonably, and justifiably relied upon such representations and was thereby induced to provide medical services, supplies and /or equipment to provide medical services, supplies and/ or equipment to patient S.M. defendants have not fully performed their promises, assurances or representations to pay Hospital.

61. Hospital reasonably and justifiably relied upon such representations and assurances in providing the services, supplies and/or equipment, and in refraining from pursuing other avenues of reimbursement.

62. As a direct and proximate cause of their conduct, defendants should be estopped from denying Hospital has suffered substantial detrimental damages in the sum of at least $114,378.35.

PRAYER FOR RELIEF

WHEREFORE, MARIN GENERAL HOSPIRAL prays for judgment as follows:

1. For the 1st, 2nd, 3rd and 5th causes of action the principal of sum of $114,378.35;

2. For the 4th cause of action the principal sum of $132,271.00

3. For all causes of action interest on such principal sum at the rate of fifteen percent (15%) per annum, pursuant to Cal. Health & Safety Code § 1371;

4. For all causes of action pre-judgment interest on such principal sum, at the legal rate, pursuant to Cal. Civ. Code § 3287 (a); and

5. For all causes of action such other and further relief as the court deems just and proper.

Dated: 18 May 2007

STEPHENSON, ACQUISTO & COLMAN

Viola Rita Brown
Attorneys for
MARIN GENERAL HOSPITAL

PROOF OF SERVICE

I am employed in the county of Los Angeles, State of California. I am over the age of 18 and not a party to the within action; my business address is 303 North Glenoaks Boulevard, Suite 700, Burbank, California 91502-3226. On 18 May 2007, I served the foregoing document(s) entitled:

FIRST AMENDED COMPLAINT FOR DAMAGES

by placing a true copy thereof enclosed in a sealed envelope addressed per the attached Service List.

[X] BY MAIL: I am "readily familiar" with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with the United States Postal Service on that same day with postage thereon fully prepaid at Burbank, California in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit. [C.C.P. 1013a(3); F.R.C.P. 5(b)]

[ ] BY FEDERAL EXPRESS: I caused such envelope(s), with overnight Federal Express Delivery Charges to be paid by this firm, to be deposited with the Federal Express Corporation at a regularly maintained facility on the aforementioned date. [C.C.P. 1013(c) 1013(d)]

[ ] BY EXPRESS MAIL: I caused such envelope(s), with postage thereon fully prepaid and addressed to the party(s) shown above, to be deposited in a facility operated by the U.S. Postal Service and regularly maintained for the receipt of Express Mail on the aforementioned date. [C.C.P. 1013(c)]

[ ] BY TELECOPIER: Service was effected on all parties at approximately ____:____ am/pm by transmitting said document(s) from this firm's facsimile machine (818/559-4477) to the facsimile machine number(s) shown above. Transmission to said numbers was successful as evidenced by a Transmission Report produced by the machine indicating the documents had been transmitted completely and without error. C.R.C. 2008(e), Cal. Civ. Proc. Code § 1013(e).

[X] State: I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

[ ] Federal: I declare that I am employed in the office of a member of the bar of this court at whose direction the service was made.

CONSUELO MARQUEZ

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SERVICE LIST

Bradley A. Post, Esq.

BORTON PETRINI, LLP

2014 Tulare Street, Suite 631

Fresno, CA 93721

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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. XXVII

BEFORE THE HONORABLE NANCY ALLF, DISTRICT COURT JUDGE

FRIDAY, APRIL 3, 2020

RECORDER'S TRANSCRIPT OF PROCEEDINGS
RE: MOTIONS

APPEARANCES (Attorneys appeared via BlueJeans):

For the Plaintiff(s): PATRICIA K. LUNDVALL, ESQ.
KRISTEN T. GALLAGHER, ESQ.
AMANDA PERACH, ESQ.

For the Defendant(s): COLBY L. BALKENBUSH, ESQ.
LEE D. ROBERTS, JR., ESQ.

RECORDED BY: BRYNN WHITE, COURT RECORDER

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LAS VEGAS, NEVADA, FRIDAY, APRIL 3, 2020

[Proceeding commenced at 1:23 p.m.]

THE COURT: All right. Let me go ahead then and call the case. It's A-792978, Fremont Emergency versus United Healthcare.

THE CLERK: Judge, you're cutting out now. Oh, she's not there anymore. I think we lost the judge.

LAW CLERK: Hold on, let me text her.

[Pause in the proceedings.]

THE COURT: So we're having some connectivity issues, but I called the case. Appearances, please, first from the plaintiff.

MS. LUNDVALL: Good afternoon, Your Honor. Pat Lundvall from McDonald Carano, here on behalf of plaintiffs.

MS. GALLAGHER: Good afternoon, Your Honor. Kristen Gallagher with McDonald Carano, also on behalf of the plaintiffs.

MS. PERACH: Good afternoon, Your Honor, Amanda Perach, also appearing on behalf of the plaintiffs.

MR. BALKENBUSH: Good afternoon, Your Honor. Colby Balkenbush and Lee Roberts for the defendants.

THE COURT: Okay. And I understand -- is Mr. Roberts on the phone?

MR. ROBERTS: Yes, Your -- good afternoon, Your Honor. Lee Roberts, 8847 [indiscernible].

THE COURT: Thank you, all.

The reason that I convened this status hearing for the

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reason that you guys have a lot going on. You've been in litigation for about a year. But this is not really an essential matter. In fact, [indiscernible] on April 15th that under the Court's order and the Governor's proclamation don't really [indiscernible] now. So I'm going to [indiscernible] jump in early and get some case management for you and get [indiscernible].

The two matters on the 15th are -- and I've read everything. I'm certainly not ready to rule on anything. Those are things I'd rather have argued in person. And I -- you know, this -- we're stayed until April 30th, and it may be longer than that. We have been able to grant trial continuances liberally, although the jury trial probably can't commit until August, because even when we go live, it'll take 30 to 45 days [indiscernible] the jurors. We're -- in the meantime, we're increasing the number of trials we put on each stack because we know that we're going to have to work really hard, as soon as we can go live again.

But we're considering, at this point, alternate means for bench trials, [indiscernible] as required [indiscernible] especially [indiscernible] for remote [indiscernible]. And we don't all think that there only -- there will even be any civil bench trials until July.

Now, the rule [indiscernible] we're currently setting for June. And I promise you, we're still working. We're not getting lazy, but the effect of the pandemic [indiscernible] our community [indiscernible] the Governor [indiscernible] all deadlines for 30 days after things resumed.

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And so I wanted just to kind of give you that as a -- to make sure that you get the enhanced case management [indiscernible] Court, but that is a [indiscernible]. The issues here are very complex [indiscernible].

So let me hear from the plaintiff and then the defendant.

MS. LUNDVALL: Your Honor, one of the things I will let you know is, at least from my standpoint, there is a little bit of a difficulty with connection with you. And so in the event that I've missed part of what you presented, my apologies. But -- and I'm hoping that I'm coming through. And if I'm not, just somebody wave an arm or a hand at me.

My folks know all too well the difficulties that we are currently in. My clients are the physician groups that staff the emergency rooms and hospitals throughout our valley, as well as through Fallon and through Elko. And so if there's anybody that is on the front line in this Coronavirus issue and the problems that is it has presented, it's our folks.

They are seeing this and they are, in essence, what many [indiscernible] groups have called the soldiers to this war. And the [indiscernible] soldiers have been in a dispute now for over a year. And what we're trying to do is to ensure that they can be paid as they go along go wrong and that they continue to fight on this war.

One of the things that I think is a helpful piece for the Court to know is that any of the outstanding legal issues, with the exception of one, have already been decided by your counterparts in

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the federal district.

The only issue [indiscernible] in this case. That is a motion that has been tee'd up by the defense. That motion is scheduled to be heard, and on -- at this point in time, on April 15th.

What we are suggesting is that because the issues are very simple and straightforward in that particular motion that it could be heard on an order shortening time because what we're really talking about is this, if we follow the path that has been suggested and laid out by the defense, in addition to the nearly year delay that has already been occasioned in this case because of the removal that was practiced then by the defense, and for which that we're now back before this court -- what they're asking for is for the Court, in essence, to tack on another 180 to 270 days before we even get to the stage of getting a responsive pleading from them.

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And what we are trying to do is to see if we can't point the Court then in a direction that allows it to decide whether or not that additional 180 to 270 days gets tacked on to this or not.

The principal issue concerns this as to whether or not the activity that was practiced by the federal district court is going to be respected and whether or not that this Court then, in essence, picks up where the federal district court left off.

We have filed our opposition to their motion that suggests that this Court, the state court, starts all brand new and all fresh and that we go back to square one.

If you examine the opposition that we filed and you

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compare and contrast that to the motion that has been filed by the defense, what you will learn is that there is not a single district court across the entire nation, since 1948, that has embraced or adopted the position that is being advanced by the defendants.

And the reason being why 1948 is the line of demarcation is because it was in 1948 that the United States then had changed its Civil Code to change the removal practice and the removal statutes then concerning what would happen in a state court versus a federal court when a matter had been removed from state court to federal court.

Once that statute changed, once that statute was enacted in 1948, uniformly, the courts across our nation have said the state court is going to pick up where the federal district court left off, rather than rework, redo, relitigate, re-evaluate, re-everything, what had happened in the federal district court.

And so, therefore, it's really a pretty simple issue, we believe, for the Court to take a look at that point because it revolves around are we working with the original complaint that initial -- that guided this case or the first amended complaint that was permitted by the federal district court and that the federal district court then allowed us to file -- granted our leave then to file, and therefore the first amended complaint is the operative pleading in this case.

That's the simple issue. And what we're looking for, at the very minimum, to try to get this case going so that it is not back stalled then by the defendants as they wish for another 180 to

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270 days is for there to be a simple determination on that motion. We filed our opposition.

And it should be, hopefully, a fairly straightforward issue for a reply brief and then that we could argue this matter as quickly as possible. We're prepared to argue it as early as next week, but at the very minimum for us to try to keep it on calendar then for April 15th at the very latest.

THE COURT: Thank you. And the response, please.

MR. ROBERTS: Your Honor, this is Lee Roberts for the defendants.

We're not going to argue the motions. That'll be for another day.

We do want to say that while we understand that the plaintiffs would like to get going, and we're not trying to cause delay, there -- it makes little sense to rush to hearing on these issues when even if once the court rules we're not going to be in a position under the current orders to serve subpoenas or to actively pursue discovery.

So we believe that these matters should be set for the earliest hearing possible after this stay has been lifted where we can argue these in person with the Court and then proceed promptly with the Court's rulings.

We certainly don't believe that would result in 180 or more days of delay and that it would be better to deal with these things in the normal course, rather than press forward now than hurry up and

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wait.

THE COURT: Okay. All right. So everybody heard my [indiscernible] at least most of my initial [indiscernible] about April 30th or only essential matters.

But my inclination is just to set this for a hearing on May 14th, where I hope I can give you the afternoon [indiscernible] at 1 o'clock. So I've blocked [indiscernible] a specific time [indiscernible] and have [indiscernible] for the courtroom.

THE CLERK: Judge, you're cutting out a lot. We can't hear you.

THE COURT: Arguments in the courtroom. So -- even if the court [indiscernible] we will [indiscernible].

MS. LUNDVALL: Judge, you're breaking up a lot.

THE COURT: I believe -- oh, I'm having connectivity.

MALE SPEAKER: [Indiscernible] we may have lost her.

LAW CLERK: Yeah. I think she knows.

THE COURT: Okay. I'm back. Sorry about that. It's [indiscernible]. Is this better? Okay. Because [indiscernible].

All right. It's my -- it's my [indiscernible]. All right. Because this [indiscernible], I'm going to vacate the hearings on April 15, and set everything for May 14 [indiscernible]. It would -- it makes a lot of sense to have you guys in that room [indiscernible].

Is that day available for both [indiscernible]?

MS. LUNDVALL: We will make it available, Your Honor.

And it's my understanding that what the Court is saying is

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that all motions that are currently pending before the Court are -- would be heard then on May 14th; is that correct?

THE COURT: That is correct.

MS. LUNDVALL: Thank you, Your Honor.

THE COURT: And even if -- even if the Governor extends the stay-at-home order, we will still have the hearing on that day, and we'll just do it telephonically.

MS. LUNDVALL: Thank you, Your Honor.

THE COURT: Mr. Roberts. Thank you. Mr. Roberts, Ms. --

MR. ROBERTS: Yes, thank you, Your Honor. I -- that's -- I am available on May 14th. I have another hearing at 9:30 before Judge Bare, but I can [indiscernible] -- that's not [indiscernible] which I can have someone else handle.

THE COURT: And we're going to do it 1 p.m. on May 14th.

MR. ROBERTS: Perfect. 1 p.m. is wide open for me. Thank you, Your Honor.

THE COURT: All right. I wish all of you health [indiscernible] and for you and all of those people who are in your lives.

Thank you for your appearance today. And I'll see you in May [indiscernible].

MR. BALKENBUSH: Thank you, Your Honor.

MS. LUNDVALL: Thank you, Your Honor.

MS. GALLAGHER: Thank you, Your Honor.

MALE SPEAKER: Thank you, so much, Your Honor.

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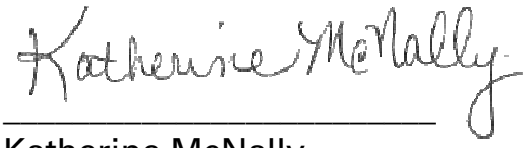
[Indiscernible.] Bye-bye.

[Proceeding concluded at 1:39 p.m.]

* * * * * * *

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio/video proceedings in the above-entitled case to the best of my ability.



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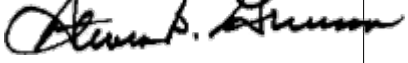

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Health Plan of Nevada, Inc.

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC. dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC. dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: A-19-792978-B Dept. No.: 27 **DEFENDANTS' REPLY IN SUPPORT OF MOTION TO DISMISS**

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I. INTRODUCTION

Plaintiff's Opposition asks this Court to disregard settled legal authority in favor of a rule that ERISA does not apply if a plaintiff's claims involve the "rate of payment" rather than the "right to payment." (Opposition at 6:7–9). Further, Plaintiff posits that, even if its claims are completely preempted, only a federal court can dismiss completely preempted claims and thus this Court should not consider the issue of complete preemption. Both of these arguments are without merit and all of Fremont's claims are subject to both conflict preemption and complete preemption.

As to conflict preemption, which is even broader than complete preemption and was never addressed in the federal court's remand order, Fremont's claims unquestionably directly conflict with federal law. ERISA requires that the employee benefit plans issued/administered by Defendants specify the rate of payment and that the plan terms be followed. Because Fremont desires a higher rate of payment than is provided for in the plan terms, it has brought these state law claims which effectively seek to modify the terms of the ERISA plans. Such a request, if granted, would force Defendants to violate ERISA's specific mandate that the plan terms be followed and would undermine the Congressional intent that employee benefit plans be uniformly administered nationwide. Thus, Fremont's claims "relate to" ERISA plans and are conflict preempted.

Fremont correctly points out that in some cases medical providers have been able to avoid preemption by anchoring their rate of payment claims to an obligation independent of the terms of the ERISA plans, like a written provider agreement, an oral promise or a state insurance statute requiring payment to out-of-network providers. For example, if Fremont had a provider agreement, the Court could simply look at the payment terms in that agreement and determine whether Defendants complied with them. There would be no need to reference the payment terms in the ERISA plans. However, a close reading of the Complaint shows that Fremont admits that it lacks a written contract, does not allege Defendants made any oral rate of payment promises and does not allege that a Nevada rate of payment statute exists. Thus, the only obligations Defendants owe to Fremont, if any, flow from the rate of payment terms of the

ERISA plans which the Court would have to reference to resolve this dispute. No court has allowed state law claims like the ones Fremont is asserting to escape conflict preemption.

As to complete preemption, Fremont's proposed "rate of payment" rule is an attempt to distract this Court from the fact that the *Davila* Test, the *only* test that governs complete preemption, is clearly satisfied for all seven of the state law claims that Fremont has asserted. The *Davila* Test is satisfied if (1) Fremont has standing to bring a statutory ERISA claim and (2) Defendants do not owe any legal duties to Fremont to reimburse Fremont at some particular rate, independent of Defendants' legal duties under the ERISA plans. If these elements are met, complete preemption applies even if Plaintiff is only bringing "rate of payment" claims because the only document governing the rate of payment to out-of-network providers is the treated patients' ERISA plans.

The first element of the *Davila* Test is met: Fremont received an assignment of benefits from Defendants' plan members that allows it to stand in their shoes and bring the same ERISA claims those members could have brought. Contrary to Fremont's contentions, the only question is whether Fremont *could* have brought an ERISA claim, not whether it actually pled such a claim in its Complaint.

The second element of the *Davila* Test is also met: Fremont has failed to allege any facts that give rise to a legal duty independent of ERISA. Fremont, by its own admission, and "[a]t all relevant times, . . . [did not have] a written "network" agreement governing rates of reimbursement" from Defendants. (Opposition at 2:21–23). Plaintiff attempts to bridge this analytical gap by claiming that an implied-in-fact contract exists, and contends that this implied-in-fact contract gives it a legal right to proceed with its state law claims. (Opposition at 10:4–6). However, support for this theory simply does not exist in fact or law. Upon the facts, Plaintiff does not allege that a single contract, statute or oral promise exists that requires it be paid at any particular rate, or be paid *at all*, for that matter. In the absence of a provider services agreement, the applicable employee benefit plans are the *only* documents that establish a legal relationship between the parties. But for Defendants' ERISA-based contractual relationship with its insureds, there would be no reason for Plaintiff to seek *any* amount of payment from Defendants. To the

extent Fremont is entitled to any additional reimbursement, the amount of that reimbursement depends entirely on the rate of payment that is established by the members' plan documents which are governed by ERISA.

Realizing that a thorough analysis of Defendants' complete preemption arguments does not favor its position, Fremont argues that only federal courts can dismiss claims on this basis. Fremont further contends that the Nevada Federal District Court already held that complete preemption does not apply in its remand order and thus this Court need not revisit the issue. First, the Nevada Supreme Court has rejected this argument and found that state courts *can* dismiss state law claims on the basis of complete preemption. Second, while the Nevada federal court did find that Fremont's implied-in-fact contract claim was not completely preempted, an Arizona federal court, faced with Plaintiff's affiliates,[1] same claims and same Plaintiff's counsel, expressly rejected Plaintiff's rate of payment argument and found that the state law claims were completely preempted.[2] The Arizona federal court's decision came a month after the Nevada federal court's decision and was made even after Plaintiffs had notified the Arizona court of the Nevada federal court's ruling. Defendants submit that the Arizona decision is more persuasive than the Nevada decision for all the reasons set forth in this briefing. In addition, the Nevada federal court only addressed whether complete preemption applied to Plaintiff's implied-in-fact contract claim and never addressed whether Plaintiff's other six state law claims were completely preempted.

Finally, to the extent any of Fremont's claims escape both conflict and complete preemption, they still must be dismissed pursuant to NRCP 12(b)(5) for failure to state a claim. Fremont fails to adequately allege the elements of its common law claims, fails to plead certain claims with the particularity required by NRCP 9(b), and lacks standing to bring certain statutory claims. For all of these reasons and those set forth below, Defendants request that the Court

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[1] Like the Plaintiff here, the plaintiffs in the District of Arizona action are medical provider groups affiliated with the privately-held company TeamHealth Holdings, Inc.

[2] *Emergency Grp. of Arizona Prof'l Corp. v. United Healthcare Inc.*, 2020 WL 1451464, at *7 (D. Ariz. Mar. 25, 2020).

dismiss Fremont's state law claims in their entirety and with prejudice. Fremont should be given leave to replead its claims as statutory ERISA claims pursuant to 29 U.S.C. § 1132(a), subject to any defenses Defendants may have to such claims.

II. FREMONT'S CLAIMS ARE SUBJECT TO CONFLICT PREEMPTION UNDER ERISA

ERISA's comprehensive scheme regulates employee benefit plans and provides the exclusive civil enforcement mechanism to deal with disputes related to these plans. The provisions of ERISA "supersede any and all state laws insofar as they may now or hereafter relate to" an ERISA plan. ERISA § 514(a). ERISA's primary purpose is to "provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208, 124 S. Ct. 2488, 2495 (2004). Congress broadly preempts state laws to accomplish this purpose.

ERISA's conflict preemption clause (29 U.S.C. § 1144(a)) has been called "one of the broadest preemption clauses ever enacted by Congress" and characterized as "clearly expansive." *Evans v. Safeco Life Ins. Co*., 916 F.2d 1437, 1439 (9th Cir. 1990); s*ee also Egelhoff v. Egelhoff*, 532 U.S. 141, 146 (2001) (calling the ERISA preemption clause "clearly expansive."). Under conflict preemption, a state law claim is subject to dismissal if it "relates to" an employee benefit plan governed by ERISA. Interpreting ERISA's preemption clause, the Supreme Court has instructed that "relates to" is to be given its broad common-sense meaning. *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739, 105 S. Ct. 2380, 2389 (1985). Courts have thus determined that a law *relates to* ERISA "if it refers to or has a connection, either direct or indirect, with covered benefit plans." *State of Nev. ex rel. Dep't of Ins. v. Contract Servs. Network, Inc.*, 873 F. Supp. 385, 390 (D. Nev. 1994) (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100, 103 S.Ct. 2890, 2901–02 (1983)). Fremont's claims are subject to conflict preemption as over 90 percent of the services it provided were to patients who had an employee benefit plan governed by ERISA. Thus, because Fremont is seeking additional reimbursement under those plans, its state law claims unquestionably "relate to" employee benefit plans.

Despite the decidedly expansive reach of ERISA, Fremont's Opposition argues that "United's Motion overstates the scope of ERISA conflict preemption." (Opposition at 14:1).

While Plaintiff does not dispute the well-established line of cases setting forth ERISA's broad preemptive force, it argues that Defendants "rel[y] on outdated and now-rejected overbroad interpretations" (Opposition at 14:2–3) and offers decades-old cases that, in Fremont's view, purport to limit the breadth of the statute. Plaintiff also argues that "[t]he proper analysis starts with a presumption that ERISA does not supplant state law claims" (at 9:20–21) but fails entirely to provide support for this theory.

A. The Cases Fremont Relies on to Support its Conflict Preemption Arguments Involve Oral or Written Agreements Independent of the ERISA plans

While there *are* cases where state common law and statutory claims have escaped conflict preemption, there is a stark difference between those cases and the case at hand. In all of the cases Plaintiff recites, the medical provider was able to show that it was suing on a basis that was independent of the ERISA plans and thus the claims did not "relate to" the plans. For example, Fremont looks to *Glastein v. Aetna, Inc.*, an unpublished case from the district of New Jersey that is readily distinguishable. Regardless of how "well-reasoned" that court's analysis may have been, it is not instructive because the facts were that "Plaintiff had contacted Defendant prior to the surgery, and Defendant sent Plaintiff a written authorization for the surgery." *Glastein v. Aetna, Inc.*, 2018 WL 4562467, at *1 (D.N.J. Sept. 24, 2018). Plaintiff's claims in *Glastein* were not preempted because they were based on the written preauthorization and this did not require reference to the ERISA plan. This case is not analogous; Fremont admits that it lacks a written contract or oral promise. The applicable employee benefit plans are the *only* documents that set forth the reimbursement rate for out-of-network providers like Fremont.

Fremont also cites to *Morris B. Silver M.D., Inc. v. Int'l Longshore & Warehouse etc*., where a California court found that a provider's quasi-contract claim was not conflict preempted. *Morris B. Silver M.D., Inc. v. Int'l Longshore & Warehouse etc*., 2 Cal. App. 5th 793, 796, 206 Cal. Rptr. 3d 461, 463 (Ct. App. 2016). However, there the provider lacked an assignment of benefits and was suing based on an oral promise by the plan administrator. *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 as the only possible basis for the suit was an oral promise independent of the plan. *See also The Meadows v. Employers Health Ins.*, 47 F.3d 1006 (9th Cir. 1995) (oral promise of coverage by plan administrator meant state law claims did not "relate to" the ERISA plan and were not conflict preempted). Here, Fremont does not allege that Defendants made any oral promise to Fremont regarding the rate of payment.

Finally, Plaintiff looks to *Gobeille v. Liberty Mut. Ins. Co.*, a case in which the Supreme Court reaffirmed ERISA's broad scope. The 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 v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016). The *Gobeille* Court proclaimed 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.* at 943. Although Plaintiff argues that "[t]he Health Care Providers are the masters of their complaint and have chosen to plead their claims based on the existence of an implied contract," (Opposition at 10:8–10), artful pleading cannot disguise that Plaintiff's claims clearly fall within the categories defined in *Gobeille*. Plaintiff is, at bottom, seeking to modify the rights and obligations set forth in ERISA-governed benefit plans and the Court would have to reference the plans at issue to determine whether or not Defendants complied with the rate of payment terms for out-of-network providers.

B. Under ERISA's Conflict Preemption clause, a State Law Claim is Subject to Dismissal if it Refers to or has a Connection, Either Direct or Indirect, with Covered Benefit Plans.

Fremont contends that the Supreme Court and Ninth Circuit have declined to adopt a literal interpretation of the "relates to" language, and looks to *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* to support this proposition. Specifically, Fremont offers an out of context citation that "the 'relates to' language of the preemption statute [is] 'unhelpful,' and . . . 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.'" (Opposition at 14:12–14) (quoting

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656, 115 S. Ct. 1671, 1677, 131 L. Ed. 2d 695 (1995). While *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. at 657, 115 S. Ct. at 1677 (quoting 120 Cong. Rec. 29,933 (1974) (statement of Sen. Williams)). *Travelers* is otherwise inapposite, as it dealt with the issue of whether a New York statute was preempted by ERISA. *Id.* at 649, 1673.

Finally, Fremont cites to *In Re Managed Care Litigation*, an unpublished case from the Southern District of Florida where the court differentiated between different plaintiffs' claims based on whether they had an express written contract with the insurer and whether they had an assignment of benefits from the plan members. *In Re Managed Care Litig.*, 298 F. Supp. 2d 1259, 1292 (S.D. Fla. 2003). The court ultimately held that the *in-network* providers' contractual claims were not completely preempted because they were suing under their independent contracts with the insurer. However, in contrast, the court found that the *out-of-network* providers' implied contract claims were subject to complete preemption because they received an assignment of benefits from the plan members and thus had standing to sue under ERISA. As to out-of-network providers who did not receive an assignment, the court found that their implied contract claims were not completely preempted.

Here, Fremont's situation is similar to that of the out-of-network providers in *In Re Managed Care*, whose implied contract rate of payment claims were preempted because Fremont received an assignment of benefits and alleges that it lacks a written contract with Defendants. Complaint at ¶ 17. The *In Re Managed Care* Court noted that Fremont's situation is not a close call, stating that "[v]irtually every court to consider this question has held that reimbursement and related claims involving services provided to ERISA beneficiaries on a non-participating basis [i.e. out-of-network providers like Fremont] may be pursued only through ERISA's civil enforcement provision." *Id.* at 1291 (emphasis added) (collecting cases).

While the courts in *Travelers* and *In Re Managed Care*, in a sense, define the outer limits of ERISA preemption, they do not represent a major shift in preemption jurisprudence. To the extent Plaintiff is arguing that there is a trend toward narrowing the preemptive scope of ERISA, these cases from 1995 and 2003 do nothing to advance that argument. Further, a recent case from the District of Arizona with nearly identical claims, *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. *Emergency Grp. of Arizona Prof'l Corp. v. United Healthcare Inc.*, 2020 WL 1451464, at *7 (D. Ariz. Mar. 25, 2020).[3] Specifically, the *Emergency Grp. of Arizona* Court held that "the Plaintiffs' approach is inconsistent with the policy of complete preemption":

> Congress intended to protect benefit plan participants by establishing national uniformity for the administration of employee benefit plans. This includes, in the Supreme Court's words, an 'integrated enforcement mechanism, ERISA § 502(a), . . . [which] is a distinctive feature of ERISA, and essential to accomplish Congress' purpose of creating a comprehensive statute for the regulation of employee benefit plans.' If 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, Fremont cannot show that it is suing on a basis independent of ERISA because "but for" the existence of the ERISA plans at issue, Defendants could have no conceivable duty to pay Fremont anything. Fremont admits that it lacks a written contract, lacks an oral agreement and lacks a state insurance statute requiring payment to out-of-network providers. The only possible legal bases for Fremont's suit are the patient assignments and the ERISA plan terms that govern Defendants' adjudication of Fremont's benefit claims.[4] Thus all of Fremont's claims are conflict preempted.

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[3] Case currently on appeal.

[4] *See* Complaint at ¶ 13 ("This is an action for damages stemming from United HealthCare's failure to properly reimburse Fremont for emergency services provided to members of their health plans.").

III. FREMONT'S STATE LAW CLAIMS ARE COMPLETELY PREEMPTED BY ERISA.

A. State Courts, Not Just Federal Courts, Regularly Dismiss State Law Claims on the Basis of Complete Preemption under ERISA

Plaintiff argues (at 17:2–3) that only federal courts can dismiss state law claims on the basis of complete preemption and that state courts are not empowered to do so. However, the Nevada Supreme Court has rejected this argument. *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).; *see also Morrison v. Health Plan of Nev.*, 130 Nev. 517, 527, 328 P.3d 1165, 1172 (2014) (finding dismissal to be appropriate where claims were preempted by the Medicare Act). Other state courts around the country are in accord: dismissal is appropriate where a plaintiff's state law claims are completely preempted by ERISA. *See, e.g., Johnson v. Lou Fusz Auto. Network, Inc.*, 519 S.W.3d 450, 453 (Mo. Ct. App. 2017); *Ambulatory Infusion Therapy Specialist, Inc. v. N. Am. Adm'rs, Inc.*, 262 S.W.3d 107, 114 (Tex. App. 2008) ("if a plaintiff's state law claims are preempted by ERISA . . . and no claim is asserted under ERISA, summary judgment dismissing those claims is appropriate."); *Summers v. U.S. Tobacco Co.*, 214 Ill. App. 3d 878, 888, 574 N.E.2d 206, 213 (1991) (affirming dismissal where plaintiff's statutory bad-faith claim was preempted by ERISA); *Houdek v. Mobil Oil Corp.*, 879 P.2d 417, 422 (Colo. App. 1994) (Upholding dismissal of Complaint based on ERISA preemption, recognizing that "[s]tate law claims which provide an alternative cause of action for the collection of ERISA benefits, refer specifically and apply solely to ERISA plans, or interfere with the calculation of ERISA benefits, have been preempted.").

The cases cited by Plaintiff do not support the conclusion that Plaintiff offers this Court. For example, while dicta drawn from *Owayawa v. Am. United Life Ins. Co.* seems to support Plaintiff's contention, the holding fundamentally supports Defendants' position. The *Owayaya* court ultimately ruled that "ERISA preempts plaintiff's state law causes of action [because] Plaintiff's claims 'relate to' the plan in this case, 29 U.S.C. § 1144(a), because they have 'a connection with' an ERISA plan." *Owayawa v. Am. United Life Ins. Co.*, 2018 WL 1175106, at

*6 (D.S.D. Mar. 5, 2018). The *Owayawa* court ultimately granted Defendants' Motion to Dismiss, with a footnote stating that "[b]ecause it is unclear how Plaintiff's complaint would be amended to state a claim for relief under ERISA, the Court will grant Defendants' motion to dismiss and dismiss this action without prejudice." *Id.* citing *Disabato v. Nat'l Automatic Sprinkler Indust. Welfare Fund*, 2016 WL 1182637, at *3 (E.D. Mo. Mar. 28, 2016).

Neither do the other cited cases support Plaintiff's argument. S*ummit Estate, Inc. v. Cigna Healthcare of California, Inc.* involved a U.S. district court considering whether state law claims were preempted where there existed "agreements between Defendants and Plaintiff that were separate from the policies under which Plaintiff's patients were insured." *Summit Estate, Inc. v. Cigna Healthcare of California, Inc.*, WL 4517111, at *4 (N.D. Cal. Oct. 10, 2017). *Marin General Hosp. v. Modesto & Empire Traction Co.* presented a similar scenario: at the pleading stage, allegations of oral representations made in a phone conversation with the plan administrator (offering to pay 90% of the medical expenses) were enough to state a claim for an oral contract independent of the patient's ERISA plan such that plaintiff hospital's state law claims based on an alleged oral contract escaped preemption on a motion to dismiss. Further, Plaintiff did not cite to a single state court case; all of Plaintiff's authority is drawn from federal court cases.

Finally, although Plaintiff looks to the remand order for support here, a federal district court in Arizona, dealing with Plaintiff's affiliates, nearly identical state law claims and the same Plaintiff's counsel raising the same arguments, 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." *Emergency Grp. of Arizona*, 2020 WL 1451464, at *7. Moreover, the Nevada federal district court's ruling on complete preemption is not binding on this Court. *Whitman v. Raley's Inc.*, 886 F.2d 1177, 1181 (9th Cir. 1989) ("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."); *AT&T Commc'ns, Inc. v. Superior Court*,

21 Cal. App. 4th 1673, 1680, 26 Cal. Rptr. 2d 802, 806 (1994) (holding that federal district court's finding that ERISA complete preemption did not apply in a remand order was "not persuasive," did not dictate the result in state court, and electing to dismiss the complaint on grounds of complete preemption).

The state law claims advanced by Fremont "directly conflict with ERISA's requirements that plans be administered, and benefits be paid, in accordance with plan documents." *Egelhoff*, 532 U.S. at 150, 121 S. Ct. 1322. Fremont cannot "circumvent the ERISA civil enforcement scheme through creative pleading." *Chilton v. Prudential Ins. Co. of America*, 124 F.Supp.2d 673, 684 (M.D. Fla. 2000). The application of the *Davila* test renders Plaintiff's claims completely preempted; dismissal is the appropriate remedy here.

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

As explained in the Motion, the first element of the *Davila* Test is met: Fremont received an assignment of benefits from Defendants' plan members that allows it to stand in their shoes and bring the same ERISA claims those members could have brought. Fremont does not contest that Defendants have established that over 90% of Fremont's claims/requests for payment to Defendants were for services provided to members of employee benefit plans governed by ERISA. Fremont also does not contest that, for all of the claims that Fremont is asserting in this litigation, Fremont received an assignment of benefits from the plan member such that Fremont now stands in the shoes of that plan member and may assert a claim for reimbursement. In fact, Fremont's Opposition expressly admits that "some of the claims for reimbursement . . . fall under health plans regulated by ERISA." (Opposition 4:14–15). The plan members' assignments of benefits to Fremont is significant because it means Fremont has 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.

Nevertheless, in an effort to circumvent the first prong of the *Davila* analysis, Fremont argues that the "rate of payment" claims it is asserting do not implicate ERISA plans. (Opposition 6:7–9). However, Fremont's focus on "rate of payment" vs. "right to payment" arises from a superficial analysis of case law. Regardless of what type of claim is at issue, a

court's focus is always on 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 Fremont cites to, the provider avoided complete preemption because it provided such an anchor by either (1) showing that it lacked an assignment of benefits and thus the ERISA plan was undisputedly not implicated or (2) 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 provider at a particular rate.

The lack of an assignment of benefits would mean that the first element of the *Davila* Test is not met since the medical provider would lack standing to bring an ERISA claim (i.e. since only "beneficiaries" and "participants" can bring claims under ERISA). The presence of a written agreement between the provider and the insurer, a state insurance statute requiring payment to out-of-network providers or an oral promise by the insurer to the provider would mean the second element of the *Davila* Test is not met since each of these creates a legal duty on the part of the plan administrator/insurer that is independent of the duties owed under the ERISA plan. Critically, it is undisputed that none of these facts are present here and thus the *Davila* Test is met and all of Fremont's state law claims are completely preempted by ERISA. Each of Fremont's allegedly favorable cases is discussed in turn below.

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1. Cases Where No Assignment of Benefits Occurred or Insufficient Evidence of an Assignment Was Presented Such that the Provider Lacked Standing to Bring an ERISA Claim

In *California Spine & Neurosurgery Inst. v. Bos. Sci. Corp*., 2019 WL 1974901, at *1 (N.D. Cal. May 3, 2019) (Opposition at 6, n.4), complete preemption was not found because the defendant failed to satisfy the first element of the *Davila* test due to a failure to bring forth sufficient evidence to demonstrate that an assignment of benefits occurred. Here, the evidence attached to Defendants' Motion establishes that Fremont received an assignment of benefits for the claims that it seeks to litigate in this suit and Fremont has not contested that it received an assignment. Thus, there is no question that Fremont stands in the shoes of Defendants' plan members and has standing to bring a statutory ERISA claim. The first element of the *Davila* test

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is undisputedly met. Under *Davila*, it is irrelevant whether Fremont has in fact asserted a statutory ERISA claim in its Complaint. If Fremont *could* have asserted such a claim due to the assignments of benefits, the first element of the *Davila* Test is met.

2. Cases Where an Express Written Provider Agreement Exists That Creates a Legal Duty Independent of the ERISA Plan

When a medical provider receives an assignment of benefits but also has a separate written agreement with the insurer/plan administrator (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.[5] The reason is that the provider agreement creates legal duties independent of the employee ERISA plan. Here, Fremont admits in its Complaint that it is an out-of-network provider and that "There is no written agreement between [Defendants] and Fremont for the healthcare claims at issue in this litigation." Complaint at ¶¶ 17, 22. Thus, this Court should disregard any case law cited by Fremont where a written provider agreement existed as Fremont admits one does not exist here. (Opposition at 18:18–24). The only legal duties owed by Defendants (if any) flow from the rights Fremont has as the assignee of Defendants' plan members. Since those rights are directly based on and related to employee benefit plans governed by ERISA, Defendants' claims are completely preempted.

3. Cases Where a Legal Duty Independent of the ERISA Plan is Created by a State Insurance Statute Requiring Payment to Out-of-Network Providers

Fremont attempts to liken its situation to that of an in-network-provider with a provider agreement by asserting a vague implied-in-fact contract claim. However, according to the case law Fremont itself cites, the only situation where such a claim has not been found to be

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[5] Plaintiff's Opposition offers *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); *see also Windisch v. Hometown Health Plan, Inc*., No. 308-CV-00664-RJC-RAM, 2010 WL 786518, at *1 (D. Nev. Mar. 5, 2010) (plaintiff had written provider agreement that created independent legal duty); *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) (same); Montefiore Med. Ctr. v. Teamsters Local 272, 642 F.3d 321, 326 (2d Cir. 2011) (same); *N. Jersey Brain & Spine Ctr. v. MultiPlan, Inc.*, 2018 WL 6592956, at *2 (D.N.J. Dec. 14, 2018) (same).

completely preempted is where a state insurance statute requiring payment to out-of-network providers creates the implied-in-fact contract.[6]

Here, no state insurance statute exists in Nevada that would create an implied-in-fact contract. There is no Nevada statute that requires payment to out-of-network providers. Indeed, while such schemes have been proposed by the Nevada Legislature in the past, they failed to pass or were vetoed prior to the 2019 Legislative Session.[7] Simply put, Fremont lacks a Nevada statute that could create a legal duty independent of Fremont's rights as an assignee of the Defendants' plan members. Thus, the *Davila* test is met and all of Fremont's claims are preempted.

4. Cases Where a Legal Duty Independent of the ERISA Plan is Created by an Oral Representation by the Plan Administrator/Insurer

Legal duties independent of those owed under an ERISA plan can also sometimes be created by oral representations such as those that allegedly occurred in the *Marin* case that Fremont relies on. *Marin Gen. Hosp. v. Modesto & Empire Traction Co*., 581 F.3d 941, 950–51

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[6] *Garber v. United Healthcare Corp.*, 2016 WL 1734089, at *5 (E.D.N.Y. May 2, 2016) (rates of reimbursement 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-contracting physicians according to certain formulas" to find that provider-plaintiff's claims were not preempted by ERISA); *Premier Inpatient Partners LLC v. Aetna Health & Life Ins. Co.*, 371 F. Supp. 3d 1056, 1069 (M.D. Fla. 2019) ("Florida law requires HMOs, such as Defendant, to reimburse out-of-network emergency medical service providers, such as Plaintiff, within certain time parameters and at specified rates for emergency services medical treatment."); *Gulf-to-Bay Anesthesiology Assocs., LLC v. UnitedHealthcare of Fla., Inc.*, 2018 WL 3640405, at *3 (M.D. Fla. July 20, 2018) (citing Florida Statutes to find that provider-plaintiff's claims fell outside the scope of ERISA § 502(a)); *Hialeah Anesthesia Specialists, LLC v. Coventry Health Care of Fla., Inc*., 258 F. Supp. 3d 1323, 1330 (S.D. Fla. 2017) (same); *but see Sarasota Cnty. Pub. Hosp. Bd. v. Blue Cross and Blue Shield of Florida, Inc.*, No. 8:18-cv-2873, 2019 WL 2567979, at *4 (M.D. Fla. June 21, 2019) (Section 641.513 of the Florida statutes "establishes no duty independent of ERISA" to healthcare providers lacking a contract with an HMO to reimburse for emergency care). Plaintiffs cite no Eleventh Circuit Court of Appeals case in support of their position, and Defendants are aware of none.

[7] 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).

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(9th Cir. 2009).[8] In *Marin*, the patient assigned his right to seek payment from the ERISA plan administrator to a hospital. The hospital was then paid the money owed to the patient under the ERISA plan. Then, the hospital sued the plan administrator seeking more money based on a phone conversation with the plan administrator where it allegedly offered to pay 90% of the billed medical expenses even though this was more than the rate of payment called for in the ERISA plan. Thus, the court held that the claims were not preempted by ERISA since the medical provider was clearly not suing on the ERISA plan (indeed it had already been paid everything it was owed under the plan). *Id.* As noted above, this determination was made at the pleading stage; the complaint's allegations of oral representations were thus merely enough to survive a motion to dismiss.

Here, in contrast to *Marin*, Fremont's Complaint does not allege that Defendants ever made any oral representations that they would reimburse Fremont at a particular rate (or at all for that matter). Thus, Fremont's only right to reimbursement (if any) flows from the assignment it received from Defendants' plan members and its claims are subject to complete preemption.

5. In Cases Where the Out-of-Network Medical Provider (1) Receives an Assignment of Benefits and (2) Lacks an Express Written Agreement, (3) Lacks a State Insurance Statute Requiring Payment to Out-of-Network Providers and (4) Lacks an Oral Promise to Pay by the Plan Administrator that Would Create a Duty Independent of ERISA, Courts Find the Medical Providers' Claims are Completely Preempted

Unsurprisingly, Fremont did not cite to the cases with facts similar to this one where the out-of-network providers' state law claims relating to the rate of payment were found to be completely preempted because they received an assignment of benefits. For example, in *Torrent & Ramos* the Court found that an out-of-network provider's implied-in-fact contract and unjust enrichment rate of payment claims were completely preempted. 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. *Torrent & Ramos, M.D., P.A. v. Neighborhood Health*

[8] Plaintiff also relies on *E. Coast Advanced Plastic Surgery v. AmeriHealth*, 2018 WL 1226104, at *3 (D.N.J. Mar. 9, 2018), where the plaintiff received [oral?] pre-authorization prior to performing surgeries, and which oral representations the plaintiff allegedly relied on.

Partnerships, Inc., 2004 WL 7320735, at *4 (S.D. Fla. July 1, 2004). 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. (emphasis added). Like the plaintiff in *Torrent & Ramos*, Fremont cannot "recast" its ERISA reimbursement claim as an implied-in-fact contract claim, unjust enrichment claim or anything else.

Fremont received an assignment of benefits for every claim form it submitted to Defendants and lacks a written contract or Nevada state insurance statute that would require payment to out-of-network providers. Thus, the *Davila* test is met and complete preemption applies.[9]

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

The second element of the *Davila* Test is also met: Fremont has failed to allege any facts that give rise to a legal duty independent of ERISA. Fremont, by its own admission, and "[a]t all relevant times, . . . [did not have] a written "network" agreement governing rates of reimbursement" from Defendants. (Opposition at 2:21–23; *see also* Complaint at ¶ 17). Fremont further admits that it is a "non-participating" or "out-of-network" provider. *Id.* Plaintiff attempts to bridge this analytical gap by claiming that an implied-in-fact contract exists, and contends that this implied-in-fact contract that gives it a legal right to proceed with its state law claims. (Opposition at 10:4–6).

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[9] This *Misic* case also has nearly identical facts. *Misic v. Bldg. Serv. Employees Health & Welfare Tr.*, 789 F.2d 1374 (9th Cir. 1986). Fremont vaguely argues in the Opposition that *Misic* is inapposite. This is wrong. ***Misic* was a so-called "rate of payment" case** and the Court found complete preemption was appropriate. In *Misic*, just as Fremont alleges here, the insurer/administrator paid a portion of the amounts billed by the medical provider but not the entire amount. *Misic*, 789 F.2d 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 Fremont.

Fremont fails to cite a single Nevada state insurance statute that requires payment to out-of-network providers. *See generally,* Plaintiff's Complaint. Fremont does cite to the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd and NRS 439B.410. Complaint at ¶ 15. 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.

Fremont also alleges that "Fremont was entitled to and expected to be paid at rates in accordance with the standards established under Nevada law." *Id.* at ¶ 36. However, Fremont's allegation is vague for a reason—no such statute exists in Nevada. Finally, Fremont's Complaint is devoid of any allegation of an oral representation by Defendants that they would pay Fremont a particular rate for its services. *See generally id*. Rather, the only allegation is that Defendants' past conduct of paying for certain medical services that Fremont provided to Defendants' plan members created an implied-in-fact contract. *Id.* at ¶¶ 35, 37, 38.

The above admissions and omissions are critical as they demonstrate that there is no legal duty independent of ERISA on which Fremont can rely and thus element 2 of the *Davila* Test is met. As discussed more fully below, courts have held that where (1) an out-of-network medical provider lacks an express written provider agreement with the plan administrator/insurer, (2) lacks a state insurance statute requiring payment to out-of-network providers, and (3) lacks any allegation of an oral promise to pay a particular rate by the insurer/plan administrator, there is no legal duty independent of ERISA and thus the providers' rate of payment claims are completely preempted. Courts have never found that federal and state statutes requiring hospitals to provide emergency services to *patients* create a legal duty on the part of plan administrators/insurers that is independent of ERISA. Nor have courts founds that a plan administrator/insurer's mere payment to an out-of-network provider for some of the services it provided to the administrator/insurer's plan members creates a legal duty independent of ERISA.

IV. FREMONT HAS FAILED TO STATE VIABLE CLAIMS UNDER NRCP 12(B)(5)

A. Fremont's Implied-in-Fact Contract Claim Should be Dismissed

While Plaintiff's Opposition, in a general sense, disputes that its claims are not subject to

conflict preemption or complete preemption, Plaintiff fails entirely to address the case law offered by Defendants regarding Plaintiff's claim for "Breach of Implied In Fact Contract." Specifically, Plaintiff failed to offer an argument or authority to dispute that its claim for breach of implied-in-fact contract is subject to both conflict preemption (*see Aetna Life Ins. Co. v. Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000) (internal citation omitted) ("We have held that ERISA preempts common law theories of breach of contract implied in fact, promissory estoppel, estoppel by conduct, fraud and deceit and breach of contract.")), and complete preemption (*see Melamed v. Blue Cross of California, 557 F. App'x 659, 661 (9th Cir. 2014)* ("Melamed's breach of implied contract claim is completely preempted because through that claim, Melamed seeks reimbursement for benefits that exist "only because of [the defendant's] administration of ERISA-regulated benefit plans.").

Plaintiff's Opposition focuses entirely on the incorrect notion that it has properly stated a claim for "Breach of Implied In Fact Contract" under Nevada law. Plaintiff offers *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." *Nevada Ass'n Servs., Inc. v. First Am. Title Ins. Co.*, 2012 WL 3096706, at *3 (D. Nev. July 30, 2012). But this unpublished federal case does not reflect the law of our state; to establish an implied-in-fact contract, Nevada law requires that both parties demonstrate that they (1) intended to contract, (2) exchanged bargained-for promises, and (3) the terms of the bargain are sufficiently clear. *Precision Constr.*, 128 Nev. at 379–80, 283 P.3d at 256.

In an attempt to meet their burden, Fremont argues that payments for some past services constitute a promise by Defendants to pay for all future services. Namely, Fremont points to ¶ 38 of its Complaint which alleges, *inter alia*, that:

> 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.

Opposition at 21:8 – 11; Complaint ¶ 38. What is lacking from this paragraph is any allegation

that the Defendants "intended to contract" with Fremont, any allegation that promises were exchanged between the Parties, and any allegation defining the terms of those supposed promises. Fremont's claim consists only of conclusory statements.

The fact that Fremont can only offer this single paragraph to support its claim is telling; the reliance on this allegation evinces that Fremont's claim is based on what "Defendants pa[id] for other substantially identical claims also submitted by the Health Care Providers." In other words, Plaintiff's 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).

Plaintiff's 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. To the extent that Fremont contends *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 Fremont, their provisions only establish requirements *that hospitals provide* emergency services to *patients* regardless of the patients' ability to pay. The statutes 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 must pay Fremont at any specific rate for these services.

Fremont has 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. Fremont's Claim for Tortious Breach Should be Dismissed

With respect to conflict preemption and complete preemption under ERISA, Plaintiff has again failed to address the legal authority offered by Defendants demonstrating that its claim for "Tortious Breach" must be dismissed. Because Plaintiff has not offered any substantive opposition to these arguments, there can be no dispute that the claim for "tortious breach" is subject to conflict preemption and complete preemption. *See Pilot Life Ins. Co.* 481 U.S. at 48–49 (claim for tortious breach of contract and the Mississippi law of bad faith were conflict

preempted); *Estate of Burgard v. Bank of America, N.A.*, 2017 WL 1273869 (D. Nev. March 31, 2017) ("[I]t is well established that breach of contract claims—whether contractual or tortious—fall within section 502(a).").

Reaching the issue that Plaintiff *did* oppose, Defendants concede 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. (Opposition at 22:9–16). Specifically, Plaintiff 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. *Martin v. Sears, Roebuck and Co.*, 111 Nev. 923, 929, 899 P.2d 551, 555 (1995). No matter that Plaintiff has correctly articulated the requisite elements, it has still failed to set forth a valid claim.

As to the first element under *Martin*, there must exist a valid contract between Fremont 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 Fremont has failed to allege an enforceable implied-in-fact contract, per IV.A, *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).

Plaintiff nevertheless contends 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." (Opposition at 23: 17–18; 24–25; *see also* Compl. at ¶ 50). This is a conclusory allegation that is defeated by the other allegations in the

Complaint. Fremont, by its own admission, is a sophisticated "professional practice group of emergency medicine physicians" that runs major emergency rooms across the Las Vegas Valley. *See* Compl. at ¶¶ 2, 14. Further, no Nevada Court has ever recognized a special relationship between an out-of-network provider and a plan administrator. While Plaintiff argues 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, even if this Court were to accept the above allegations as true, Fremont has failed to set forth that the parties' dynamic amounts to a "special relationship" within the purview of Nevada law. Fremont's Opposition offers *Ins. Co. of the W. v. Gibson Tile Co.* as support for what constitutes a "special relationship" (at 22:14 – 16), but even a cursory reading of the case indicates that the Nevada Supreme Court intended the term to be narrowly construed. *See Ins. Co. of the W. v. Gibson Tile Co.*, 122 Nev. 455, 134 P.3d 698 (2006). Specifically, 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. Fremont's allegations do not demonstrate "rare and exceptional" circumstances such that it should be allowed to proceed with this claim. Pursuant to Fremont's own cited authority, this claim should be dismissed.

C. Fremont's Claim for Unjust Enrichment Should be Dismissed

As an initial matter, and again, Fremont did not address the case law offered by Defendants which sets forth that Plaintiff's "unjust enrichment" claim should be dismissed for conflict preemption and complete preemption under ERISA. Because Plaintiff has not offered any legal authority in opposition, it is estopped from disputing Defendants' cited authority. *See Alcalde v. Blue Cross & Blue Shield of Fla., Inc.*, 62 F. Supp. 3d 1360, 1365 (S.D. Fla. 2014) (medical provider's unjust enrichment claim against plan found to be conflict preempted); *Hill v. Opus Corp.*, 841 F. Supp. 2d 1070, 1086 (C.D. Cal. 2011) (unjust enrichment claim was subject to ERISA preemption).

Looking to remedy the Complaint's deficiencies under Nevada law, Fremont cites to *Topaz Mut. Co. v. Marsh* for the proposition that a "benefit in [an] unjust enrichment claim can be 'indirect.'" (Opposition at 24:3–6). Defendants do not disagree with this general proposition, but it is irrelevant here, where Defendants did not receive *any* benefit, direct or indirect, from Fremont's treatment of the patients at issue. For example, 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). There is simply no application here, where Fremont has not provided any services to Defendants, and where there was no indirect benefit for services provided to third parties.

Under Nevada law, a cause of action for unjust enrichment is only available when a "plaintiff [1] confers a benefit on the defendant, [2] the defendant appreciates such benefit, and there is [3] acceptance and retention by the defendant of such benefit under circumstances such that it would be inequitable for him to retain the benefit without payment of the value thereof." *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 381, 283 P.3d 250, 257 (2012). Considering the first element, there has been no benefit indirectly or otherwise bestowed to, or retained by Defendants. Defendants offered a multitude of cases in support of its position, which Plaintiff attempted to distinguish in its Opposition

First, Plaintiff claims that *Adventist Health Sys./Sunbelt Inc. v. Med. Sav. Ins. Co.*, 2004 WL 6225293, at *6 (M.D. Fla. Mar. 8, 2004) and *Peacock Med. Lab, LLC v. UnitedHealth Grp., Inc.*, 2015 WL 2198470, at *5 (S.D. Fla. May 11, 2015) are distinguishable because "Florida law requires that the benefit conferred be 'direct' [so] any indirect benefit would not be actionable under Florida law." (Opposition at 25:2–7). While it is true that Florida law does require a direct benefit, the holdings set forth that *all* "benefits of healthcare treatment, [both direct and indirect,] flow to patients, not insurance companies." A*dventist Health Sys./Sunbelt Inc. v. Med. Sav. Ins. Co.*, 2004 WL 6225293, at *6 (M.D. Fla. Mar. 8, 2004). The cases do not draw a distinction to say that there were indirect benefits that were otherwise "[in]actionable under Florida law." (Opposition at 25:7).

Plaintiff next attempts to distinguish *Encompass Office Sols., Inc. v. Ingenix, Inc.*, 775 F.

Supp. 2d 938, 966 (E.D. Tex. 2011) and *Electrostim Med. Servs., Inc. v. Health Care Serv. Corp.*, 962 F. Supp. 2d 887, 898 (S.D. Tex. 2013), aff'd in part, rev'd in part, 614 F. App'x 731 (5th Cir. 2015) on the basis that they did not arise in "the context of emergency medical services." (Opposition at 25:7–12). This is an aimless argument; no matter that the fact patterns did not involve emergency medical services, the cases still set forth that quantum meruit claims should be dismissed because the benefit of medical treatment flows only to the patient.

While Plaintiff argues 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 case at bar where Fremont was likewise already reimbursed. And while Plaintiff argues 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 case, Plaintiff did not provide a citation for Defendant to verify same. Nevertheless, the *Cedars Sinai* ruling 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), Plaintiff incorrectly claims 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." (Opposition at 25:13–14). 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 company[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.

Plaintiff cites to a number of cases for the proposition that insurers receive benefits in the form of having their obligations to plan members discharged. (Opposition at 24:6–28). However, the cases cited by Plaintiff are inapposite here. *See Bell v. Blue Cross of California*, 131 Cal.App.4th 211, 218, Cal.Rptr.3d 688 (2005) (established that the California Department of Managed Health Care's jurisdiction over a California code violation did not *preclude* private

citizens from bringing suit under a different legal theory; 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 [and therefore] arises from Plaintiff's status as a beneficiary of its patients . . . [and] is preempted by ERISA"). Finally, *Emergency Physicians LLC v. Ark. Health & Wellness Health Plan, Inc.*, acknowledges that "[f]ederal district courts appear to be split on the issue," but otherwise gives no analysis for follow plaintiff's line of reasoning. *Emergency Physicians LLC v. Ark. Health & Wellness Health Plan, Inc.* 2018 WL 3039517, at *5–6 (E.D. Ark. Jan. 31, 2018).

Here, there has been no legally recognizable benefit bestowed to, or retained by Defendants. Further, Plaintiff has failed to establish the second element; that Defendants have appreciated any purported benefit. Absent a tangible benefit to Defendants, direct or indirect, Plaintiff's unjust enrichment claim must be dismissed.

D. Fremont's Unfair Trade Practices Claim Should be Dismissed

Here again, Fremont did not offer authority in opposition to Defendants' position that the "Unfair Trade Practices" cause of action is preempted under ERISA. Specifically, Plaintiff failed to offer any argument or authority to dispute that its claim for Unfair Trade Practices should be dismissed, under *Villescas v. CNA Ins. Companies*, for both conflict preemption and complete

preemption. *Villescas v. CNA Ins. Companies* 109 Nev. 1075, 1084, 864 P.2d 288, 294 (1993) ("We add Nevada's voice to the growing body of case law holding state unfair insurance practice claims to be preempted by ERISA. . . .").

In its Opposition, Fremont argues that "the absence of a contract between Gunny and the insurer makes this case distinguishable." (Opposition at 26:9–10). Defendants agree that *Gunny* holds that third party claimants lack standing to bring this claim absent a direct contractual relationship with the insurer. However, Fremont seeks to use its implied-in-fact contract allegation to supply the needed contract and, as discussed at length at IV.A, Plaintiff's implied-in-fact contract claim fails. Further, Fremont does not offer any opposition to *Tweet v. Webster*, 614 F. Supp. 1190agr (D. Nev. 1985) or *Crystal Bay Gen. Imp. Dist. v. Aetna Cas. & Sur. Co*., 713 F. Supp. 1371 (D. Nev. 1989), which provide "that the Act created no private right of action in favor of third party claimants against [] insurer[s]." *Crystal Bay Gen. Imp. Dist. v. Aetna Cas. & Sur. Co.*, 713 F. Supp. 1371, 1376 (D. Nev. 1989). Fremont is nothing more than a "third party claimant" with no contractual relationship with Defendants. Therefore, this claim should be dismissed.

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E. Fremont's Claim for Violation of Nevada's Prompt Pay Statutes Should be Dismissed

Plaintiff claims that "United did not challenge the Health Care Providers' claim for violation of Nevada's prompt pay statutes under Rule 12(b)(5)," but this is incorrect. Defendants provided ample case law showing that Plaintiff's prompt pay claim unquestionably "has a connection with or reference to" an ERISA plan and should be dismissed as conflict preempted. *See e.g., N. Jersey Brain & Spine Ctr. v. CIGNA Healthcare of NJ, Inc*., 2010 WL 11594901, at *6 (D.N.J. Jan. 12, 2010) (out-of-network providers' New Jersey prompt pay statute claims found to be conflict preempted). Further, Defendants offered authority such that "prompt pay" statutes are completely preempted, unless the claim for payment specifically arises from an independent agreement between the provider and plan. *See America's Health Ins. Plans v. Hudgens*, 742 F.3d 1319 (11th Cir. 2014) (Georgia's prompt-pay provision was preempted as applied to self-funded ERISA plans because the provision interfered with uniform administration

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of benefits.). Fremont did not offer any argument or authority in opposition, and its claim for violation of Nevada's prompt pay statutes should be dismissed as it is preempted under ERISA.

F. Fremont's Deceptive Trade Practices Claim Should be Dismissed

Fremont's Opposition again fails to address the fact that the claim at issue here is subject to conflict preemption and complete preemption under ERISA. *Pachuta v. Unumprovident Corp.*, 242 F. Supp. 2d 752, 764 (D. Hawaii, March 19, 2002) (holding that plaintiff's Hawaii Deceptive Trade Practices Act claim "related to" an ERISA plan and did not fall within the ERISA saving clause); *Davila*, 542 U.S. at 209 ("any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted."); *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1009 (9th Cir. 1998), as amended (Aug. 3, 1998) ("Extracontractual, compensatory and punitive damages are not available under ERISA.").

The Nevada Supreme Court and a Nevada Federal District Court have expressly held that claims sounding in fraud must be pled with particularity and that a deceptive trade practices claim sounds in fraud. *See Brown v. Kellar*, 97 Nev. 582, 583–84, 636 P.2d 874, 874 (1981) (discussing requirements to plead claims under Rule 9(b); *Davenport v. Homecomings Fin.*, LLC, 2014 WL 1318964, at *3 (Nev. Mar. 31, 2014) (upholding dismissal of deceptive trade practices claim because it was not pled with particularity); *see also Sommers v. Cuddy*, 2012 WL 359339, at *4 (D. Nev. Feb. 2, 2012) ("a plaintiff must plead a deceptive trade practices claim with Rule 9(b) particularity.").

As Defendants explained in their Motion, Fremont's fraud allegations are formulaic and conclusory. This is inadequate; Nevada law requires, under Rule 9(b), that "[t]he circumstances that must be detailed include averments to the time, the place, the identity of the parties involved, and the nature of the fraud or mistake." *Brown*, 97 Nev. at 583–84, 636 P.2d at 874. While Plaintiff's Opposition points to ¶ 246 of its First Amended Complaint, that pleading is not currently before this Court. Further, that paragraph fails entirely to meet the criteria specified above. Fremont has failed to allege the identity of a single individual employed by Defendants, and has not set forth the time, place, or specific content of *any* false representations by the

Defendants. Further, where Fremont points to ¶¶ 69-71 and 77-80 of its Complaint, these paragraphs still lump all of the Defendants together and again fail to identify the role that each played in the alleged fraudulent scheme.

Finally, Fremont does 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 that are brought under NRS 41.600(1). Rather, Fremont only contends that it still qualifies as a victim under these holdings. (Opposition at 29:27–30:1). Fremont's position is nonsensical, however, because Fremont voluntarily participated in the negotiations and business interactions that led to its alleged harms.

In sum, Fremont's claim for Deceptive Trade Practices fails because (1) Fremont is not a "victim" within the meaning of NRS 41.600 and therefore lacks standing, and (2) Fremont has not pled this claim with particularity. This claim must be dismissed under Nevada law.

G. Fremont's Claim for Declaratory Relief Should be Dismissed

Defendants provided ample case law supporting that Plaintiff's claim for declaratory relief should be dismissed because it is subject to both conflict and complete preemption under ERISA. *See*, *Brandner v. UNUM Life Ins. Co. of Am*., 152 F. Supp. 2d 1219, 1225 (D. Nev. 2001) (declaratory relief claim related to an ERISA plan, did not fall within ERISA saving clause and was preempted); *Franchise Tax Board of California v. Construction Laborers Vacation Trust for S. California*, 463 U.S. 1, 27 n.31 (1983) ("ERISA has been interpreted as creating a cause of action for a declaratory judgment"). Fremont did not offer any argument or authority in opposition, and its claim for declaratory relief should be dismissed as it is preempted.

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V. CONCLUSION

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

Dated this 7th day of May, 2020.

/s/ Colby L. Balkenbush

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CERTIFICATE OF SERVICE

I hereby certify that on the 7th day of May, 2020, a true and correct copy of the foregoing **DEFENDANTS' REPLY IN SUPPORT OF MOTION TO DISMISS** was electronically filed/served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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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. XXVII

BEFORE THE HONORABLE NANCY ALLF, DISTRICT COURT JUDGE

THURSDAY, MAY 14, 2020

RECORDER'S TRANSCRIPT OF PROCEEDINGS
RE: PENDING MOTIONS

APPEARANCES (VIA VIDEO CONFERENCE):

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For the Defendant(s): D. LEE ROBERTS JR., ESQ.
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RECORDED BY: BRYNN WHITE, COURT RECORDER

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LAS VEGAS, NEVADA; THURSDAY, MAY 14, 2020

[Proceedings convened at 12:30 p.m.]

THE COURT: All right. So let me call the case of Fremont Emergency Services versus United Healthcare, et al., Case A-792978.

Let's take appearances from the plaintiff first.

MS. LUNDVALL: Good afternoon, Your Honor. This is Pat Lundvall from McDonald Carano, here on behalf of Fremont Emergency Services, Team Physicians of Nevada, as well as Crum, Stefanko, Jones that do business as Ruby Crest Emergency Medicine.

We've got two client representatives that are also listening in on the call: a woman by the name of Carol Owen and Kent Bristowe are the two client representatives.

THE COURT: Thank you.

MS. LUNDVALL: I know that I am joined also on the call by my partners Amanda Perach as well as Kristen Gallagher.

THE COURT: Thank you.

MS. PERACH: Good afternoon, Your Honor.

MS. GALLAGHER: Good afternoon, Your Honor.

THE COURT: And for the defendants, please.

MR. ROBERTS: Good afternoon, Your Honor. This is Lee Roberts, Nevada Bar 8877, appearing for defendants.

THE COURT: Thank you. And do you have anyone with you, Mr. Roberts?

MR. ROBERTS: Yes. Mr. Colby Balkenbush is also on the

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line for defendants.

THE COURT: Thank you. And any client representatives?

MR. ROBERTS: No, Your Honor. No client representatives are attending.

THE COURT: Good enough. All right, you guys. This is a series of motions here. I think that we have to address the issue about whether or not the -- I'm going to recognize the pre-remand court files because that will determine the way that I look at the Motion to Dismiss.

And let me start off that I don't think I can even consider granting this motion. I understand that in litigation you can take alternative positions, but I don't know how I can ignore what was filed in federal court. I'll keep an open mind to your argument, but that's the tentative ruling. And certainly I encourage you to try to change my mind, but that's the way it seems to me.

MR. ROBERTS: Thank you, Your Honor. I think what the Court needs to focus on with regard to this motion is the actual language of Nevada Rule of Civil Procedure Rule 81(c). The Nevada Supreme Court, in adopting this motion -- I'm so sorry, Your Honor. I have a little child.

THE COURT: Don't apologize (unintelligible) because we are all professionals.

THE RECORDER: Judge, we're having a lot of feedback from you.

MR. ROBERTS: Okay. So I -- thank you, Your Honor. I

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appreciate the indulgence.

I -- as I was saying, Nevada Rule of Civil Procedure 81(c) indicates that after remand, repleading -- excuse me. I apologize. I've lost my place. I hope -- I hope the Court didn't hear the reason my two-year-old said she needed me.

THE COURT: I did not.

MR. ROBERTS: So as I was starting to say, under the language of Rule 81(c), it states that a defendant should move or plead as it would have done had the action not been removed. In this case it's impossible to both require the defendant to plea in response to federal court orders and federal court pleadings, and still literally comply with the rule that says we should move or plead as we would have done had the action not been removed. Those two requirements are simply incompatible.

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And with regard to the case law, there's only one other state that we could find, and that's New Mexico, which has a similar rule. Therefore, the decision by other states to make a policy decision to adopt federal pleadings and federal filings and federal orders is just that: It's a policy decision made by other states; states which did not have a similar to Nevada Rule of Civil Procedure 81(c).

It's also very significant here, Your Honor, in looking at the order of the Nevada Supreme Court when it adopted this rule. In general, the Supreme Court accepted the language of the federal rules, but made Nevada specific changes.

In this case, the Federal Rule of Civil Procedure 81(c) talks

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about how the federal court would create pleadings and documents after removal, and it says that you don't have to refile claims unless ordered by the Court. Well, if you -- if the Nevada Supreme Court had simply changed the language of this federal statute the way they did with every other sentence in Federal Rule of Civil Procedure 81, then we would have a rule that says after remand the parties don't have to refile documents unless ordered by the Court.

But that's not what they said. They struck that out. They redlined. And it indicated that the defendants (unintelligible) would have done had the action not been removed. Therefore, it's our position that the only thing that governs the Court's decision in this case is the actual wording of the Nevada statute which has never been ruled on by the Nevada Supreme Court and is an issue of first impression with you.

Going further, Your Honor, there are considerations which would make simply recognizing everything filed in federal court and all of the federal court orders especially problematic in this action.

One, we did move to dismiss the amended complaint in federal court. And if the Court were to recognize all filings and pleadings made in federal court and adopt them in this action, then we have already moved to dismiss the amended complaint and default could not be entered.

But let's look at that practically. Right now our Motion to Dismiss the federal complaint is based on the federal rules and the federal law. As this Court knows, Nevada has expressly rejected the

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Motion to Dismiss standard, such as Iqbal, that has been adopted in federal court.

So how can the Court simply accept the -- both the amended complaint in the Motion to Dismiss and rule on them if it's based on federal law, which is not applicable in this court? Similarly, even if you look at the amended complaint filed in federal court, the motion for leave to amend (unintelligible).

United, prior to remand, had filed a timely objection to that decision. Under the federal court rules, the federal court judge had a duty to resolve that objection under a de novo standard. So right now the remand happened before the federal judge could rule on our objection to the amended complaint de novo.

So, therefore, what is before you is not even a final federal court decision allowing an amended complaint. This Court could not simply accept the amendment without ruling de novo on United's objection prior to considering and requiring a Motion to Dismiss, because no one has ruled on our objection due to the removal -- excuse me -- due to the remand of the action.

So as a practical matter, Your Honor, the motions and decisions in the federal court are based on federal law which do not govern this case now that it has been remanded to state court. And rather than simply pick and choose which of the pleadings this court recognizes -- which of the federal court orders this court recognizes -- whether or not to require to amend those orders based on neighboring state law than federal law.

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The most practical thing, the thing required by Nevada Rule of Civil Procedure 81(c), is to allow the defendant to move as it would have done had the action not been removed and to allow plaintiff to seek whatever relief would be appropriate. What one of the common themes underlined some of the cases which have been cited to this court by the plaintiffs --

THE RECORDER: Mr. Roberts, I'm sorry. Can I interrupt real quick? This is the recorder.

Ms. Lundvall, can you put yourself on mute, please? We're getting a lot of feedback, and it's getting hard to hear.

MS. LUNDVALL: Absolutely.

THE RECORDER: Sorry about that. Thank you.

MR. ROBERTS: Very good. So one of the things that those decisions we're trying to prevent is a "got you" -- is trying to prevent someone from being placed in default based on removal and then remand and things not being done. That's not a concern for the Court in this action.

And again, none of those decisions were based on a state court with a rule that read the way the Nevada court rules read. For example, Your Honor, if the Court were to say "I'm going to recognize everything done in federal court prior to remand," then United filed a Motion to Dismiss prior to remand and no timely opposition was filed due to the remand. So is this Court going to find that the Motion to Dismiss was never opposed? That it was required to be opposed because it was filed in federal court prior to remand and all those

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proceedings are being recognized? That wouldn't be fair. And certainly the Court would not do that.

But how do you both accept everything that was done in federal court and not be faced with a decision to do that? There should be no "got you." There should be no conflict between what the Court needs to do now that this case is governed by Nevada state law and what the federal court did, both with regard to the motion for leave to amend potentially with regard to a pending Motion to Dismiss, which is never been briefed under state law and federal court, and with regard to discovery orders based on a federal standard that is completely at odds with Nevada's Rule 16.1.

So, Your Honor, I will submit to you that while it would seem to make sense superficially, to say, I can't just ignore what was done in federal court, the fact is that recognizing everything done in federal court would create more problems than it solves. And it's also clear that the federal court found it was without jurisdiction, whether we agree with that or not. They found they were without jurisdiction; therefore, everything a court does that is without jurisdiction is void and a nullity.

Now, the Supreme Court decisions going back over a hundred years find that state courts are not required to recognize what happened in federal court, but they have discretion to do so. In this case, there is no Nevada Supreme Court indicating that Nevada has made that policy decision to accept federal filings and decisions which they are not obligated to accept. And, in fact, the Nevada

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Supreme Court's adoption of the Nevada version of Rule 81(c) indicates that a policy decision has been made not to recognize the federal court actions and to allow a defendant to move as it would have done had the action not been removed to federal court.

Thank you, Your Honor.

THE COURT: Thank you, Mr. Roberts.

Ms. Lundvall, your opposition, please.

MS. LUNDVALL: Thank you, Your Honor.

One of the things that Mr. Roberts and I agree on -- two points -- and that those two points are this: That our Nevada Supreme Court has not affirmatively made a decision on the legal issue that is before you, number one; and, number two, is that the cases from the other jurisdictions recognize that it is a discretionary decision by an individual state as to whether or not that it will recognize then pre-remand filings that were made in the federal court during the pendency for a motion for remand.

The one thing that this legal issue then requires the Court to do is to look for some guidance from other jurisdiction. And what we have done is we have provided this Court with that guidance. And respectfully, we believe that resolution of this motion should turn on what those cases actually say and what the uniform decision actually is rather than what Counsel has claimed in their brief regarding those cases.

We had an opportunity to address those representations in our opposition brief. We have not had an opportunity to address the

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representations contained in the reply brief. And so I am going to address the issues that were raised because there was a brand new tact that was taken in the reply brief that was taken in the -- in the moving papers.

In the moving papers one of the things that we had went through is whether or not that there was a uniform decision across the decisions that have been issues since 1948 when the federal court then made some amendments to our federal removal statute.

One of the things that they also represented is that there was a default rule. And that that default rule -- in other words -- that a majority of -- of jurisdictions across our nation then had taken the position that they would not recognize activity that had occurred in the federal court during the pendency then of a motion for remand.

In our opposition we address both of those representations. And one of the things that you can look at and see that every court that has addressed this legal issue since 1948 has embraced the position that the state court is going to respect the decisions of the federal court that was made during the pendency then of the motion for remand, no different than the federal court respects then the decisions that are made by the state court at the time that it receives the case that has been removed.

Every court since 1948 has uniformly adopted that position. There aren't any outliers. There is not a split of authority on this particular point when you look at the proper Rules of Civil Procedure that were at issue in these cases.

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And the principal reason that these courts across the nation have adopted what has gone on in the federal court as its own after remand is principally judicial economy. And the respect then that is afforded both between day court judges and federal court judges both when a federal court receives a removed case and when a state court then receives a remanded case.

One of the things that we pointed out to the Court is that -- and we brought to the Court then the uniformity of those decisions, and that was found in our opposition brief. In the reply brief, one of the things that you see United do is they took a different tact. They completely changed; they regrouped; they, in essence, ignored our argument about the cases that have been uniform since 1948. And they now claim that in 2019 Nevada adopted a rule of civil procedure from New Mexico. And as a result, Nevada adopted the case law interpreting that rule of civil procedure, and it claims then that this court should respect what New Mexico has done in this regard.

Number one, Nevada did not adopt a rule of civil procedure from New Mexico; and, number two, is New Mexico case law based upon an amended rule of civil procedure actually supports the position that we have articulated, and that is that the state court will respect the activity of the federal court after remand and will respect those decisions made during the pendency.

Let me see if I can't make it -- try to streamline this a little bit. I know that the Court is well aware that Nevada did amend our Rules of Civil Procedure in 2019. We have an advisory committee

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that made proposed amendments. All the public, as well as the judges, were given an opportunity for amendment -- for input into those, and then ultimately our Nevada Supreme Court then adopted those new revised rules.

Our Michie book, that probably all of us have on our desk, published those new rules. What's most interesting -- well, it's most applicable for the argument today is that Michie also published the advisory committee notes for each one of the rules that was amended. And it had a general premise that began that articulated the fact that those amendments were being based upon the federal rules except where certain specific -- Nevada specific issues were going to be adopted.

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And at the conclusion of each one of the rules that was actually amended, there is a specific advisory committee note. For example, I don't know if you have your Michie book in front of you, but if you do, if you turn to page 530 for Rule 4, the advisory committee note for the 2019 amendment is very clear. It says Rule 4 is revised and reorganized, and it is incorporating provisions from both the federal rules as well as the Arizona Rules of Civil Procedure.

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If you turn to Rule 5. Rule 5 made amendments in 2019. Rule 5 has the advisory committee note for the 2019 amendments. It specifically states that once again that Rule 5 was being amended in accord with the Arizona Rules of Civil Procedure. And I can march through each and every one of the Rules of Civil Procedure, the amendments that were made in 2019, and can point out specifically

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where the Nevada Supreme Court, in adopting the rules and the advisory committee notes, identified what the origin or where they got the amendment.

So one would think that if, in fact, that Mr. Roberts was accurate that Rule 81, particularly Rule 81(c), had been adopted from New Mexico, that you could go the Michie book, you could look for the advisory committee notes, and you could see that it had adopted the New Mexico Rules of Procedure. That's what one would expect based upon the arguments that they make.

Well, when you go to Rule 81 and you look -- it's specifically found at page 791 -- and what you will see is that it -- there's no mention of the New Mexico Rule of Civil Procedure whatsoever. There's no mention at all of New Mexico. There's no mention of adopting any rule of civil procedure from New Mexico or adopting the case law that went along with that.

In fact, what it does is it makes express reference that the changes to Rule 81(c) are stylistic only. And it goes on to state that the stylistic changes did not affect the substance of Rule 81(c). And it identified then that it was patterned after Rule 81(c) from the federal rules.

Now, Mr. Roberts contends in his reply brief that the Federal Rule 81(c) is not similar to the State Rule 81(c), but, in fact, the only real difference is that the federal court deals with removed cases whereas the state rule deals with remanded cases. So of course it's going to use different language. It's going to make reference to

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removal versus remand and what the consequences of what those are.

Now, in my opinion that should be the end of the hunt and being able to reject that argument, but I think that one of the things that is important is -- let's take a look at what New Mexico case law actually states. New Mexico case law, based upon it's old rule -- there's two decisions. One was issued in 19- I think -33, the other one was in '39. And it was based upon an old rule of civil procedure in New Mexico.

It is supportive of United's position. However, when New Mexico amended it's Rules of Civil Procedure, there's also a New Mexico decision that interpreted Rule 81(c), and that New Mexico decision actually supports then the position that we have staked out. That New Mexico decision is found at the state -- the State of New Mexico v. City of Albuquerque, and it dealt with a lot of the controversy in the city of Albuquerque over whether or not a bridge was going to be built over the Rio Grande.

And one of the things that you look at is the decision then that came from the New Mexico intermediate court of appeal was that fact that it embraced the interpretation that we've been given. In other words, that whatever happened in the federal court would be respected then by the state court in New Mexico after remand. That's what the City of Albuquerque decision states.

Now, Mr. Roberts, in his reply brief, suggests that this court should ignore that because that somehow the fact is different than

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what the Nevada -- than what the New Mexico -- than a supreme court had done. Well, candidly that's not accurate either. If you look at the citing history, or have your law clerk look at the citing history, one of this things that you see is that the intermediate court of appeal decision that was handed down in 1994 was upheld by the New Mexico Supreme Court. And it embraced then the timing aspect as to which of the operative pleadings was going to be recognized, and the operative pleading then was based upon what had happened in the federal court, not in the state court.

And so if you look at, then, what New Mexico law actually is, it is supportive of the position that the plaintiffs have articulated in this case. And that is that the Court should respect, then, the activity -- particularly the activity as it relates to the pleadings during the time that this case was pending in the federal district court.

The -- if you look at all the cases that we had collected in our opposition, we basically are able to pull together three policy considerations that the courts have analyzed. Those three policy considerations of judicial economy. You know, principally it's like, why does a state court then need to revisit then each and every decides that the federal court may have made? The other is that it tries to avoid prejudice then to the parties. And we had articulated that how if you embrace United's position how that that would prejudice the parties, and would also then avoid any forfeiture then of any claims so that we have litigation on the merits.

Now, one thing that it has been suggested is that somehow

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that the health-care providers, the plaintiffs in this action, could impermissibly take default from the federal decision that had granted leave to amend then are complaint and to recognize then the first amended complaint. We stated specifically in our opposition that we're not seeking default.

We don't think that there's a legitimate dispute on this point between the parties, but we do recognize that it is within the Court's discretion then to make this decision. And so, therefore, we expressly stated that no default then was going to be considered or that we were not taking any default then as a result of their failure to plead a response to the first amended complaint.

Moreover, Rule 81(c), if you look at the plain language, look at the rule in its entirety, the rule is pretty simple. It is that if there hadn't been a pleading, a responsive pleading then to a complaint, then there's an additional 14 days that a party has in which to either answer the complaint or move on the complaint then if it had not done so. It used to be 10 days; now it's 14 days. That's all Rule 81(c) accomplishes at this point in time.

But the one thing that I think is an important consideration, and that is, this is a very important case to the health-care providers. What we do not want to do is to invite any argument that there's any type of error on appeal.

And so I have a proposal for procedure as it relates in the event that the Court does go with your tentative ruling and to deny the motion then that has been made by United. And I say that for this

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reason: At this point in time United has been recalcitrant, and it has only filed a Motion to Dismiss on the original complaint. But the first amended complaint, though, contained an additional claim, and that additional claim has not been briefed by United.

And so what we would propose to the Court is a briefing schedule that would allow United then the opportunity to address that single complaint -- single additional claim that was set forth in our first amended complaint, for us to do this on a shortened time, and then for the Court to have the full first amended complaint before it in resolving then any motions to dismiss. That's what our proposal would be.

THE COURT: That would be the 8th cause of action of the first amended complaint; is that correct?

MS. LUNDVALL: Yes. That's correct.

THE COURT: And what is the --

MS. LUNDVALL: We've got --

THE COURT: -- and what is the grounds for request for relief under that cause of action?

MS. LUNDVALL: It's a RICO claim, Your Honor. Our RICO claim was --

THE COURT: (Unintelligible.)

MS. LUNDVALL: I'm sorry. It's a state law RICO claim. Yes, it's a state law RICO claim.

And so our proposal because these issues have already been briefed in the context of the futility argument that was advanced

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by United in their motions -- in their opposition to our motion for leave to amend.

And so both sides have had the opportunity to brief this, and it's not going to take a lot of retooling for them -- for either side then to retool, then, those briefs. And so our recommendation to the Court would be for them to file an updated Motion to Dismiss addressing this new 8th cause of action to -- the state law RICO claim, and for them to have seven days in which to file their updated Motion to Dismiss. That takes us to May 21st.

We can do a turn on an opposition then in three days, which would take us to May 26th. We would give United three days then for reply, which takes us to May 29th. And then we could have a hearing on the Motion to Dismiss the full first amended complaint the week of June 1st. That way that the Court has everything before it, know the party can contend that there's some type of error on appeal, both sides have full and ample opportunity to address all of the claims that are set forth in that first amended complaint, and then Court then could hear the arguments in full on the claims that have been asserted in the first amended complaint. That's what our recommendation would be to the Court.

THE COURT: And so you're -- under that proposal we would not get with the Motion to Dismiss at all today?

MS. LUNDVALL: We are prepared to go forward on the Motion to Dismiss today, but in the event that the Court would adopt our proposal, so as to try to streamline this, rather than to extend it

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out further or to invite any argument by United that there's some type of error on appeal, this is what we are proposing in an abundance of caution to try to make sure that United's not trying to offer up any suggestion that somehow that they have been prejudiced then by the Court's ruling.

They've taken this action -- we believe that the action that they've taken -- and they're kind of putting the blinders on and focussing only on the original complaint -- is a decision that they've made. But I'm not going to try to take advantage of that decision. What I want is a decision that is on the merits of a Motion to Dismiss, and I would like for then that decision to be full and robust rather than piecemeal and in part.

Thank you, Your Honor.

THE COURT: And I'm going to ask both of you to consider something. I'll ask Mr. Roberts to respond first and then later Ms. Lundvall. But even if I considered the Motion to Dismiss today, very often I grant (unintelligible) leave to amend. So -- and under the pleading standard in Nevada, that's very discretionary and should be applied by very (unintelligible). So I want to offer Mr. Roberts the chance to consult with his client (unintelligible) to you today. We can reconvene in half an hour, or we can just go forward at this point.

Mr. Roberts, how do you wish to proceed?

MR. ROBERTS: I apologize, Your Honor. I was getting a lot of feedback, and I couldn't make out everything that the Court said.

THE COURT: Would you like for me to repeat it?

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MR. ROBERTS: Yes. Just -- I heard you offer me an opportunity to consult with my client, but if you could repeat what the issue was for me, that would be helpful.

Thank you, Your Honor.

THE COURT: Well, the issue is that in business court motions to dismiss, usually when I grant them, I grant them with leave to amend so that any deficiencies that are addressed in the motion can be cured and then we have an optative complaint. I -- you know, I'm going to consider that as an opportunity.

My biggest concern with both of you is the delay in this case. This case is over a year old now. It goes back to April 15th of 2019. So I will give you a chance to consult with your client and get back on the phone in half an hour. So that, Mr. Roberts, gives you chance to consult with your -- with the plaintiff's proposal. So it gives you the discretion as to how to respond.

MR. ROBERTS: Thank you, Your Honor. And I do appreciate that. Unfortunately, I have another hearing on a Motion to Dismiss before Judge Bear in Department 32 at 1:30, so I would not be able to return.

THE COURT: Well, we could do it tomorrow. I have hearings scheduled for tomorrow as well. And there's more bandwidth on Friday afternoons than any other time, which is why we've been doing our hearings usually on Friday.

MR. ROBERTS: Thank you, Your Honor. I do have one question for the Court to consider, and I guess to get Ms. Lundvall's

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reaction to it.

Even if the Court recognized the pleadings filed in federal court and were to follow Ms. Lundvall's suggestion, which I appreciate, to allow us to move to dismiss the one count we have not yet addressed, we still have the issue that we had filed an objection to motion to leave to amend, which was going to be decided de novo by the judge if the courts had not remained closed. How do we get that in front of the Court? And shouldn't that be ruled upon before we're required to file a Motion to Dismiss against the amended compliant.

THE COURT: Ms. Lundvall, need to respond.

MS. LUNDVALL: Thank you, Your Honor.

One of the things that our proposal does is it addresses that exact issue. Futility was the argument that was raised in opposition then to our motion for leave to amend. What United had argued is that futility, which is the same standard is applicable under a Motion to Dismiss, that our RICO claim would be futile.

The court -- the federal district court had looked at that issue had -- therefore, had denied -- had denied United's position and had granted us leave to amend.

By allowing United to address under the proposal that we had proffered an opportunity to address on a Motion to Dismiss the single RICO claim, what the Court then is doing is looking at the identical argument, the futility argument, that was done and, therefore, give them the same opportunity to address that. And, therefore, we could have by the first of June then an operative

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complaint, and that operative complaint then could be one by which that we could use for scheduling purposes, discovery purposes, et cetera. So the concern that had been articulated by Mr. Roberts is addressed.

THE COURT: Right. Mr. Roberts, your response, please.

MR. ROBERTS: I do agree that the Court would address the same issues in the Motion to Dismiss as in the leave to amend. And, in fact, I've brought motions opposing leave to amend and then bring the Motion to Dismiss and the Court said to me "I don't know what you're doing, I've already ruled on this when I found it wasn't futile." So I think I understand the proposal and how that would work, and I would like the opportunity to consult with my client on that.

With regard to the whole scope of what's going to be recognized and what isn't, does the Court believe that a new scheduling order should be issued under the Nevada rules or is it --

THE COURT: Yes. Yes, absolutely.

MR. ROBERTS: Okay.

THE COURT: Absolutely.

MR. ROBERTS: So if we agree to this compromise, we wouldn't be agreeing that everything ordered by the federal court is binding on the state court; correct?

MS. LUNDVALL: Well, what we're doing is because there was no scheduling order that had been issued then by the federal court. The parties had competing proposals -- competing suggestions to the Court for a scheduling order, but that had not been

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embraced.

MR. ROBERTS: And specifically, Your Honor, I was talking about a date for the completion of certain discovery and a ruling on the disclosure of experts that the Court would address those de novo based on the Nevada rules.

THE COURT: That's correct. That was my plan.

MR. ROBERTS: Very good.

THE COURT: So does that mean we will recess until tomorrow afternoon then?

MR. ROBERTS: Yes, Your Honor. I would like to take up the Court on its suggestion that I confer with my client, and maybe I'll be in agreement tomorrow afternoon.

THE COURT: Good enough. All right, you guys. Yes, Ms. Lundvall?

MS. LUNDVALL: Would you like me to repeat the proposal that we had made from a timing standpoint just so that there's no --

THE COURT: No. No. No. What I'm going to require you to do is put it in writing for Mr. Roberts, (unintelligible), and he can go over it with his client.

MS. LUNDVALL: Thank you, Your Honor. Will do.

THE COURT: If the two of you have the chance to talk before the hearing tomorrow -- but if you don't, that's fine. We'll hash it out tomorrow. What is the last scheduled hearing we have tomorrow?

THE CLERK: Judge, the last scheduled hearing is 2:30. This is Nicole.

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THE COURT: All right. So is the 3:00 o'clock tomorrow convenient for everyone?

MS. LUNDVALL: We will make it convenient, Your Honor.

THE COURT: Mr. Roberts?

MR. ROBERTS: Yes, Your Honor. Yes, Your Honor.

THE COURT: Good. Thank you both. At this point I'm concluding the hearing, but I am going to take a point of personal privilege at this point. I have a law clerk and an extern who have -- the three of us --

[Proceedings adjourned at 1:13 p.m.]

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ATTEST: I do hereby certify that I have truly and correctly transcribed the audio/video proceedings in the above-entitled case to the best of my ability.

Shannon Day
Independent Transcriber

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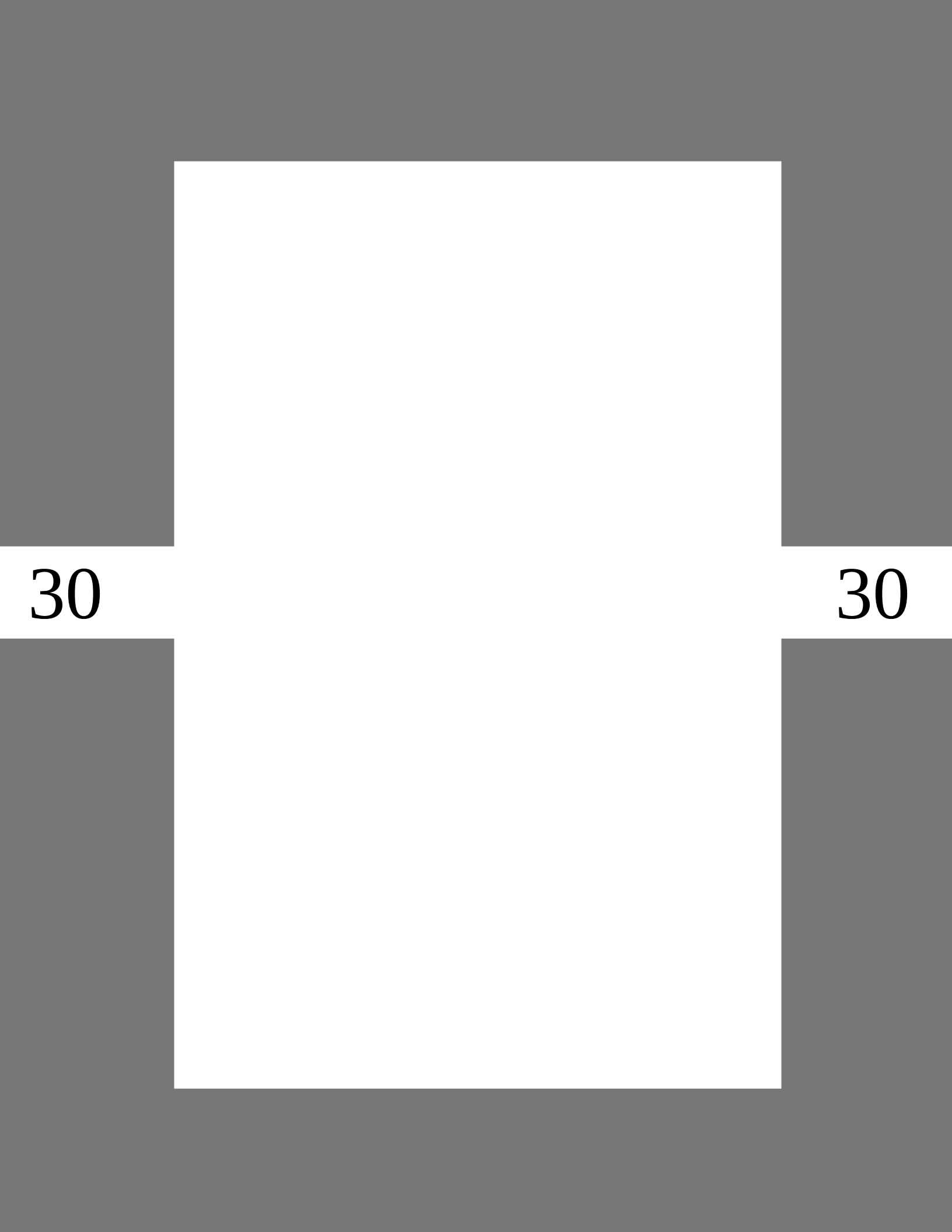
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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

Defendants.

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

FIRST AMENDED COMPLAINT

Jury Trial Demanded

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

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832-JAD-VCF **FIRST AMENDED COMPLAINT** **Jury Trial Demanded**

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

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

NATURE OF THIS ACTION

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

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

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

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PARTIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

JURISDICTION AND VENUE

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

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

FACTS COMMON TO ALL CAUSES OF ACTION

The Health Care Providers Provide Necessary Emergency Care to Patients

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

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

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

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

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

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

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

24. The uhc.com website state:

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

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

25. Relevant to this action:

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

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

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

The Relationship Between the Health Care Providers and Defendants

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Defendants Paid the Health Care Providers Unreasonable Rates

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Defendants' Prior Manipulation of Reimbursement Rates

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Defendants' Current Schemes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Defendants' and Data iSight's Activities Constitute Racketeering Activity

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

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

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

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

The Enterprise and Scheme

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

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

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

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

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

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

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

The Enterprise's False Statements: Transparency

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(emphasis added).

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

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

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

155. These statements are false.

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

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

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

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

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

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

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

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

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

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

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

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

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

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