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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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.

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.

COUNT V – Declaratory Judgment

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.

Respectfully submitted,

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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-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

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).

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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.

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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:

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
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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

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

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EXHIBIT 1

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MARIN GENERAL HOSPITAL, a non-profit California corporation

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.

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.

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.

SECOND CAUSE OF ACTION

(Breach of Oral Contract)

(Against all defendants)

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.

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[ ] 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

SERVICE LIST

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DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation,

Plaintiff,

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

PLAINTIFFS' OPPOSITION TO DEFENDANTS' SUPPLEMENTAL BRIEF IN SUPPORT OF THEIR MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT ADDRESSING PLAINTIFFS' EIGHTH CLAIM FOR RELIEF

Hearing Date: June 5, 2020
Hearing Time: 1:00 p.m.

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POINTS AND AUTHORITIES

I. INTRODUCTION AND STATEMENT FACTS

The Health Care Providers[1] allege a Nevada state law claim for civil racketeering ("civil RICO") against United because they have been financially harmed by an orchestrated scheme crafted and implemented by an Enterprise consisting of United and third parties

[1] Terms not otherwise defined herein shall have the meanings ascribed to them in the Health Care Providers' Opposition to Motion to Dismiss First Amended Complaint.

including National Care Network, LLC dba Data iSight ("Data iSight") to artificially and fraudulently reduce payment rates and manipulate the related benchmark pricing data to "support" United's position. Unfortunately, this scheme is not new: United was previously caught manipulating and skewing payment rates for out-of-network providers, but it appears that United has not been deterred by the sanctions it previously suffered. *Id.* ¶¶ 70-75.

In this new scheme cut from old cloth, United decided what rates it wanted to pay – a substantial reduction from 2018 rates – and then went about influencing and manipulating the data so that it will ultimately "support" its unilaterally imposed pricing system. It did this all under the guise of legitimacy by pointing to Data iSight as an independent company which was charged with analyzing payment data to determine reasonable and customary payment rates for the geographic region. In reality, Data iSight is simply a cover for United to manipulate its own payment rates. In fact, when Fremont's representatives called Data iSight (as suggested on Provider Remittance Forms for providers to discuss payment rates), Data iSight told Fremont's representatives that United was the ultimate decision maker and the rates were developed by Data iSight and United. *See e.g.* First Amended Complaint ("FAC") ¶¶ 136, 140. The scheme is in place to make it look like a legitimate business relationship, but it does not work as it is portrayed.

Specifically, the Health Care Providers allege that United's and Data iSight's scheme has been in development and implementation over the last several years (FAC ¶¶ 90-109) and that United and Data iSight concealed the scheme (*id.* ¶¶ 123-131). Given the nature of the allegations, the Health Care Providers did not have sufficient information to lodge the allegations when it commenced the action in state court on April 15, 2019. As claims were processed and Data iSight increasingly emerged as a new entity providing supposed benchmark pricing, the Health Care Providers' representatives became aware of reductions in payments and began uncovering the scheme. *Id.* ¶¶ 132-141; ¶¶ 104-105, 109 (recounting communications from United in July 2019 regarding the plan to drastically cut payment rates with no objective basis); ¶ 108 (August 2019 threats and intended leverage aimed at intentionally interfering with existing contracts); ¶ 136 (July 2019 communications with Data

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iSight).

II. LEGAL ARGUMENT

A. ERISA Does Not Govern the NV Civil RICO Claim and Dismissal is Not Supported Under Either a Complete or Conflict Preemption Analysis

The Health Care Providers have alleged United is engaged in a "scheme and conspired with Data iSight to impose arbitrary and unreasonable payment rates on the Health Care Providers under the guise of utilizing an independent, objective database purportedly created by Data iSight to dictate the rates imposed by Defendants." FAC ¶ 102, *see also* FAC ¶¶ 90-188. Nothing in the FAC's Nevada state civil racketeering claim concerns United's obligation under any employee benefit plan that it provides to its members.[2] Nevertheless, United's leading argument is that the Health Care Providers' civil racketeering claim is preempted by ERISA's Sections 502 (complete preemption) and 514 (conflict preemption).[3] United's Supplemental Brief ("Supplement") at 3:3-21.

As in the Amended Motion to Dismiss, United does not fully explain these two distinct preemptive provisions for the Court, instead pointing the Court to a case not factually analogous to this case (*Moorman v. UnumProvident Corp*) and asking the Court to follow a legally divergent case that found federal RICO preemption under different statutory schemes

[2] As is detailed by the Health Care Providers in the Opposition and as the Nevada federal district court determined in this matter prior to remand, Ninth Circuit precedent dictates that disputes concerning the ***rate of payment*** rather than the ***right to payment*** are not governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), and are not subject to complete preemption under *Davila* and its progeny. "[R]emoval on ERISA grounds is only appropriate if ERISA completely preempts a state law claim." *California Spine & Neurosurgery Inst. v. Boston Sci. Corp.*, No. 18-CV-07610-LHK, 2019 WL 1974901, at *3 (N.D. Cal. May 3, 2019) (citing *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 944-45 (9th Cir. 2009)).

[3] As explained in the Opposition, the proper analysis starts with a presumption that ERISA does not supplant state law claims. 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 Cervantes v. Health Plan of Nevada, Inc.*, 127 Nev. 789, 794, 263 P.3d 261, 265 (2011); *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: (1) laws "with a reference to ERISA plans," which include laws which "act[ ] immediately and exclusively upon ERISA plans . . .or where the existence of ERISA plans is essential to the law's operation," and (2) laws with "an impermissible connection with ERISA plans, meaning a state law that governs a central matter of plan administration or interferes with nationally uniform plan administration." *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016)

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the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901 *et seq*. (*Bridges v. Blue Cross and Blue Shield Ass'n*) and Section 210 of the Energy Reorganization Act ("ERA") (*Norman v. Niagara Mohawk Power Corp.*). As explained below, United has not presented the Court with any legal authority that necessitates dismissal of the Health Care Providers' Nevada state law RICO claim under either ERISA Section 502 or 514.

Despite a heading that suggests the Court can dismiss this claim on complete preemption grounds, United does not cite to any case that discusses complete preemption, much less holds, that ERISA's Section 502 (complete preemption) preempts a state civil racketeering claim. Thus, the Court can readily reject the argument because United has not presented the Court with any legal authority supporting dismissal.

Nor does United's conflict preemption case law support dismissal of the Nevada RICO claim. In *Moorman v. UnumProvident Corp.*, CIV.A. 104CV2075BBM, 2007 WL 4984162, at *1 (N.D. Ga. Oct. 30, 2007), the plaintiff-plan member moved for reconsideration of the lower court's dismissal of a state law racketeering claim. The lower court ruled the claim was conflict preempted because the alleged "bad faith claims handing scheme" stemmed from the health plan's denial of disability benefits.[4] *Id.* The facts in *Moorman* are not analogous here because the claims do not concern a denial of benefits whatsoever (FAC ¶¶ 42-44) and the Health Care Providers' civil racketeering allegations do not meet *Gobeille's* two identified categories of state laws that would result in conflict preemption: (1) NRS 207.350 *et seq.* is not a state law "with a reference to ERISA plans," and is not a law which "acts immediately and exclusively upon ERISA plans…or where the existence of ERISA plans is essential" its operation," and (2) NRS 207.350 *et seq*. does not "govern[] a central matter of plan administration or interfere[] with nationally uniform plan administration." *Gobeille*, 136 S.Ct. at 943; *see also Lynam v. Health Plan of Nevada, Inc.*, 128 Nev. 915, 381 P.3d 636 (2012) (reversing district court's dismissal of plaintiff's claims under ERISA Section 514 and indicating that whether tort claims were preempted depended on the evidence adduced). Instead, the FAC's allegations detail improper conduct to manipulate and deflate reimbursement payment rates so that United can

[4] The *Moorman* court referred to the "relates to" analysis which is the conflict preemption analysis under Section 514. *Moorman*, 2007 WL 4984162 at *1.

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then point to that same manufactured data as justification for paying the Health Care Providers a fraction of what they are owed for the emergency medicine services provided. FAC ¶¶ 90-188, ¶¶ 261-273. Therefore, *Moorman* does not support dismissal under Section 514 (conflict preemption).[5]

Next, United contends that *Bridges v. Blue Cross & Blue Shield Ass'n*, 935 F.Supp. 37, 44 (D.D.C. 1996) supports ERISA preemption. Supplement at 3:6-7. To be clear, *Bridges* does not involve an ERISA plan at all. In a footnote without analysis, United asserts that "FEHBA is analogous to ERISA in that it is a federal law that governs claims related to federal health employee benefit plans and courts regularly find state causes of action preempted by it." Supplement at 3 n.2. Notably, the *Bridges* court stated "[t]he FEHBA is a different scheme altogether…and comparisons to ERISA law are unavailing in this context." *Bridges*, 935 F.Supp. at 44-45.[6]

But if United wants to rely on FEHBA case law, then the Court should be guided by *Cedars-Sinai Med. Ctr. v. National League of Postmasters of U.S.*, 497 F.3d 972, 976 (9th Cir. 2007) because the court explained that FEHBA recognizes the distinction between a challenge by a member relating to plan benefits and, on the other hand, an independently existing dispute between insurance companies and health care providers:

> This preemption mechanism was not designed for, nor available to resolve, contractual disputes between carriers and health care providers….FEHBA's implementing regulations make clear that OPM has created a remedial mechanism solely for the claims of "covered individuals," not for the claims of providers.

Id. The court held that where "a health care provider seeks to recover money on its own behalf pursuant to its contract with a carrier, it is not acting on behalf of a covered individual." *Id.* The

[5] *Moorman* does not involve any analysis under ERISA Section 502 (complete preemption).

[6] Other cases have also noted there are fundamental differences between ERISA and FEHBA. For example, ERISA's statutory scheme is not as strict in terms of who can sue and who can be sued. *Botsford v. Blue Cross & Blue Shield of Montana, Inc.*, 314 F.3d 390, 398 (9th Cir. 2002), opinion amended on denial of reh'g, 319 F.3d 1078 (9th Cir. 2003). United cites another FEHBA case that should also be disregarded: *Danielsen v. Burnside-Ott Aviation Training Ctr., Inc.*, 746 F. Supp. 170, 176 (D.D.C. 1990), aff'd, 941 F.2d 1220 (D.C. Cir. 1991). The *Danielsen* court held that plaintiffs' RICO claims against their government-contractor employer were subsumed by the statutory remedies offered under the Service Contract Act, 41 U.S.C. § 351 *et seq.*

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crux of this case is exactly that – the Health Care Providers are not acting on behalf of a covered individual but are seeking to recover billed charges pursuant to an implied-in-fact contract, among additional legal theories. FAC 1 n. 1, ¶ 57(d).

Next, United's citation to *Norman v. Niagara Mohawk Power Corp.*, 873 F.2d 634, 637 (2d Cir. 1989) fares no better because it does not concern ERISA preemption either. There, the court upheld dismissal of a civil racketeering claim related to an employee's claims for discrimination and retaliatory conduct that was deemed governed by Section 210 of the Energy Reorganization Act ("ERA") – a statutory framework that provides an exclusive administrative remedy. *Id.* ("the administrative remedy provided in section 210 is exclusive."). ERISA's preemption framework is not so strictly construed. Rather, the analyses under Sections 502 (complete preemption) and 514 (conflict preemption) must be met for the Health Care Providers' Nevada civil racketeering claim to be preempted. Because the Health Care Providers' claim is premised on an illegal scheme unrelated to any health plan, ERISA cannot serve to preempt the claim and it is, therefore, not subject to dismissal under either Section 514 or 502.

B. The Health Care Providers Have Stated an Actionable Civil Racketeering Claim Under Nevada Law

Any person who is injured in his business or property by reason of any violation of NRS 207.400 has a cause of action against a person causing such injury for three times the actual damages sustained. NRS 207.470(1).[7] In order to recover, three conditions must be met:

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

> engag[ed] in at least two crimes related to racketeering that have the same or similar pattern, intents, results, accomplices, victims or methods of commission, or are otherwise interrelated by distinguishing characteristics and are not isolated incidents, if at least one of the incidents occurred after July 1, 1983, and the last of the incidents occurred within 5 years after a prior commission of a crime related to racketeering.

NRS 207.390. "Crimes related to racketeering" are enumerated in NRS 207.360 and include the crime of obtaining money or property valued at $650 or more, violation of 205.377 and

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(1) the plaintiff's injury must flow from the defendant's violation of a predicate Nevada RICO act; (2) the injury must be proximately caused by the defendant's violation of the predicate act; and (3) the plaintiff must not have participated in the commission of the predicate act.[8] *Allum v. Valley Bank of Nevada*, 109 Nev. 280, 283, 849 P.2d 297, 299 (1993). "A state RICO complaint need allege no more than that which is set forth in the Nevada statute." *Siragusa v. Brown*, 114 Nev. 1384, 1399, 971 P.2d 801, 811 (1998). As the Health Care Providers have done, the FAC satisfies each of these elements and United's challenges must be rejected.

1. The Health Care Providers Have Adequately Alleged Proximate Cause

To have standing to bring a civil RICO claim, a plaintiff must allege injury that flowed from the violation of a predicate RICO act. *Allum*, 109 Nev. at 284, 849 P.2d at 300 (citing *Holmes v. Securities Investor Protection Corp.*, 503 U.S. 258, 266-268 (1992)); *Brown v. Kinross Gold, U.S.A.*, 378 F. Supp. 2d 1280, 1287 (D. Nev. 2005). A plaintiff satisfies this requirement by alleging "some direct relation between the injury asserted and the injurious conduct alleged." *Holmes*, 503 U.S. at 266-268; *Canyon County v. Syngenta Seeds, Inc.*, 519 F.3d 969, 980 (9th Cir. 2008) (a court evaluates proximate causation under federal civil RICO by asking "whether the alleged violation led directly to the plaintiff's injuries."); *Allum*, 109 Nev. at 286, 849 P.2d at 301. Important to the Court's adjudication of this issue, proximate cause is a factual issue not appropriate on a Rule 12(b)(5) motion. *Yamaha Motor Co., U.S.A. v. Arnoult*, 114 Nev. 233, 238, 955 P.2d 661, 664-665 (1998).

The requirement of proximate cause seeks to "limit a person's responsibility for the consequences of that person's own acts." *Painters & Allied Trades Dist. Council 82 Health Care Fund v. Takeda Pharmaceuticals Co. Ltd.*, 943 F.3d 1243, 1248 (9th Cir. 2019). Ultimately, the analysis is concerned with: (1) whether plaintiff would have difficulty showing its damages flowed from defendant conduct; (2) whether there is a risk of double recovery; and

involuntary servitude, the crimes that the Health Care Providers have alleged. NRS 207.360(28), (35), (36).

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

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(3) whether others are positioned to make the same claims. *Holmes* at 503 U.S. at 269.[9] These factors emphasize that proximate cause is "a flexible concept that does not lend itself to a black-letter rule that will dictate the result in every case." *Takeda Pharmaceuticals Co. Ltd.*, 2019 WL 6484263, at *5. In *Painters*, the court held allegations sufficient to satisfy RICO's proximate cause requirement where the plaintiff alleged a third party had relied on the defendants' false statements. *Painters*, 943 F.3d at 1260.

Here, the three *Holmes* (and reiterated in *Mendoza v. Amalgamated Transit Union Int'l*, No. 2:18-cv-959-JCM-NJK, 2019 WL 4221078, at *6 (D. Nev. Sept. 5, 2019)) factors are met. The Health Care Providers are directly being defrauded by the Enterprises' scheme (*see e.g.* FAC ¶¶ 148, 187-188) and no one else is better suited to bring this action:

> 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.
>
> 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
>
> 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

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

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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.

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.

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.

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.

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.

FAC ¶¶ 102, 107-109, 113-115, 148. These allegations squarely link the scheme to manipulate and reduce rate payment data to an actual reduction in payment for emergency services to the Health Care Providers. Further, there is no risk of double recovery because the Health Care Providers only seek recovery for emergency services they rendered and no one else is positioned to make the same civil RICO claims regarding the emergency services at issue in this case. *Holmes*, 503 U.S. at 266-268.[10]

[10] United argues that (1) the civil racketeering allegations fail because the alleged underpayment has no causal connection to alleged misrepresentations as the Health Care Providers are required to provide emergency care under federal and state law; and (2) United previewed its scheme, resulting in a break in the causal connection. Supplement at 5:14-6:3.

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2. As alleged, the fraud-based crimes related to racketeering meet recognized pleading standards

United contends that the Health Care Providers have failed to plead the civil RICO claim with the requisite particularity under NRCP 9(b). Supplement at 6:18-25. United's argument is merely a recitation of pleading standards while overlooking no less than 100 paragraphs of factual allegations recounting the scheme including who is involved, what the scheme entails, the purpose of the scheme and how the scheme has been perpetrated.[11] In addition to paragraph 115 (cited above), the Health Care Providers have set forth the alleged scheme and the resulting harm arising from the acts and omissions:

> 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(37) (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.

Both arguments misunderstand the proximate cause inquiry. Under *Holmes*, the proper inquiry is whether there is "some direct relation between the injury asserted and the injurious conduct alleged." *Holmes*, 503 U.S. at 266-268. For example, in *Allum*, the plaintiff was not the victim of the predicate act of obtaining money by false pretenses; therefore, was not proximately caused by the predicate act. Here, the Health Care Providers have alleged that they are the direct victims of the predicate acts of obtaining money by false pretenses, multiple transactions involving fraud or deceit and involuntary servitude.

[11] United cites *American Dental Ass'n v. Cigna Corp.*, 605 F.3d 1283, 1292 (11th Cir. 2010) for the proposition that the Court should dismiss the civil RICO claims, but there the plaintiff did not include allegations that there were any misrepresentations or falsities in the subject advertisements. Here, Fremont expressly alleges there have been false statements. *See e.g.* FAC ¶¶ 123-131.

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See e.g. FAC ¶¶ 115, 117-120; *see also* ¶¶ 100-188, 261-273. These allegations meet recognized pleading requirements.

United also relies on a series of cases for the proposition that the civil racketeering claims should be dismissed because the Health care Providers "lumped" the United Defendants together. Supplement at 9:18-23.[12] But the cases United relies on involve allegations that are different than those here; there, referring to multiple, unrelated defendants and where the complaints at issue were otherwise wholly deficient, "conclusory, convoluted, vague and generally fail to satisfy the pleading standards under Rule 8(a) or 9(b)." *Doane*, 2012 WL 2129369 at *6. The same is not true here because each defendant is a subsidiary and affiliate of the parent company, defendant UnitedHealth Group, Inc. and the claims are supported by detailed factual allegations as is detailed herein.[13] FAC ¶ 6.

…

…

[12] In *Doane v. First Franklin Financial*, No. 2:11-CV-02130-MCE, 2012 WL 2129369, at *8 (E.D. Cal. June 12, 2012), plaintiff named four unrelated defendants: a mortgage broker, a lender, the nominee beneficiary under the loan and the trustee for the securitization pool that contained the loans pursuant to a pooling and servicing agreement. There, the plaintiff merely listed the elements of the claim and that defendants violated the statute, but "without specifying what, exactly, Defendants did, which Defendants were involved, when the alleged actions occurred or anything else that might satisfy Rule 9(b)'s particularity requirement." *Id.* at *7. Ultimately, the court deemed the issue curable and dismissed the racketeering claim with leave to amend. In *Mai Ngoc Bui v. Lan Bich Nguyen*, No. SACV140757DOCRNBX, 2014 WL 12775081, at *9 (C.D. Cal. Oct. 14, 2014), the plaintiff named a series of individuals that were allegedly part of a scheme. The court dismissed certain individual defendants because the "minimal involvement" of those defendants did not support a plausible inference that those defendants participated in the allege scheme. But the court did not dismiss all defendants based on this argument, contrary to United's implication. Here, there are substantial allegations that detail the scheme and United's involvement. Further, in *Walker-Cook v. Integrated Health Res.*, also cited by United, while the Court did discuss the grouping together of defendants, it determined that dismissal was appropriate in that case because all of the fraud allegations lacked a description of "the time, place and manner of the act, as required by Federal Rule of Civil Procedure 9(b)." *Walker-Cook v. Integrated Health Res., LLC*, No. CV 12-00146 ACK-RLP, 2012 WL 12893272, at *13 (D. Haw. Oct. 3, 2012), judgment entered, No. CV 12-00146 ACK-RLP, 2012 WL 12893885 (D. Haw. Dec. 21, 2012).

[13] In cases similar to the facts alleged here, numerous courts have found that the reference to "defendants" collectively can be utilized where other specific allegations are contained elsewhere in complaint. *Designing Health, Inc. v. Erasmus*, No. CV-98-4758 LGB (CWX, 2000 WL 35789501, at *6 (C.D. Cal. Oct. 31, 2000) (rejecting argument that conspiracy based claims should be dismissed because they referenced "defendants" rather than identifying each individual to allege conspiracy); *Emcore Corp. v. PricewaterhouseCoopers LLP*, 102 F. Supp. 2d 237, 244–45 (D.N.J. 2000) (finding that predicate acts were adequately alleged even where, as defendants argued, "plaintiff failed to attribute specified fraudulent acts to each named defendant, but [] instead [] "lumped them together.")

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3. The Health Care Providers have sufficiently alleged the requisite requirements of the fraud-based civil RICO claims

United claims that the Health Care Providers have failed to sufficiently allege the elements for two fraud-based predicate acts in violation of NRS 205.377 (multiple transactions involving fraud or deceit in course of enterprise or occupation) and for obtaining possession of money or property by false pretenses.[14] Supplement at Section II(B)(2)(i). The Health Care Providers have provided ample allegations to support a claim for violation of NRS 205.377[15] and for obtaining money by false pretenses in violation of NRS 207.360(28).[16] Specifically, in establishing the elements of NRS 205.377, the Health Care Providers have pled that in at least two transactions (*see, e.g., id.* ¶ 115), the Enterprise[17] intended to defraud, engage in an act, practice or course of business or employ a device, scheme or artifice which operates or would operate as a fraud or deceit upon a person by means of a false representation or omission of a material fact (*see, e.g., id.* ¶¶ 177-179, 182, 183); that the Enterprise knows to be false or omitted (*see, e.g.*, ¶¶ 99, 100, 102, 107, 109, 113, 271); upon which United intends the Health Care Providers to rely (*see e.g. id.* ¶¶ 111, 183-185); and which has resulted and continues to result in losses to Fremont the Health Care Providers who relied on the false representations or omissions (*see, e.g., id.* ¶¶ 187-188). And with respect to the claim under NRS 207.360(28), the

[14] Even if true, this does not make the claim subject to dismissal without prejudice because the Health Care Providers could cure any alleged deficiency, just like in *Mendoza*, 2019 WL 4221078, at *6 (D. Nev. Sept. 5, 2019), a case on which United relies. The *Mendoza* court dismissed the civil RICO claim without prejudice, allowing amendment. Therefore, *Mendoza* does not stand for the proposition that the failure to plead the essential elements means that the claim must be dismissed with prejudice as United suggests. Supplement at 7:8-18.

[15] Section 205.377 provides, in part:

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

[16] "False pretense is a representation of some fact or circumstance which is not true and is calculated to mislead, and may consist of any words or actions intended to deceive." *Hale*, 104 Nev. at 636–37, 764 P.2d at 869; NRS 205.380.

[17] As alleged, "Defendants illegally conduct the affairs of the Enterprise, and/or control the Enterprise, that includes Data iSight though a pattern of unlawful activity." FAC ¶ 112.

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Health Care Providers have sufficiently alleged that the Enterprise intended to defraud the Health Care Providers through written false representations (*see, e.g., id.* ¶¶ 126, 177-178), causing the Health Care Providers' reliance thereon (*see, e.g., id.* ¶¶ 111, 183-185). FAC ¶¶ 123-126; *see also* ¶¶ 149-188. Accordingly, the Court can deny the Amended Motion to Dismiss and Supplement.

4. The Health Care Providers have sufficiently pled involuntary servitude under NRS 207.360(36)

The Health Care Providers have pled, the scheme amounts to involuntary servitude under NRS 200.463 because United and Data iSight have orchestrated a manipulation of payment rates that unlawfully withholds money owed to the Health Care Providers for the provision of emergency services to United's Members. In the Supplement, United points to several cases that are not on point.[18] Supplement at 11:17-26. Under NRS 207.360(36), involuntary servitude is defined as:

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

NRS 200.463(1) (emphasis added). The FAC sufficiently pleads such a claim premised on subsections (c) and (f). United has developed and implemented a scheme that forces the Health Care Providers to perform services at arbitrarily deflated payment rates and has threated to abuse the law or legal process by interfering with other contracts, disclaiming it has an obligation to pay a reasonable rate for emergency services and has caused and threatened to

[18] For example, *Bonanza Beverage Co. v. MillerCoors, LLC*, No. 2:18-cv-01445-JAD-GWF, 2018 WL 6729776, at *8 (D. Nev. Dec. 21, 2018) does not involve a civil RICO claim whatsoever and *Crawford v. State*, No. 76918-COA, 2019 WL 3854796, at *3 (Nev. App. Aug. 14, 2019) dealt with specific crimes that involved physical abuse. But the statute is not so limited. *See* NRS 200.463(1)(c), (f). *Zavala v. WalMart Stores Inc.* concerned involuntary servitude by physical coercion. 691 F.3d 527, 540 (3d Cir. 2012). The Court in *Zavala* did not address involuntary servitude by legal coercion and that decision concerned a claim for involuntary servitude under the Thirteenth Amendment of the U.S. Constitution not under NRS 207.360(36). *Id*. The facts of this case are, therefore, readily distinguishable from *Zavala*.

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cause financial harm to the Health Care Providers. *See* FAC ¶¶ 21, 55, 69, 108-109, ¶¶ 90-188.

5. The Health Care Providers have sufficiently alleged the existence of an Enterprise.

Next, United contends that the Health Care Providers have failed to adequately plead the existence of an "enterprise" under NRS 205.377 (multiple transactions involving fraud or deceit in the course of enterprise). Supplement at 12:12. An "enterprise" is defined in NRS 207.380:

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

As a threshold matter, the existence of an enterprise is not required in connection with the alleged violations of NRS 207.400(1)(d), (1)(f) or (1)(i). *See* NRS 207.470. Therefore, this argument can only be applicable to alleged violation of NRS 207.400(1)(a)-(c) and 1(j). Nevertheless, the Health Care Providers have adequately alleged the existence of an enterprise in paragraphs 121 and 122. FAC ¶¶ 121-122. United and third-party entities, including Data iSight have joined together to falsely claim to provide transparent, objective and geographically-adjusted determinations of reimbursement rates; and they illegally conduct the affairs of the Enterprise, and/or control the Enterprise through a pattern of unlawful activity. *Id.* ¶¶ 112, 115, 124.

United also contends that the Enterprise's conduct should be overlooked because it purports to have "an ordinary commercial contractual relationship…through MultiPlan's Data iSight tool." Supplement at 13:19-21. United relies on *Gomez v. Guthy-Renker*, No. EDCV 14–01425 JGB (KKx), 2015 WL 4270042 (C.D. Cal. July 13, 2015) and others for the proposition

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that civil RICO liability must depend on something more than a routine contract.[19] Supplement at 13:5-8. The Health Care Providers have alleged "something more" than a routine contract. FAC ¶ 115. These allegations sufficiently detail the existence of an "enterprise." As alleged, United would not be able to operate its deceptive scheme absent Data iSight's purported functioning as a third-party supplier of transparent, market-based benchmark data. Data iSight is conduit through which United seeks to color its arbitrary, deficient payments with the false appearance of good faith objectivity.

III. CONCLUSION

For all of these reasons, the Health Care Providers respectfully request that the Court deny United's Motion To Dismiss their Nevada state law claims for violation of NRS 207.350 *et seq.*

DATED this 29th day of May, 2020.

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[19] In *Gomez*, the plaintiff's allegations were deficient, with the court finding the "claim begins and ends with the fraud allegedly committed by [one defendant]." *Gomez*, 2015 WL 4270042 at *9. In other words, there were no allegations of fraud of other enterprise participants. Similarly, in *Hilton v. Apple Inc.*, No. CV 13-7674 GAF (AJWx), 2014 WL 12597143, *8 (C.D. Cal. Jan. 9, 2014), the plaintiff did not allege that Apple disclosed its intention to commit fraud to AT&T. The court found that without disclosing this intent, AT&T could not have joined together to commit illegal acts. *Id.* Here, the Health Care Providers have adequately alleged involvement by third-parties including Data iSight. *See e.g.* FAC ¶ 111.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 29th day of May, 2020, I caused a true and correct copy of the foregoing **PLAINTIFFS' OPPOSITION TO DEFENDANTS' SUPPLEMENTAL BRIEF IN SUPPORT OF THEIR MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT ADDRESSING PLAINTIFFS' EIGHTH CLAIM FOR RELIEF** to be served to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

Defendants.

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

DEFENDANTS' REPLY IN SUPPORT OF MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT

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I. INTRODUCTION

Plaintiffs' Opposition asks this Court to disregard settled legal authority in favor of a rule that ERISA does not apply where disputes over health plan benefit claims involve the "rate of payment" rather than the "right to payment." (Opposition at 6:3–5). Further, Plaintiffs posit that, even if their 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 Plaintiffs' claims should be dismissed because they are subject to both conflict preemption and complete preemption

With respect to conflict preemption, which is even broader than complete preemption and was *never* addressed in the federal court's remand order, Plaintiffs' state law causes of action unquestionably directly conflict with—and "relate to"—federal law. ERISA requires that the controlling employee benefit plans issued/administered by Defendants specify the rate of payment and that the plan terms be followed. Because Plaintiffs want claims reimbursed at rates not provided for in the plan terms, they have asserted state law causes of action to try to inappropriately 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, Plaintiffs' causes of action are conflict preempted.

Plaintiffs correctly point 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 certain payment to out-of-network providers. For example, if Plaintiffs had written provider agreements, the Court could simply look at the payment terms in that agreement and determine whether Defendants complied with them. However, a close reading of the First Amended Complaint shows that Plaintiffs admit that they lack a written contract, do not allege that Defendants made any oral rate of payment promises, and do not allege that a Nevada rate of payment statute exists. Thus, the only obligations Defendants owe to Plaintiffs, if any, flow from the coverage terms of the ERISA plans which the Court would have to reference to resolve this

dispute. Nevada courts, as well as courts in the Ninth Circuit, do not allow state law causes of action similar to the ones Plaintiffs are asserting to escape conflict preemption.

With respect to complete preemption, Plaintiffs' proposed "rate of payment" rule is an attempt to distract this Court from the fact that the U.S. Supreme Court's *Davila* test—the *only* test that governs complete preemption—is clearly satisfied for each of the eight state law causes of action that Plaintiffs have asserted. The *Davila* test is satisfied if (1) Plaintiffs have standing to bring a statutory ERISA claim, and (2) Defendants do not owe any legal duties to Plaintiffs to reimburse them at some particular rate, independent of Defendants' legal duties under the ERISA plans. If these elements are met, complete preemption applies even if Plaintiffs are 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.

Here, the first element of *Davila* is met: Plaintiffs received assignments of benefits from Defendants' plan members that allows them to stand in their shoes and bring the same ERISA claims those members could have brought. Contrary to Plaintiffs' contentions, the only question is whether they *could* have brought an ERISA claim, not whether Plaintiffs actually pled such a claim in their First Amended Complaint.

The second element of *Davila*, too, is met: Plaintiffs have failed to allege any facts that give rise to a legal duty independent of ERISA. Plaintiffs, by their own admission, and "[a]t all relevant times, . . . [did not have] a written "network" agreement governing rates of reimbursement" from Defendants. (Opposition at 2:24–27). Plaintiffs attempt to bridge this analytical gap by claiming that an implied-in-fact contract exists, and contend that this implied-in-fact contract gives them a legal right to proceed with their state law claims. (Opposition at 9:25–28). However, support for this theory simply does not exist in fact or law. Upon the facts, Plaintiffs do not allege that a single contract, statute or oral promise exists that requires they be paid at any particular rate, or be paid *at all*, for that matter. But for Defendants' ERISA-based contractual relationship with their insureds, there would be no reason for Plaintiffs to seek *any* amount of payment from Defendants.

Realizing that a thorough analysis of Defendants' complete preemption arguments does

not favor their position, Plaintiffs argue that only federal courts can dismiss claims on this basis. Plaintiffs further contend 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 Plaintiffs' implied-in-fact contract claim was not completely preempted, an Arizona federal court, faced with Plaintiffs' affiliates,[1] the same claims, and the same counsel, expressly rejected Plaintiffs' 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 Plaintiffs' implied-in-fact contract claim and never addressed whether Plaintiffs' other seven state law claims were completely preempted.

Finally, to the extent any of Plaintiffs' claims escape both conflict and complete preemption, they still must be dismissed pursuant to NRCP 12(b)(5) for failure to state a claim. Plaintiffs fail to adequately allege the elements of their common law claims, fail to plead certain claims with the particularity required by NRCP 9(b), and lack standing to bring certain statutory claims. For all of these reasons and those set forth below, Defendants request that the Court dismiss Plaintiffs' state law claims in their entirety and with prejudice. Plaintiffs should be given leave to replead their claims as statutory ERISA claims pursuant to 29 U.S.C. § 1132(a), subject to any defenses Defendants may have to such claims.

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[1] Like the Plaintiffs 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).

II. PLAINTIFFS' 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)). Plaintiffs' claims are subject to conflict preemption as over 90 percent of the services they provided were to patients who had an employee benefit plan governed by ERISA. Thus, because Plaintiffs are seeking additional reimbursement under those plans, their state law claims unquestionably "relate to" employee benefit plans.

Despite the decidedly expansive reach of ERISA, Plaintiffs' Opposition argues that "United's Motion overstates the scope of ERISA conflict preemption." (Opposition at 13:15). While Plaintiffs do not dispute the well-established line of cases setting forth ERISA's broad preemptive force, they instead argue that Defendants "rel[y] on outdated and now-rejected overbroad interpretations" (Opposition at 13:16–17) and offer decades-old cases that, in

Plaintiffs' view, purport to limit the breadth of the statute. As is set forth further below, none of the cases offered by Plaintiffs undermine the conclusion that their claims are conflict preempted.

A. The Cases Plaintiffs Rely on to Support their 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 Plaintiffs rely on, the plaintiff-provider was able to demonstrate that it was suing on a basis that was independent of the ERISA plans and thus the claims did not "relate to" the plans. (Opposition at 9:13–13:14)

First, for example, Plaintiffs look 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 such 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; Plaintiffs admit that they lack 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 Plaintiffs.

Second, Plaintiffs cite 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, Plaintiffs do not allege that Defendants made any oral promises to Plaintiffs regarding reimbursements of medical services for the at-issue claims.

Finally, Plaintiffs look 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 Plaintiffs argue 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 10:1–3), artful pleading cannot disguise that Plaintiffs' claims clearly fall within the categories defined in *Gobeille*. Plaintiffs are, 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.

Plaintiffs contend 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, Plaintiffs offer 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 14:8–10) (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, Plaintiffs cite to *In Re Managed Care Litigation*, an unpublished decision 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, Plaintiffs' allegations are similar to that of the out-of-network providers in *In Re Managed Care*, whose implied contract rate of payment claims were preempted because Plaintiffs received an assignment of benefits and alleges that they lack a written contract with Defendants. First Amended Complaint ("Compl.") at ¶ 20. The *In Re Managed Care* court noted that Plaintiffs' 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 Plaintiffs] 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 Plaintiffs are 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 and plaintiff-providers affiliated with the Plaintiffs here, *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, Plaintiffs cannot demonstrate that they are 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 Plaintiffs anything. Plaintiffs admit that they lack a written contract, lack an oral agreement, and lack a state insurance statute requiring payment to out-of-network providers. The only possible legal bases for Plaintiffs' suit are the patient assignments and the ERISA plan terms that govern Defendants' adjudication of Plaintiffs' benefit claims.[4] Thus all of Plaintiffs' claims are conflict preempted.

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[3] Case currently on appeal.

[4] *See* Compl. at ¶ 64 ("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.").

III. PLAINTIFFS' 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

Plaintiffs argue (Opposition at 16:13–17) 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 Plaintiffs do not support the conclusion that Plaintiffs offer this Court. For example, while dicta drawn from *Owayawa v. Am. United Life Ins. Co.* seems to support Plaintiffs' 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 Plaintiffs' argument. For example, in *Summit Estate, Inc. v. Cigna Healthcare of California, Inc.* involved a federal 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). And, *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, Plaintiffs did not cite to a single state court case; all of Plaintiffs' authority is drawn from federal court cases.

Finally, although Plaintiffs look to the remand order for support here, a federal district court in Arizona, dealing with Plaintiffs' affiliates, nearly identical state law claims and the same Plaintiffs' 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 Plaintiffs "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. Plaintiffs 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 Plaintiffs' 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: Plaintiffs received assignments of benefits from Defendants' plan members that allows them to stand in their shoes and bring the same ERISA claims those members could have brought. Plaintiffs do not contest that Defendants have established that over 90% of Plaintiffs' claims/requests for payment to Defendants were for services provided to members of employee benefit plans governed by ERISA. Plaintiffs also do not contest that, for all of the claims that they are asserting in this litigation, they received an assignment of benefits from the plan member such that Plaintiffs now stand in the shoes of that plan member and may assert a claim for reimbursement. In fact, Plaintiffs' Opposition expressly admits that "some of the claims for reimbursement . . . fall under health plans regulated by ERISA." (Opposition 4:11–13). The plan members' assignments of benefits to Plaintiffs is significant because it means Plaintiffs have standing to bring a claim under ERISA § 502(a)(1)(B), ERISA's civil enforcement statute, and thus the first element of the *Davila* Test is met.

Nevertheless, in an effort to circumvent the first prong of the *Davila* analysis, Plaintiffs argue that the "rate of payment" claims they are asserting do not implicate ERISA plans. (Opposition 6:3–5). However, Plaintiffs' focus on "rate of payment" versus "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 that Plaintiffs cite 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.[5] Each of Plaintiffs' allegedly favorable cases is discussed in turn below.

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.2), 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 Plaintiffs received an assignment of benefits for the claims that they seek to litigate in this suit, and Plaintiffs have not contested that they received an assignment. Thus, there is no question that Plaintiffs stand in the shoes of Defendants' plan members and have standing to bring a statutory ERISA claim. The first element of the *Davila* test is undisputedly met. Under *Davila*, it is irrelevant whether Plaintiffs have in fact asserted a statutory ERISA claim in its Complaint. If Plaintiffs *could* have asserted such a claim due to the assignments of benefits, the first element of the *Davila* Test is met.

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[5] 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.

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.[6] The reason is that the provider agreement creates legal duties independent of the employee ERISA plan. Here, Plaintiffs admit in their First Amended Complaint that they are out-of-network providers and that "[t]here is no written agreement between Defendants and the Health Care Providers for the healthcare claims at issue in this litigation." Compl. at ¶ 20. Thus, this Court should disregard any case law cited by Plaintiffs where a written provider agreement existed as they admit one does not exist here. (Opposition at 18:18–24). The only legal duties owed by Defendants (if any) flow from the rights Plaintiffs have as the assignees of Defendants' plan members. Since those rights are directly based on and related to ERISA-governed plans, Plaintiffs' 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

Plaintiffs attempt to liken their 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 Plaintiffs themselves cite, the only situation where such a claim has not been found to be completely preempted is where a state insurance statute requiring payment to out-of-network providers creates the implied-in-fact contract.[7]

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[6] Plaintiffs' 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).

[7] *See 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

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.[8] Simply put, Plaintiffs lack a Nevada statute that could create a legal duty independent of Plaintiffs' rights as an assignee of the Defendants' plan members. Thus, the *Davila* test is met and all of Plaintiffs' 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 occurred in the *Marin* case that Plaintiffs rely on. *Marin Gen. Hosp. v. Modesto & Empire Traction Co*., 581 F.3d 941, 950–51 (9th Cir. 2009).[9] 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

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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.*, 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.

[8] 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).

[9] Plaintiffs also rely on *E. Coast Advanced Plastic Surgery v. AmeriHealth*, 2018 WL 1226104, at *3 (D.N.J. Mar. 9, 2018), where the plaintiff received pre-authorization prior to performing surgeries, and which oral representations the plaintiff allegedly relied on.

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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*, Plaintiffs' Complaint does not allege that Defendants ever made any oral representations that claims would be reimbursed in a particular way (or at all for that matter). Thus, Plaintiffs' only right to reimbursement (if any) flows from the assignments they received from Defendants' plan members and their 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, Plaintiffs 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 Partnerships, Inc.*, 2004 WL 7320735, at *4 (S.D. Fla. July 1, 2004). The court rejected this "rate of payment" argument, stating:

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> 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*, Plaintiffs cannot "recast" their ERISA reimbursement claim as an implied-in-fact contract claim, unjust enrichment claim or anything else. Plaintiffs received an assignment of benefits for every claim form they submitted to Defendants, and lack 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.[10]

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

The second element of the *Davila* test is also met: Plaintiffs have failed to allege any facts that give rise to a legal duty independent of ERISA. Plaintiffs, by their own admission, and "[a]t all relevant times, . . . [did not have] a written "network" agreement governing rates of reimbursement" from Defendants. (Opposition at 2:24–27; *see also* Compl. at ¶ 20). Plaintiffs further admit that the Health Care Providers are "non-participating" or "out-of-network" providers. *Id.* Plaintiffs attempt to bridge this analytical gap by claiming that an implied-in-fact contract exists, and contends that this implied-in-fact contract gives them a legal right to proceed with their state law claims. (Opposition at 9:25–28).

Plaintiffs fail to cite a single Nevada state insurance statute that requires payment to out-of-network providers. *See generally*, Plaintiffs' Compl. Plaintiffs *do* cite to the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd and NRS 439B.410. Compl. at ¶

[10] This *Misic* case also has nearly identical facts. *Misic v. Bldg. Serv. Employees Health & Welfare Tr.*, 789 F.2d 1374 (9th Cir. 1986). Plaintiffs vaguely argue 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 Plaintiffs allege 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 Plaintiffs.

18. 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.

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

The above admissions and omissions are critical as they demonstrate that there is no legal duty independent of ERISA; thus, element 2 of the *Davila* test is met and complete preemption applies. 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 Plaintiffs offered any case law supporting 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. PLAINTIFFS HAVE FAILED TO STATE VIABLE CLAIMS UNDER NRCP 12(B)(5)

A. Plaintiffs' Implied-in-Fact Contract Claim Should be Dismissed

While Plaintiffs' Opposition disputes that their claims are subject to conflict preemption or complete preemption, Plaintiffs fail entirely to address the case law offered by Defendants regarding Plaintiffs' claim for "Breach of Implied In Fact Contract." Specifically, Plaintiffs failed to offer an argument or authority to dispute that their 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.").

Plaintiffs' Opposition focuses entirely on the incorrect notion that they have properly stated a claim for "Breach of Implied In Fact Contract" under Nevada law. Plaintiffs offer *Nevada Ass'n Servs., Inc. v. First Am. Title Ins. Co.*, for the proposition that "through a course of dealing. . . [parties] can manifest[] an intent to be bound and agreed to material terms of an implied contract." *Nevada Ass'n Servs., Inc. v. First Am. Title Ins. Co.*, 2012 WL 3096706, at *3 (D. Nev. July 30, 2012). But this unpublished decision does not reflect Nevada law; to establish an implied-in-fact contract it is required 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, Plaintiffs argue that payments for some past services constitute a promise by Defendants to pay for all future services. Namely, Plaintiffs point to ¶ 197 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 20:23–21:5; Compl. ¶ 197. What is lacking, however, is any allegation that the Defendants "intended to contract" with Plaintiffs, any allegation that promises were exchanged between the Parties, and any allegation defining the terms of those supposed promises. Plaintiffs' claim consists only of conclusory statements.

The fact that Plaintiffs can only offer this single paragraph to support their claim is telling; the reliance on this allegation evinces that Plaintiffs' claim is based on what "Defendants pa[id] for other substantially identical claims also submitted by the Health Care Providers." In

other words, Plaintiffs' claim is based on consideration from previously submitted claims. Under Nevada law, "[p]ast consideration is the legal equivalent to no consideration." *Smith v. Recrion Corp.*, 91 Nev. 666, 669, 541 P.2d 663, 665 (1975).

Plaintiffs' attempt to distinguish *Recrion* based on the existence of the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd, and NRS 439B.410 is misplaced. To the extent that Plaintiffs 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 Plaintiffs, 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 Plaintiffs at any specific rate for these services.

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

B. Plaintiffs' Claim for Tortious Breach Should be Dismissed

With respect to conflict preemption and complete preemption under ERISA, Plaintiffs have again failed to address the legal authority offered by Defendants demonstrating that their claim for "Tortious Breach" must be dismissed. Because Plaintiffs have 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 Plaintiffs *did* oppose, Defendants agree that *Martin v. Sears, Roebuck and Co.* sets forth the appropriate elements to establish a valid claim for "tortious breach of the implied covenant of good faith and fair dealing" under Nevada law. (Opposition at

22:3–8). Specifically, Plaintiffs must establish: (1) an enforceable contract (2) "a special relationship between the tortfeasor and the tort victim…a relationship of trust and special reliance" and (3) the conduct of the tortfeasor must go beyond the bounds of ordinary liability for breach of contract. *Martin v. Sears, Roebuck and Co.*, 111 Nev. 923, 929, 899 P.2d 551, 555 (1995). While Plaintiffs have correctly articulated the requisite elements, they have still failed to set forth a valid claim.

As to the first element under *Martin*, there must exist a valid contract between Plaintiffs and Defendants to give rise to the implied covenant of good faith and fair dealing. *A.C. Shaw Const., Inc. v. Washoe Cty*., 105 Nev. 913, 914, 784 P.2d 9, 10 (1989). Because Plaintiffs have failed to allege an enforceable implied-in-fact contract, 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).

Plaintiffs nevertheless contend that "a special relationship exists between United and the Health Care Providers," such that Defendants "wield[] a disparate level of power over whether the Health Care Providers get paid for its services." (Opposition at 23:11–12). This is a conclusory allegation that is defeated by the other allegations in the Complaint. Plaintiffs, by their own admission, are a sophisticated "professional practice group of emergency medicine physicians" that run major emergency rooms across the Las Vegas Valley. *See* Compl. at ¶¶ 3–5, 17. Further, no Nevada Court has ever recognized a special relationship between an out-of-network provider and a plan administrator. While Plaintiffs argue that this does not foreclose the recognition of such a relationship, it is nonetheless still true that Nevada law has ***never*** recognized this tort as arising from contracts between sophisticated parties in the commercial

realm, and the Nevada Supreme Court has not signified that it will broaden the tort to cover such circumstances in the future.

Finally, Plaintiffs have failed to set forth that the parties' dynamic amounts to a "special relationship" within the purview of Nevada law. Plaintiffs' Opposition offers *Ins. Co. of the W. v. Gibson Tile Co.* as support for what constitutes a "special relationship" (at 22:8–10), but that 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. Plaintiffs' allegations do not demonstrate "rare and exceptional" circumstances such that they should be allowed to proceed with this claim. Pursuant to Plaintiffs' own cited authority, this claim should be dismissed.

C. Plaintiffs' Claim for Unjust Enrichment Should be Dismissed

Plaintiffs again did not address the case law offered by Defendants which sets forth that Plaintiffs' "unjust enrichment" claim should be dismissed as preempted by ERISA. Because Plaintiffs have not offered any legal authority in opposition, they are 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, Plaintiffs cite to *Topaz Mut. Co. v. Marsh* to support the proposition that a "benefit in [an] unjust enrichment claim can be 'indirect.'" (Opposition at 23:24–26). Defendants do not disagree with this general proposition, but it is irrelevant here, where Defendants did not receive *any* benefit, direct or indirect, from Plaintiffs' 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 Plaintiffs have not provided any services to Defendants, and where there was no indirect

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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 Plaintiffs attempted to distinguish in their Opposition

First, Plaintiffs claim 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 24:12–15). 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." *Adventist 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 24:15).

Plaintiffs next attempt 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 24:17–25:4). This is an aimless argument; the cases still set forth that quasi-contractual causes of action should be dismissed because the benefit of medical treatment flows only to the patient.

While Plaintiffs argue that *Joseph M. Still Burn Centers, Inc. v. AmFed Nat. Ins. Co.*, 702 F. Supp. 2d 1371, 1377 (S.D. Ga. 2010) is distinguishable because "plaintiff was already paid

reimbursement rates set forth in Mississippi's and Georgia's workers' compensation fee schedules," this is similar to the case at bar where Plaintiffs were likewise already reimbursed. And while Plaintiffs argue that the court in *Cedars Sinai Med. Ctr. v. Mid-W. Nat. Life Ins. Co.*, 118 F. Supp. 2d 1002, 1013 (C.D. Cal. 2000) supposedly issued an inconsistent ruling in a later case, Plaintiffs did not provide a complete 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), Plaintiffs incorrectly claim 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 25:4–6). While this was an argument by one of the *parties*, the *Travelers* court never actually signaled that it was adopting that 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.

Plaintiffs next cite to a number of cases for the proposition that insurers receive benefits in the form of having their obligations to plan members discharged. (Opposition at 24:20–28). However, the cases cited by Plaintiffs are inapposite. *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 to follow Plaintiffs' 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, Plaintiffs have failed to establish the second element to support their cause of action: that Defendants have appreciated any purported benefit. Absent a tangible benefit to Defendants, direct or indirect, Plaintiffs' unjust enrichment claim must be dismissed.

D. Plaintiffs' Unfair Trade Practices Claim Should be Dismissed

Here again, Plaintiffs did not offer authority in opposition to Defendants' position that the "Unfair Trade Practices" cause of action is preempted under ERISA. Specifically, Plaintiffs failed to offer any argument or authority to dispute that their 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. . . .").

Plaintiffs, however, argue that "the absence of a contract between Gunny and the insurer makes this case distinguishable." (Opposition at 25:27–28). Plaintiffs agree that *Gunny* holds that third party claimants lack standing to bring this claim absent a direct contractual relationship with the insurer. However, Plaintiffs seek to use their implied-in-fact contract allegation to supply the needed contract and, as discussed at length at IV.A., Plaintiffs' implied-in-fact

contract claim fails. Further, Plaintiffs do not offer any opposition to *Tweet v. Webster,* 614 F. Supp. 1190 (D. Nev. 1985) or *Crystal Bay Gen. Imp. Dist. v. Aetna Cas. & Sur. Co*., 713 F. Supp. 1371 (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). Plaintiffs are nothing more than "third party claimants" with no contractual relationship with Defendants. Therefore, this claim should be dismissed.

E. Plaintiffs' Claim for Violation of Nevada's Prompt Pay Statutes Should be Dismissed

Plaintiffs claim that "United did not challenge the Health Care Providers' claim for violation of Nevada's prompt pay statutes under Rule 12(b)(5)," (Opposition at 26:16–18), but this is wholly incorrect. Defendants provided ample authorities showing that Plaintiffs' 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 of benefits.). Plaintiffs did not offer any argument or authority in opposition, and their claim for violation of Nevada's prompt pay statutes should be dismissed as preempted by ERISA.

F. Plaintiffs' Deceptive Trade Practices Claim Should be Dismissed

Plaintiffs' Opposition again fails to address the fact that the claim at issue here is subject to conflict preemption and complete preemption under ERISA. *See Pachuta v. Unumprovident Corp*., 242 F. Supp. 2d 752, 764 (D. Haw. 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, Plaintiffs' 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 Plaintiffs' Opposition points to ¶ 246 of its First Amended Complaint, that paragraph fails entirely to meet the criteria specified above. Plaintiffs have failed to set forth the time, place, or specific content of *any* false representations by the Defendants. Further, where Plaintiffs point to ¶¶ 25, 57, and 65 of their First Amended 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.[11]

[11] Plaintiffs, at 29:12–20, accuse Defendants of a violating the stipulation on briefing of this matter by arguing in the opening brief that "while Plaintiffs have alleged that *non-party* Data iSight made various false representations (Compl. at ¶¶ 128-188), the Complaint improperly lumps all the Defendants in with Data iSight by simply alleging they conspired together as part of a fraudulent 'enterprise.'" Plaintiffs argue that these allegations were only related to the Health Care Providers' Nevada RICO claim and thus should have been addressed in the Supplemental Brief rather than this brief. However, the statute Plaintiffs rely on that prohibits fraudulent acts by "enterprises" declares that "A violation of this section constitutes a deceptive trade practice." NRS 205.377(5). Accordingly, the allegations at §§ 128-188 of the

Finally, Plaintiffs do 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, Plaintiffs only contend that they still qualify as a victim under these holdings. (Opposition at 30:11–14). Plaintiffs' position is nonsensical, however, because Plaintiffs voluntarily participated in the negotiations and business interactions that led to their alleged harms.

In sum, the cause of action for Deceptive Trade Practices fails because (1) Plaintiffs are not "victims" within the meaning of NRS 41.600 and therefore lack standing, and (2) Plaintiffs have not pled this claim with particularity. This claim must be dismissed under Nevada law.

G. Plaintiffs' Claim for Declaratory Relief Should be Dismissed

Defendants provided ample case law supporting that Plaintiffs' 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"). Plaintiffs did not offer any argument or authority in opposition, and their claim for declaratory relief should be dismissed as it is preempted.

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First Amended Complaint could be viewed as applying to Plaintiffs' Deceptive Trade Practices claim as well as their RICO claim and it was not inappropriate to address these allegations in this brief.

V. CONCLUSION

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

Dated this 3rd day of June, 2020.

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CERTIFICATE OF SERVICE

I hereby certify that on the 3rd day of June, 2020, a true and correct copy of the foregoing **DEFENDANTS' REPLY IN SUPPORT OF MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT** was electronically filed/served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

Defendants.

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

DEFENDANTS' REPLY IN SUPPORT OF THEIR SUPPLEMENTAL BRIEF IN SUPPORT OF THEIR MOTION TO DISMISS PLAINTIFF'S FIRST AMENDED COMPLAINT

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I. INTRODUCTION

Plaintiffs' Opposition fails to address the core argument in Defendants' Supplemental brief: how can Defendants' alleged fraudulent manipulation of reimbursement rates be the proximate cause of Plaintiffs' damages when Plaintiffs admit that state and federal law required them to treat Defendants' plan members regardless of what representations Defendants may have made about reimbursement? To answer that critical question, the Court only needs to refer to Plaintiffs' admission in paragraph 21 of their Complaint that alleged that they would have treated Defendants' plan members *even if* Defendants had not allegedly misrepresented how rates of reimbursement would be calculated because such treatment was required by law. Thus, by Plaintiffs' own admission, Plaintiffs' have failed to plead causation and their RICO claim fails for this reason alone.

Even if Plaintiffs could overcome this fatal causation problem, Plaintiffs' RICO claim is doomed because Plaintiffs have not—and cannot—adequately allege predicate RICO crimes. Indeed, Plaintiffs' own factual allegations contradict the existence of the exact RICO predicate crimes they seek to plead. First, two of the RICO predicate crimes that Plaintiffs attempt to allege, NRS 207.360(28) (obtaining money by false pretenses) and NRS 207.360(35) (transaction involving fraud or deceit) require *reliance* by the plaintiff on a false statement and "*intent to deceive*." Plaintiffs have failed to plead these essential elements with particularity under NRCP 9(b). Nor could Plaintiffs do so within the bounds of NRCP 11 because Plaintiffs admit that (1) they were going to render treatment to Defendants' plan members regardless of what Defendants said or promised since Plaintiffs were required to provide treatment by law—defeating any allegation of reliance, and (2) that Defendants provided advance notice to Plaintiffs that their out-of-network payment rates were expected to drop—defeating any intent to deceive. Second, Plaintiffs have not adequately pleaded their third attempt at a RICO predicate crime, "involuntary servitude" under NRS 207.360(36). Crimes of involuntary servitude have been construed to involve physical abuse or compulsory labor. Tellingly, Plaintiffs do not cite a single case supporting a claim of involuntary servitude under circumstances akin to those Plaintiffs' allege here.

Plaintiffs' RICO claim should also be dismissed because it is preempted by ERISA. Reimbursement of medical services are dictated by the terms of Defendants' members' ERISA-governed health plans. Plaintiffs' state-law RICO claim attempts to sidestep ERISA's exclusive statutory scheme, which was intended to comprehensively and uniformly regulate employer-provided health benefits. Plaintiffs' RICO claim should be dismissed in its entirety and with prejudice.

II. LEGAL ARGUMENT

A. The Opposition Fails to Address Defendants' Core Argument—that Plaintiffs Cannot Plead Proximate Cause

Plaintiffs admit that they were required by state and federal law to treat Defendants' plan members regardless of "insurance status or ability to pay." Compl. at ¶ 21. Thus, it is impossible for Defendants' alleged misrepresentations about the rate of reimbursement to have been the proximate cause of Plaintiffs' damages. Plaintiffs admit they would have provided emergency medical services to Defendants' plan members even absent the Defendants' misrepresentations. *Id.*

In opposition, Plaintiffs try to circumvent this glaring problem by citing to *Holmes, Takeda,* and *Mendoza* to argue that, because Plaintiffs' allegations allegedly meet the three factor *Holmes* test for proximate cause, Plaintiffs do not need to allege that Defendants' misrepresentations were the "but for" cause of Plaintiffs' injuries. Opposition at pp. 7-8. This is an incorrect statement of the law, as a court should not consider the three-factor causation test set forth by the U.S. Supreme Court in *Holmes* unless it first determines that a RICO plaintiff has adequately alleged that the predicate RICO crimes are the "but for" cause of the plaintiff's injuries. *Holmes v. Sec. Inv"r Prot. Corp.*, 503 U.S. 258, 269 (1992) (holding that even if a plaintiff had adequately alleged the "but for" element of causation, it would still have to satisfy the separate three-factor causation test to determine whether the connection between the predicate crime and the harm to plaintiff was too attenuated to permit a recovery); *Painters & Allied Trades Dist. Council 82 Health Care Fund v. Takeda Pharm. Co. Ltd.*, 943 F.3d 1243, 1248, n.6 (9th Cir. 2019) (stating that the court would only address the three factor *Holmes* test

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because the defendant had not challenged the "but for" causation element of the civil RICO claim); *Mendoza v. Zirkle Fruit Co.*, 301 F.3d 1163, 1171 (9th Cir. 2002) (only addressing three-factor test because the plaintiff had adequately alleged "but for" causation).

Here, the Court does not need to reach the three-factor *Holmes* test since Plaintiffs have failed to allege "but for" causation. Again, the Plaintiffs admit in their Complaint, and their Opposition does not dispute, that they were legally obligated to provide emergency medical services regardless of the promises Defendants and Data iSight allegedly made regarding how the amount of reimbursement would be calculated. Compl. at ¶ 21. Notwithstanding the fact that the *Holmes* test has no application here, Plaintiffs cannot satisfy the *Holmes* test. The first factor of the test, "whether plaintiff would have difficulty showing its damages flowed from defendant conduct" (Opposition at 7:24-25), is not met because Plaintiffs admit that their damages flow from the state and federal laws that require Plaintiffs to provide emergency medical services even if they will not be compensated for those services—not from Defendants' alleged misrepresentations about the rate of reimbursement. Thus, whether this Court looks at "but for" causation or the three-factor *Holmes* test, Plaintiffs have failed to adequately allege causation.

Plaintiffs then seek to escape this result by citing to *Yamaha Motor* for the proposition that proximate cause is a factual issue that should not be addressed at the motion to dismiss stage. *Yamaha Motor Co., U.S.A. v. Arnoult*, 114 Nev. 233, 238, 955 P.2d 661, 665 (1998). However, *Yamaha* is inapplicable, as it was a personal injury case dealing with negligence and strict liability claims. *Id.* The Nevada Supreme Court has expressly held that a district court *can* dismiss a Nevada RICO claim at the pleading stage for failure to adequately plead proximate cause. *See Allum v. Valley Bank of Nevada*, 109 Nev. 280, 286, 849 P.2d 297, 301 (1993) (affirming the district court's granting of a motion to dismiss a Nevada RICO claim because the plaintiff had failed to plead proximate cause and stating: "his loss of income was not proximately caused by the predicate act. Accordingly, Allum does not have a cause of action under Nevada RICO."). Thus, it is procedurally proper to dismiss a Nevada RICO claim at the pleading stage, if the plaintiff has failed to adequately plead proximate cause like Plaintiffs here.

B. Plaintiffs Fail To Allege the Elements of Reliance and Intent to Deceive For the Two Fraud Based RICO Predicate Crimes

Plaintiffs do not dispute that to adequately allege a predicate RICO crime under NRS 207.360(28) (obtaining money by false pretenses) or NRS 207.360(35) (transaction involving fraud or deceit) a complaint must allege *reliance* by the plaintiff on the false statement. *See* Supplement at 7:2-18. But just as with the proximate cause issue, Plaintiffs' Opposition never engages with Defendants' argument that, because Plaintiffs have admitted in their Complaint that they were required by law to provide emergency medical services, Plaintiffs have by definition failed to allege that they relied to their detriment on Defendants' alleged false representations about how the rate of reimbursement would be calculated. Rather than addressing this issue, Plaintiffs simply cite to a plethora of allegations in the Complaint that say nothing about whether or how the Plaintiffs *relied* on the alleged false representations by the Defendants and Data iSight. Opposition at 12:9-28 -13:1-5. The inescapable fact is that it is not possible for Plaintiffs to have relied on Defendants' alleged false representations because Plaintiffs were going to render treatment to Defendants' plan members regardless of what Defendants said or promised since Plaintiffs were required to provide treatment by law.

Plaintiffs also fail to address Defendants' argument that they have failed to plead "intent to deceive." *See* Supplement at 7:27-28 – 8:1-8. Plaintiffs admit that Defendants provided advance notice to Plaintiffs that their out-of-network payment rates were expected to drop which defeats any suggestion of deception. Compl. at ¶¶ 93-97, 104-106. Because Plaintiffs have failed to plead the required elements of "reliance" and "intent to deceive," they have failed to properly allege two predicate RICO crimes and the RICO claim as whole must fall.

C. For the Two Fraud Based RICO Predicate Crimes, Plaintiffs Fail to Meet NRCP 9(b)'s Particularity Requirement Because They Have Lumped All Eight Defendants Together

Plaintiffs admit to "lumping" the eight Defendants together and to not differentiating the fraud allegations against each Defendant. Opposition at 11:3-11. However, Plaintiffs argue that such improper pleading is permissible where the defendants are affiliates or subsidiaries of each other rather than unrelated entities. For this proposition, Plaintiffs cite to the *Erasmus* and

Emcore Corp. cases out of California and New Jersey. Neither case supports Plaintiffs' argument. In *Erasmus*, which Plaintiffs grossly mischaracterize, the court denied a motion to dismiss a civil conspiracy claim because "Plaintiffs refer [in the complaint] to the statements made and the contracts formed by each of the Defendants . . . [and] Below each claim, Plaintiffs name the Defendant(s) against whom the claim is brought and identify the Defendant(s) individually in the allegations." *Designing Health, Inc. v. Erasmus*, No. CV-98-4758 (LGB)(CWX), 2000 WL 35789501, at *6 (C.D. Cal. Oct. 31, 2000). Thus, rather than condoning the practice of lumping defendants together, *Erasmus* found that no lumping had occurred because each of the defendants' roles in the conspiracy was pled with particularity, as were the false statements made by each defendant. *Id.* Similarly, the *Emcore Corp*. case did not condone failing to plead fraud allegations with particularity when defendants are affiliated, but rather held that the plaintiff had included particularized allegations against nine accountants at the same firm and thus had not engaged in lumping. *Emcore Corp. v. PricewaterhouseCoopers LLP*, 102 F. Supp. 2d 237, 247 (D.N.J. 2000).

Here, Plaintiffs have not included particularized allegations against any Defendant other than UnitedHealth Group, Inc.[1] and it is unclear why allegations related to that entity should be allowed to be attributed to the other seven defendants. Compl. at ¶¶ 97-98 (acknowledging that Mr. Schumacher only works for one Defendant but attributing his statements to all eight Defendants); *see also id.* at ¶ 106. Where are the allegations in the Complaint describing UnitedHealthcare Insurance Company's role in the RICO enterprise and how it has violated RICO? Where are the allegations regarding UMR, Inc., Oxford Health Plans, Inc. and Health Plan of Nevada, Inc., etc.? Plaintiffs have not alleged that the eight Defendants are alter egos of each other who fail to observe the appropriate corporate formalities. These are distinct corporate entities and Plaintiffs' failure to plead the RICO claims against them with particularity is fatal.

[1] Moreover, rather than supporting Plaintiffs' RICO theory, the statement attributed to UnitedHealth Group, Inc. via Mr. Schumacher actually undermines the claim. Mr. Schumacher allegedly advised the Plaintiffs that significant cuts were coming and this statement then came true. Compl. at ¶¶ 102-106. Thus, it is also unclear how a RICO claim for fraud and deceit can be asserted against UnitedHealth Group, Inc. either.

D. Plaintiffs' Lumping of the Eight Defendants Together is Also Fatal to Their "Enterprise" Allegation

Plaintiffs argue that paragraphs 121-122 of the Complaint adequately allege the existence of an enterprise under NRS 207.380. However, these paragraphs engage in the same type of prohibited "lumping" that was described above. Plaintiffs accuse all eight Defendants of working with Data iSight to "manipulate reimbursement rates" (Compl. at ¶ 122), but there is no explanation of the individual Defendants' roles in this alleged fraudulent enterprise. Moreover, while the Plaintiffs do allege a contractual relationship between at least some of the Defendants and Data iSight, they also fail to adequately differentiate their allegations on this point. Which Defendants allegedly have contract(s) with Data iSight that make them part of the alleged fraudulent enterprise? Plaintiffs' vague enterprise allegations do not satisfy NRCP 9(b) and constitute another instance of impermissible pleading in a collective and vague fashion.

E. Plaintiffs Cannot Allege the Predicate Crime of Involuntary Servitude

Plaintiffs argue that the predicate crime of involuntary servitude is not limited to instances of physical coercion but can also include legal coercion. Opposition at p. 13. However, even accepting this proposition as true, it was not Defendants' alleged misrepresentations that legally coerced the Plaintiffs into providing emergency medical services. Rather, Plaintiffs admit that it was state and federal law that legally forced them to provide emergency medical services to Defendants' plan members. Compl. at ¶ 21. To the extent Plaintiffs have been forced into involuntary servitude such actions are mandated by state and federal law, not Defendants.

Defendants' moving brief also argued that Plaintiffs lack standing to assert an involuntary servitude claim because the victims would be the doctors pressed into service rather than the Plaintiffs themselves, and the Plaintiffs have not alleged they possess an assignment of the doctors' claims. *See* Supplement at 12:6-11. Plaintiffs' Opposition fails to address this argument, which should be construed as an admission that Plaintiffs lack standing to bring this claim.

F. Plaintiffs' RICO Claim is Subject to Conflict Preemption and Complete Preemption

Plaintiffs argue that ERISA preemption should not apply here because the Court will not need to reference or consult the employee benefit plans to determine whether Defendants violated RICO by "deflat[ing] reimbursement rates." Opposition at 4:26-27. This is incorrect. As with Plaintiffs' other seven state law claims, one of the defenses will be that Plaintiffs are not owed any additional reimbursement as the Defendants have already paid Plaintiffs what they are owed pursuant to the payment terms in the applicable employee benefit plans. Clearly, Defendants cannot be guilty of fraudulently manipulating reimbursement rates if all they did was pay Plaintiffs pursuant to the terms of the controlling ERISA-governed plans. To assess the validity of such a defense, the Court and/or jury will unquestionably have to review the ERISA plans themselves. Thus, this RICO claim will require "reference to" ERISA plans and is preempted.

Plaintiffs also argue that certain cases cited by Defendants are inapplicable because they discuss preemption of RICO claims by federal laws other than ERISA. While there certainly are differences between these laws and ERISA, each of the cases cited involved laws that, like ERISA, established a legislative scheme that was intended to comprehensively and uniformly regulate a particular area of the law by providing an exclusive statutory remedy(ies). *See e.g.*, *Bridges v. Blue Cross & Blue Shield Ass'n*, 935 F. Supp. 37, 40 (D.D.C. 1996) (rejecting an argument that case law discussing preemption of RICO claims by federal statutes other than FEHBA was inapplicable because "Although the governing statute in this case is different, the underlying principles are the same, and the claims cannot stand."). And, contrary to Plaintiffs' argument, their state-law RICO claim is conflict preempted under the Supreme Court's decision in *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 941 (2016). Opposition at 4:18-23. Plaintiffs' RICO claim—which effectively seeks higher reimbursement than Defendants contend must be paid under the members' health plans—would interrupt a central matter of plan administration, namely the plans' payment methodology for out-of-network benefit claims, and interfere with nationally uniform plan administration, by potentially forcing ERISA-governed

health plans to issue reimbursements differently in Nevada than they do in other states.[2] Thus, Plaintiffs' RICO claim fits squarely under the second category in *Gobielle* and is preempted.[3]

Further in each of the cases cited by Defendants, courts rejected attempts by plaintiffs get around the exclusive statutory remedies provided by Congress through use of artfully pled RICO claims. Supplement at 3:6-13. The result should be no different here. Congress has provided an exclusive statutory remedy to recover against an insurer/plan administrator if it is underpaid for its medical services—a federal claim under 29 U.S.C. § 1132(a)(1)B) of ERISA. Plaintiffs' RICO claim is an artful attempt to plead around this exclusive remedy and should be found to be subject to both complete preemption and conflict preemption.

III. CONCLUSION[4]

For all the above reasons, Defendants request that this Court dismiss Plaintiffs' RICO claim with prejudice.

Dated this 3rd day of June, 2020.

/s/ Colby L. Balkenbush
D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn, Esq.
Attorneys for Defendants

[2] Notably, in holding that a Vermont statute was preempted, the Supreme Court did not "limit" the expansive nature of § 514(a). To the contrary, the "two categories" of preempted state laws mentioned in Plaintiffs' Opposition were based on "the [Supreme] Court's case law ***to date***," recognizing that there may be other categories, and that "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." *Gobeille*, 136 S. Ct. at 943 (2016) (emphasis added).

[3] Plaintiffs argue that *Moorman* is not analogous to the present matter because the RICO claim in this case "do not concern a denial of benefits whatsoever." Opposition at 4:16-17. *Moorman* is factually similar: the court analyzed a state law RICO claim that, at its core, challenged conduct relating to a denial of benefits under an ERISA-governed health plan—challenging, like Plaintiffs' here, what should be reimbursed and covered. *Moorman v. UnumProvident Corp.*, No. CIV.A. 104CV2075BBM, 2007 WL 4984162, at *3 (N.D. Ga. Oct. 30, 2007). And, the *Moorman* court noted that although "Plaintiff's allegation that Defendants' fraud 'goes far beyond' refusal to pay benefits does not change the fact that the conduct Plaintiff complains of 'is intertwined with the refusal to pay benefits.'" *Id*. (quoting *Garren v. John Hancock Mut. Life Ins. Co.*, 114 F.3d 186, 188 (11th Cir. 1997)). So, too, here—Plaintiffs are demanding payment of additional benefits under controlling ERISA-governed plans.

[4] The Parties' previously stipulated to allow 13 pages for the Supplemental Brief, 13 pages for the Opposition Brief, and 7 pages for Defendants' Reply. Defendants' Supplemental Brief abided by this stipulation and did not exceed 13 pages but Plaintiffs' Opposition was over 14 pages long. Thus, Defendants have added an additional page to this Reply to address the extra argument by Plaintiffs.

CERTIFICATE OF SERVICE

I hereby certify that on the 3rd day of June, 2020, a true and correct copy of the foregoing **DEFENDANTS' REPLY IN SUPPORT OF THEIR SUPPLEMENTAL BRIEF IN SUPPORT OF THEIR MOTION TO DISMISS PLAINTIFF'S FIRST AMENDED COMPLAINT** was electronically filed/served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., Plaintiff,	)	CASE NO. A-19-792978-B
vs.	)	DEPT. NO. XXVII
UNITED HEALTHCARE INSURANCE COMPANY, ET AL., Defendants.	)	**Transcript of Proceedings**

BEFORE THE HONORABLE NANCY ALLF, DISTRICT COURT JUDGE

ALL PENDING MOTIONS

FRIDAY, JUNE 5, 2020

APPEARANCES:

For the Plaintiff:	PATRICIA K. LUNDVALL, ESQ. AMANDA PERACH, ESQ. KRISTEN T. GALLAGHER, ESQ. (All Via Video Conference)
For the Defendants:	D. LEE ROBERTS, JR., ESQ. COLBY L. BALKENBUSH, ESQ. (All Via Video Conference)
RECORDED BY:	BRYNN WHITE, DISTRICT COURT
TRANSCRIBED BY:	KRISTEN LUNKWITZ

Proceedings recorded by audio-visual recording; transcript produced by transcription service.

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FRIDAY, JUNE 5, 2020 AT 1:01 P.M.

THE COURT: Okay. This is the Judge. I'm calling the case of *Paris Las Vegas* -- ah, sorry. That was done. I'm on the wrong screen. *Fremont Emergency versus United HealthCare*, A792978. Appearances, first starting with the plaintiffs.

MS. LUNDVALL: Good afternoon, Your Honor. This is Pat Lundvall from McDonald Carano here on behalf of the plaintiffs who we refer to as the Healthcare Providers.

THE COURT: Thank you.

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

THE COURT: Thank you.

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

THE COURT: Thank you.

MR. ROBERTS: Sorry about that. I had you on mute. Good afternoon, Your Honor. Lee Roberts on behalf of the defendants, who I'll refer to as United.

THE COURT: Thank you all. And is there anyone with you, Mr. Roberts?

MR. ROBERTS: Yes.

MR. BALKENBUSH: Yes. Good afternoon, Your Honor.

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Colby Balkenbush also appearing on behalf of the defendants.

THE COURT: Thank you all.

All right. So, this is a continued hearing. I am in the courtroom today. I don't have a screen -- a camera on my computer. So I look straight at you, but I have all of you on the screen next to me. So, when you're arguing, I'm going to be looking at you. I'm not looking away. So, please understand that. I ask everyone to keep yourself muted except for when it's your turn to talk and we'll -- because we've had preliminary arguments. I've reviewed everything. We have an hour set aside for this hearing, but I don't want you to feel that you haven't been heard. If you need more time, we'll find a way to do that.

All right. So, let's take first the Motion to Dismiss and all parts of it, please, Mr. Roberts.

MR. ROBERTS: Thank you, Your Honor. And with the Court's permission, I would request that we be able to split the argument in the same way that we've split the briefing. I will handle the Motion to Dismiss that was previously before the Court and Mr. Balkenbush is prepared to address the Motion to Dismiss the RICO claims, which are the subject of the supplemental briefing.

THE COURT: That's fine.

MR. ROBERTS: Thank you, Your Honor.

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The first issue that I'd like to point out, and I know that we have done extensive briefing and the Court has reviewed it, so I'm not going to review everything, but I would like to highlight what we believe is a compelling argument for a complete preemption. The tenants for complete preemption is the *Davila* test. The first element of that test is that plaintiffs have standing to bring a statutory ERISA claim due to the assignments of benefits they received from defendants' plan members. And although that is not apparent from the face of the Complaint, we have attached documents which demonstrate for the Court the percentage of claims against each one of the individual defendants which is being pursued or which they would have the right to pursue pursuant to an assignment of benefits received from our --

THE COURT: Excuse me --

MR. ROBERTS: -- planned members.

THE COURT: Excuse me. We're getting a lot of feedback. There's someone who does not have themselves on mute. I'm going to ask you, Mr. Roberts to go back a couple of sentences because I had a hard time following with the background noise.

MR. ROBERTS: Sure.

According to my screen, Amanda, -- oh, okay. Thank you.

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So, going back, I was just discussing the *Davila* test for complete preemption and whether it's met here. The first question -- the first part of the test is that the plaintiffs have standing to bring a statutory ERISA claim due to an assignment of benefits they receive from the defendants' plan members.

Although that is not apparent from the face of the Complaint, as noted in our briefing, the Court can rely on evidence outside the four corners of the Complaint presented by defendants in order to determine whether or not that part of the test is met and that is to prevent a plaintiff through artful pleading to avoid ERISA preemption. And we have set forth in our Motion to Dismiss the specific percentages of the claims which we believe we have demonstrated they have received assignments of benefits and have standing to pursue ERISA claims, if they chose to do so. The second part of the test is that there's no legal obligation owed by defendants other than those created by the ERISA benefits plans. And really, Your Honor, that is the crux of the issue before you.

The plaintiffs claim that this part of the test is not met because they have independent claims arising under state law. They have also cited a number of cases to the Court where they have argued a right to payment versus amount of payment argument. The -- and, Your Honor, the

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Federal Court, in remanding these, did appear to accept some of that argument that was being made by the defendants. This Court is not bound by those findings, first because the Federal Court was relying on a strong presumption against removal and, also, because we had no right of appeal from the Order of Remand.

Interestingly, after the Court remanded this case from the District of Nevada to your Court, very similar claims brought by another subsidiary of Keen Health Holdings, and, in fact, represented by some of the same counsel that are in this litigation, was actually dismissed based upon complete preemption under almost identical facts. And the Arizona Court took a hard look at this right to payment versus amount of payment. And we have cited the Court to the Westlaw citation for that District Court of Arizona opinion at Footnote 2 of our Reply brief.

Essentially, what the Court in Arizona accepted is the same argument that we're making in our briefing before you today, Your Honor. And that is that the whole right of payment versus amount of payment is a superficial analysis of several decisions which have been misconstrued by the plaintiffs in this matter. In every single case where the Court found that claims were not preempted because the dispute was not about a right of payment, but it was about a rate of payment, in every one of those cases there was an

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independent duty to pay outside of an ERISA plan. And we've extensively talked about those cases, Your Honor, but they fall into several categories. One is that there -- in some of the cases, there was a state statute requiring payment to out of network providers. Nevada has no similar statute. In other cases, there was an express oral promise of some sort made. Not an implied promise, but an express promise to pay, creating a legal obligation outside of the ERISA obligation.

There are no cases that have been cited to you and none that we can find where a rate of payment versus right of payment was used to find a complete preemption did not apply where there was no independent argument that a duty to pay was owed outside of the ERISA plan.

In this case, based on the allegations of the Complaint and the attachments that we have made to our Motion to Dismiss, the Court can determine that there simply is no basis for payment, no basis for a claim of payment, other than the fact that they treated someone who held a policy issued by the defendants. In this case, because they treated our policy members with no agreement that we would pay a particular rate, their only right to reimbursement from us is that which they have taken based on an assignment of benefits received from our plan members. Think about that, Your Honor. If these

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individuals did not hold a health plan issued by one of the defendants, there would be no claim for payment, express or implied. There's no allegation in the Complaint that anyone promised to pay for this treatment.

The only thing that is alleged is some sort of implied contract arising out of the fact that United had reimbursed these plaintiffs in the past for treating its plan members. We've cited the *Recrion* case to the Court, 91 Nevada 666 at page 669, and although not directly on point, the principles there do apply. What that Court said that -- if someone performs unsolicited services for the benefit of someone else and then seeks an agreement to be paid for those services, the past consideration is no consideration at all.

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So, in order for an implied contract to exist under Nevada law, there had to be an intent to contract and some sort of consideration or exchange of mutual agreements before the services were provided. And, in this case, they cannot allege anything and had not alleged anything in that regard. There is simply no promise to pay before the services were provided.

It's not extensively briefed by the plaintiffs, Your Honor, but I'm sure this Court has dealt with course of dealing, and custom and practice, and cases arising out of that legal theory. And, primarily, the course of

dealing deals with the waiver of conditions [indiscernible] in a written contract. But a course of dealing cannot create a duty which does not exist outside the course of dealing.

And, even more importantly, Your Honor, assuming that you could have implied contract to pay, based on the fact United had paid some rate for treatment of its people under plans, that alone is not enough. In a course of dealing case, you have to have reliance on the past course of dealing in order to create the obligation to pay based on that course of dealing. And the plaintiffs have not and cannot allege any reliance on past course of dealing which they relied upon to their detriment in deciding to treat our plan members on these claims. And the reason is simple and it's a reason that's set forth expressly in the Complaint and that is for every single person that they're now seeking to recover payment, largely due to assignments from plans, they had an obligation to treat those patients, regardless of any course of dealing. They were obligated under the law to provide payment -- I mean, to provide treatment and the law provides no duty for a plan issuer, such as the defendants, to pay.

So, they couldn't have said -- let's just assume that they're right. There's a past course of dealing. What does the law require in order for you to get out of a

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past course of dealing and not have it apply to future treatment? What someone could do is say: I know I paid you in the past, even though you haven't submitted a written notice within seven days under the contract, but I am going to enforce the contract from here on. Or: I'm not going to pay you without a written contract from now on. And, then, the person would have the right to say: Well, now that I know I'm not going to get paid without a written contract, I'm not going to treat. But, in this case, they had no choice. Even if we had provided a notice such as that, they still would have had to treat. So, they cannot establish detrimental reliance on any past course of dealing.

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Ultimately, the state law claims are simply a way to artfully plead around the fact that the only reason United had a duty to pay on any of these claims was the existence of the health plan, most of which are ERISA plans. And, because of that, the authority that we've cited to the Court applies. The exceptions found by other courts where there was an independent duty to pay simply have not been plead and do not apply here. This case is exactly on four corners with the case that was dismissed by the District Court in Arizona after actually reaching the merits of the same arguments that have been raised here to this Court.

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There's one other decision, which I'd like the Court to take a hard look at, and that is a decision out of Florida and it's at page 16 of 30 of our Reply briefs: *Torrent & Ramos v. Neighborhood Health Partnerships*. In that case, very similar to this case, there was no independent duty. There was no promise to pay. There was no state law requirement to pay. And the plaintiffs were seeking to make this same rate of payment argument and claiming implied in fact contract, unjust enrichment claims, and things like that.

What the Court said at Westlaw page 4 is: This is simply a suit for benefits under an ERISA plan where a provider rendered certain emergency services to an ERISA plan member, submitted claims forms to the various ERISA plans, and failed to receive the payment it expected. Pathologist's attempt to recast its claims, one of implied contract, does not change this reality. You cannot artfully plead around ERISA complete preemption.

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And because they cannot point to any legal duty to pay, independent of ERISA, the second element of the duty test is met, that is that there is no duty independent of ERISA which would allow them to pursue non-ERISA claims outside of complete preemption.

If they had called a plan administrator when one

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of these patients arrived seeking emergency treatment and said: Hey, I've got your plan member here, he's not on our -- on a plan that's on our network. He's an out of network. Will you agree to pay 90 percent of billed charges? And if we had said yes, then there would be a reason why we owed more than the ERISA plan requires, but nothing like that happened here as alleged.

Therefore, the only way this Court is going to be able to determine what the appropriate rate of payment is, if the Court determines to keep jurisdiction, is to look at each one of the plans for all 15,000 individual claims that are being lumped together here over this period of time and determine what the rate of payment is that's provided in that plan. Some might be 150 percent of the Medicaid rate. Some might be 50 percent of billed charges. Some might have another standard. But the Court is going to have to look at those plans and they simply cannot evade the fact that those plans are the only thing giving rise to a legal duty to pay through artful pleading of some sort of implied contract when the elements of an implied contract under Nevada law have not been satisfied by the allegations of the Complaint.

Going back, Your Honor, to our alternative grounds, which is 12(b)(5), I have sort of covered that in arguing that the elements of an implied contract are not

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met here and I think that I'll rely on our briefing and simply address any points that come up in opposition as to any of the additional elements that have been added in order to try to plead around ERISA complete preemption.

There are decisions specifically saying that each one of the alternative allegations that they've made under state law is preempted by ERISA if the claims do arise out of an ERISA plan. Conflict preemption, if the Court has read the Arizona District Court decision, that Court never reached conflict preemption or other alternative grounds because they found that complete preemption required the dismissal of the claims, but should this Court find that complete preemption does not apply, conflict preemption is even broader than complete preemption and was never addressed by the Federal Court's Remand Order.

If the Court looks at conflict preemption, the Court will see that if you allow these claims to proceed under the theories that have been raised by the plaintiffs, the Court will allow them to claim that they get a higher rate of payment than is provided for in the plan terms. And that's exactly what conflict preemption is designed to prevent. It's designed to conflict state law claims which seek to modify the terms of an ERISA plan and would require defendants to meet some separate state law requirement and undermine congressional intent that employee benefit plans

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be uniformly administered nationwide.

And with that, Your Honor, I will turn it over to Mr. Balkenbush to address the RICO claims.

THE COURT: Thank you, Mr. Roberts. Mr. Balkenbush.

MR. BALKENBUSH: Good afternoon, Your Honor.

So, in evaluating the new RICO claim that the plaintiffs have asserted, I think it's important first to just take a step back and think about: What is the core of this dispute between the parties?

At its core, what has been alleged by the plaintiffs is that they've provided emergency medical services to numerous patients. Those patients were members of defendants' health plans. After providing that emergency medical treatment, the plaintiffs billed the defendants for the services provided and the defendants paid a portion of the amounts billed, but not the entire amount. So, now the plaintiffs have brought this lawsuit and, at its core, the suit is focused on an attempt to recover an additional amount of reimbursement for medical services beyond what was originally paid. That's it. That's the core of this lawsuit. It's a commercial dispute between a number of large medical providers and a number of large insurers and/or plan administrators. And that is what the -- most of plaintiff's claims are aimed at. You

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look at their unjust enrichment claim, it's an argument that they weren't paid the reasonable value of the medical services they provided. You look at their implied in fact contract claim, it's an argument that somehow through the course of conduct a contract was created and the defendants have breached that contract by not paying the amounts due.

But what they've done now with this new RICO claim is they're trying to [indiscernible] on to this dispute which is, in its core, a commercial dispute, a claim that the Nevada Supreme Court has specifically stated is a, quote/unquote, quasi-criminal cause of action. And what they are essentially arguing is that one of the nation's largest insurers and plan administrators, United HealthCare and its affiliates and subsidiaries, is effectively a criminal syndicate akin to the mafia. It just doesn't fit under the facts they've alleged, Your Honor, if you look at the Complaint.

The Nevada RICO statute was patterned after the Federal RICO statute that was passed in 1970 and the statute is aimed at serious criminal behavior, not routine, commercial disputes.

When you look at the list under NRS 207.360, the list of the RICO predicate acts that are necessary to be alleged to state a RICO claim, it makes clear how serious a civil RICO claim really is. Things are listed there like

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murder, mayhem, kidnaping, and burglary. Those are the kinds of RICO predicate acts that someone has to allege with particularity under Rule 9(b) to state a civil RICO claim against a defendant.

And so I have given that context of where this RICO statute came from. The Nevada Supreme Court has repeatedly expressed reluctance to allow RICO claims to be asserted in what are essentially routine, commercial disputes and has cautioned District Courts to be careful in policing their dockets and making sure that plaintiffs are not allowed to turn what is essentially a commercial dispute into a quasi-criminal dispute similar to an Indictment.

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There are a few cases I want to refer the Court to that the Nevada Supreme Court has issued regarding the Nevada RICO statute and the first is *Allum v. Valley Bank*. In that case, the essential allegations were that a bank was alleged that it defrauded its investors by issuing loans that did not comply with FHA or Housing Act guidelines. And the Court did allow certain claims to go forward there, but it did not allow the RICO claim to go forward because, again, it was -- did not fit the facts of the case.

Another case, *Cummings v. Charter Hospital of Las Vegas*, the allegation was that a mental hospital had held

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patients there against their will and the patients brought a RICO claim against the hospital. The Nevada Supreme Court, again, upheld a dismissal of the RICO claim while allowing other claims, such as claims alleging that the patients' constitutional rights had been violated, to go forward.

And in a case we cited extensively in our briefing, *Hale v. Burkhardt*, the Court dismissed a RICO claim that was essentially about a real estate broker who was not paid his commissions and fees that were owed to him for work he did for a property developer. And what the Court said in the *Hale* case is that District Courts need to, quote:

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Watch for the overenthusiastic use of RICO.

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The Nevada Supreme Court noted the, quote, social stigma that comes with allowing the assertion of a RICO claim in what is essentially a routine, civil, commercial dispute.

So, I think just at the outset, before delving into the specific allegations that the plaintiffs have set forth in their Complaint, it's important for this Court to be skeptical, especially skeptical of this RICO claim, even more skeptical than of the other seven state law causes of action that the plaintiffs have alleged.

And when you delve into the specific allegations

that they've set forth in the First Amended Complaint, you see that they have not met the elements of a civil RICO claim under Nevada statute and that this really is just a routine, commercial dispute in which a RICO claim should never have been asserted.

The first major issue with plaintiff's RICO claim, and it's one that they generally gloss over in the motion briefing, is that they have failed to allege but for causation. One of the core elements of a Nevada RICO claim is that a plaintiff has to allege that the defendants' predicate RICO acts which, here, are essentially a series of alleged misrepresentations, that those acts directly caused the plaintiff's damages. And they defeat their own causation element, Your Honor, in Paragraph 21 of their Complaint where they admit that regardless of what alleged misrepresentations defendants may have made, regardless of what alleged promises may have been made about how reimbursement would be calculated, about how Data iSight would process data, or look at the market data from different areas of the country, regardless of that, the plaintiffs were going to treat these patients no matter what because they admit that under state and federal law they had a duty to treat the patients regardless of what misrepresentations were or weren't made to them about rates of reimbursement.

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The misrepresentation -- the alleged misrepresentations by United HealthCare and its affiliates could be even more -- could be alleged to be even more egregious. Even if they put in their Complaint even more egregious allegations than they set forth here, they still wouldn't be able to meet the causation element of a RICO claim because they admit that they would have treated these patients no matter what and thus they would have not received the payment that they hoped to receive no matter what.

The second issue that arises with their RICO claim is that -- and it comes again from this issue that -- it stems again from this issue of state and federal law requiring that they treat these patients regardless of whether or not they'd be reimbursed, regardless of whether or not the patients were covered under their insurance policies, and that is for both of the fraud-based RICO predicate acts. The fraud-based act under NRS 207.360 subsection 28, obtaining money by false pretenses, and also the predicate act under NRS 207.360 subsection 35, transactions involving fraud or deceit. For both of those predicate acts, the intent to deceive and reliance are key elements that have to be plead with particularity under Rule 9(b). And not only have they not plead those with particularity, but they haven't plead them at all.

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Because, again, where is the reliance by plaintiffs on defendants' misrepresentations?

No matter what defendant said about how the rate of reimbursement will be calculated, no matter what defendant said about their relationship with Data iSight, no matter what defendants said about -- even if there are allegations that we had -- which there aren't allegations, but even if we had -- there were promises about a particular rate of reimbursement, that would not show detrimental reliance because the plaintiffs would have treated these patients no matter what by their own admission because they had a duty to under state and federal law.

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They also allege a -- the third predicate RICO act they allege is a claim for involuntary servitude. And the Court should be especially skeptical of this claim. This is a claim that has only been addressed by the Nevada Supreme Court in the criminal context and in all of those contexts, the context was physical coercion. And the Third Circuit in a case of the Third Circuit called *Zavala v. Wal-Mart*, the Third Circuit characterized the RICO predicate act of involuntary servitude as -- in the modern context: Limited to situations involving, quote:

> Labor camps, isolated religious sects, or forced confinement.

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And, so, I think in evaluating this particular RICO predicate act, the Court needs to seriously think about and consider whether it's going to allow one of the nation's largest insurers and plan administrators to be accused of essentially physically, forcibly forcing various medical providers to provide medical services.

And I think what the Court also needs to consider is: How is it possible for an insurer or plan administrator to force a medical provider to provide services to patients when those medical providers, by their own admission, in Paragraph 21 of their Complaint, admit they were required to provide those services, regardless of payment by state and federal law?

If there's anything that has forced, quote/unquote, involuntary servitude on the plaintiffs, the only thing that could be accused of doing that is -- are the state and federal laws that require the plaintiffs to treat the defendants' plan members, regardless of those members' ability to pay and regardless of those members' insurance status. The state and federal laws are what the plaintiffs should be aiming at, not defendants.

Another issue that again goes to Rule 9(b)'s role in this RICO claim is that the plaintiffs have lumped together all of the defendants in their pleadings. So rather than state that -- for example what role Oxford

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Health Plans had in this alleged RICO syndicate, you know, what role Health Plan of Nevada had in the RICO syndicate, what role the Sierra Health entities had in the RICO syndicate, the plaintiffs just lump everyone together under the heading of defendants and then accuse the defendants of engaging in a criminal enterprise with Data iSight that is -- that rises to the level of a RICO claim.

And what Rule 9(b) says and what the Nevada Supreme Court and Ninth Circuit caselaw interpreting the identical federal rule says is that to state a RICO claim with particularity, you have to state the who, what, where, when, and why, not just for one of the alleged conspirators, but for all of the co-conspirators who make up the alleged criminal syndicate. And I think if the Court looks closely at the Complaint, the sections we've pointed out in our briefing, the Court will see that the plaintiffs failed to differentiate the allegations between each of the eight defendants.

And the plaintiff's response to this in the briefing is essentially that, well, because the defendants are affiliates and subsidiaries of each other, because there's some connection between United HealthCare and these various other seven defendants, that that is enough to just assume that they are all -- they all can just be alleged to be a part of the same criminal syndicate and the RICO

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claims will be alleged against them. But they don't cite any caselaw for that, Your Honor, stating that a mere affiliation is enough to allow -- to get around Rule 9(b)'s particularity requirement and to get around the prohibition on lumping.

And the issue with the plaintiff's failure to differentiate the allegations, the RICO allegations, against the various defendants also bleeds into the problem with their enterprise allegation here. To state a RICO claim, plaintiffs also have to allege that it -- more than just one person conspired together to engage in a pattern of racketeering activity. And, so, here, the plaintiffs try to meet that by alleging that the enterprise is essentially the defendants and this third party called Data iSight. That's the criminal enterprise that's defrauding them and forcing them into involuntary servitude.

But when you look at the caselaw that has interpreted the requirements for stating an enterprise under RICO, it's clear that an ordinary commercial transaction is not sufficient to meet the enterprise element of a RICO claim. There are two cases we cited that I think are particularly relevant here, both out of Federal Courts in California. One is the *Gomez v. Guthy-Renker* case and, in that case, the Court said, quote:

Courts have overwhelmingly rejected attempts to

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characterize routine, commercial relationships as RICO enterprises.

And what happened in *Gomez*, for example, is there was a beauty supply -- seller of beauty supplies that would sell beauty products to customers and once the customer made one purchase, the company would just continue charging them on a regular basis for additional beauty products, even if that customer hadn't specifically ordered it. And, so, the customers brought a class action against the defendants arguing that they had engaged in RICO violations and the enterprise that they alleged was that the seller of these beauty products had basically conspired with the third party vendors that would charge the plaintiffs' credit cards. And what the Court had said is that they had failed to state an enterprise -- meet the enterprise element because the relationship between the core defendant, this seller of beauty products, and the vendors was just a purely commercial relationship. There was no co-conspirator relationship. It was a standard, ordinary relationship. So, they dismissed the claim.

And the other case that I think is on point is the *Gardner v. Starkist Co.* case. Another case out of the federal district courts out of the federal district courts of California from 2019. And, similarly there, there were RICO claims brought against the seller of tuna, alleging

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that they had made false representations about the nature of the product they were selling. And the plaintiffs tried to meet the enterprise element by saying the enterprise consisted of the seller of the tuna, that the -- the entity that was selling the tuna and then the entities that were canning and delivering the tuna to the stores. And what the Court again said is that doesn't meet the enterprise element because all that's been alleged is an ordinary, commercial relationship between the seller and these various vendors that are carrying out normal tasks that any business entity would carry out engaged in the business of selling tuna.

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And, so, when you look at their Complaint here, that's exactly -- that is the only thing that the plaintiffs have alleged here. And, specifically, I'd like to direct the Court to Paragraph 100 of the First Amended Complaint. In Paragraph 100, it states, quote:

> 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 providers' claims and to determine reasonable reimbursement rates.

And if you turn to Paragraph 175 of the First Amended Complaint, it states:

> To perpetuate the scheme and conceal it from the

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healthcare 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.

And that's a critical admission in the Complaint, Your Honor. They admit that the only relationship between defendants and Data iSight that makes up the enterprise is an alleged contractual relationship where Data iSight determines rates of reimbursement for out of network providers and they admit that the agreements between the United entities and Data iSight are, quote -- they are -- excuse me. That they are, quote:

> Consistent with Data iSight's agreements with similar health insurance companies.

That is other companies out there, whether it be Aetna, or Blue Cross Blue Shield, have similar agreements with Data iSight.

All they have alleged here then is a routine, commercial relationship between the defendants and Data iSight and the caselaw is clear that that kind of commercial relationship is not sufficient to meet the enterprise element of a RICO claim. So, that is another independent reason we believe that their RICO claim fails and should be dismissed.

THE COURT: Does that conclude --

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MR. BALKENBUSH: And, finally, --

THE COURT: Does that -- it's 44 minutes. We have an hour. How much longer do you have, Mr. Balkenbush?

MR. BALKENBUSH: I apologize, Your Honor. I'm almost done.

The last thing I just wanted to briefly address, and this just goes back to what my colleague, Mr. Roberts, was arguing, is that this -- in addition to failing to state a RICO claim, the plaintiff's RICO claim is also subject to complete preemption and conflict preemption. And the parties essentially agree in their briefing that one of the key cases is the -- it's *Gobeille v. Liberty Mutual Insurance Co.*, a U.S. Supreme Court case. And, again, the key issue is: Would allowing a RICO claim to stand here essentially interfere with a central -- a central plan of administration and interfere with a national uniform plan administration? And, if it would, the RICO claim is preempted by ERISA.

And we point this out in our briefing, our original briefing papers, Your Honor. ERISA requires a plan administrator to comply with the planned documents. So, if the planned documents say that an out of network provider should only be paid, for example, 50 percent of its billed charge, ERISA requires United to comply with that plan term.

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At its core, what the RICO claim is trying to do is to force the defendants to pay a different rate than is set forth in the health benefit plans at issue. And for that reason, we believe it's also preempted by ERISA.

Thank you, Your Honor.

THE COURT: All right. Does that conclude the presentation of the Defendants' Motion? All parts of the Motion to Dismiss?

MR. ROBERTS: Yes, Your Honor.

THE COURT: It's 1:45. I have another hearing at 1 o'clock [sic]. We have hearings through about 4 p.m. today. And I will not cut off the plaintiff timewise with a regard to a chance to respond. So let's go until say 1:59 and then we'll talk logistics.

I assume that Ms. Lundvall is doing the argument?

MS. LUNDVALL: Thank you, Your Honor.

And I do appreciate the recognition that we're going to need more time, given the presentations, not only on the papers but also the oral presentations that have been made here. One of the things that I was going to try to do is to short-circuit my presentation to try to shoehorn it into about maybe 35, maybe 45 minutes, but there's no way I can complete then by 2 o'clock.

One of the things that I was going to try to do was to bypass then any description of the facts that had

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been asserted in our Complaint so as to give the Court a foundation or a premise by which then you could evaluate not only the jurisdictional arguments, but also the 12(b)(5) arguments.

But the one comment that I want to make preliminarily, especially in light of the presentation that was made regarding the RICO claim, deals with the contention by United that somehow -- that they, being the largest insurance company in the nation, would never engage in criminal conduct or conduct that could be construed to be a RICO violation and that, therefore, our RICO claims are above and beyond the pale are actually defied by the direct allegations that we have within our Complaint. We brought to the Court's attention that back in 2008 the Attorney General for the Southern District of New York had investigated United for nearly the exact same scheme that is being practiced here. United settled those criminal investigations with a payment of $50 million.

In addition, there was a civil action that was brought based upon those same facts. That civil action had advanced the nearly exact same scheme that is being practiced by United in this circumstance and United paid $350 million by which to settle those claims.

So, to somehow suggest that the factual allegations in this case are beyond the pale of a large

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organization like United is actually defied by the factual allegations that the Court has before it. And what we have been able to uncover through a very tedious process is that United is basically up to its same tricks again.

One of the things that is important, I think, to understand is that for a 10-year period of time, the Health Care Providers were out of network with United. From 2008 to 2018, these parties had established a course of conduct that led to and establishes the implied in fact contract that we allege now has been violated by United. Across that 10-year period of time, there were literally thousands upon thousands of claims that were submitted by United. On occasion that there were disputes regarding the coding, the timing, coverage, those types of issues and the parties had worked through to form a dispute resolution. So, in order by which they -- to establish the course of conduct then had originated between them and laid as its predicate to the implied in fact contract that we have asserted in our Complaint.

It was beginning in 2018 though that things began to go awry and United breached that implied in fact contract. And they did it in the context first by erratically paying our claims, claims all across the board with no rhyme or reason. After that erratic payment, they came back to us and said: We want to enter into a written

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agreement now with the Health Care Providers, but we want a 50 percent discount off --

THE COURT: Right. I saw that in the -- that's in Paragraph 104 of your Complaint, the First Amended Complaint.

MS. LUNDVALL: That's correct, Your Honor. It's like beginning in the -- like the late '70s through the allegations found at -- in the '80s, the '90s, and into the 100s, those are the factual foundations then that I was just going to recite. If the Court is familiar with those, then you know that the plan, and the scheme, and the attempts by which that the United undertook in an effort to try to coerce us into a written agreement that was substantially below our cost to providing these services.

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And as they ratcheted up their forms of coercion against us, including making demands for discounts, terminating contracts, putting pressure on the hospitals by which that we contracted with in an effort to convince them to terminate our contracts, etcetera, etcetera. When we asked United why it was engaging in these hardball negotiating tactics, their response was: Because we can.

And, so, to the extent, Your Honor, that is the factual predicate then by which this case comes before this Court and that is the factual predicate that has been laid out in great detail then, not only in our original

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Complaint, but also in our First Amended Complaint.

Now there are three arguments that the defense had advanced in their moving papers and that they have touched upon in their oral presentation, two of those arguments, in my opinion, are fairly sophisticated arguments and they deal with both complete preemption as well as conflict preemption and then they have the standard Motion to Dismiss on 12(b)(5) grounds for failure to state a claim.

Before I get into the legal argument, I guess my suggestion would be, in light of the time, Your Honor, as to whether or not you wish us then to talk about logistics and talk about whether or not that we need to find another time then to thoroughly explore the preemption arguments as well as the 12(b)(5).

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THE COURT: All right. Thank you for that and for being willing to take a break.

I have formed impressions and read everything, but I think there's value to allowing the attorneys to having all of the time they need. I think you all are going to need more than an hour. I'm willing to do it Monday morning, although bandwidth is low on Monday. Afternoons is always better for bandwidth. So, let me suggest that the parties suggest some times next week. Next week I do have other hearings scheduled Thursday afternoon and Friday afternoon. So, I have something Wednesday at 1:30 as well.

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So, I'm going to suggest that you guys look -- let me know about Monday afternoon and Tuesday afternoon.

MS. LUNDVALL: Tuesday afternoon is terrific, at least for me, Your Honor. I can't speak for my colleagues, but that is preferable. On Monday afternoon I am before Judge Denton in another matter.

THE COURT: All right. And Mr. Roberts and Mr. Balkenbush, how do you look Tuesday afternoon?

MR. ROBERTS: Your Honor, I am open on Tuesday afternoon. I've actually got a pro bono case on Monday afternoon, so that works well -- much better for Tuesday for me also.

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THE COURT: All right. So, Tuesday afternoon at 1:30. I won't schedule anything else. And I'm not sick, I promise. I have allergies.

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So, thank you both for your professional courtesy. And that's not to leave out Ms. Gallagher, Ms. Perach, and Mr. Balkenbush, thank you for your professional courtesy. And I will see you guys Tuesday at 1:30 for our third bite at the apple at this case. Stay safe.

MS. LUNDVALL: Thank you, Your Honor.

THE COURT: Stay healthy.

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MR. ROBERTS: Thank you, Your Honor.

MR. BALKENBUSH: Thank you, Your Honor.

MR. ROBERTS: We appreciate it.

PROCEEDING CONCLUDED AT 1:55 P.M.

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CERTIFICATION

I certify that the foregoing is a correct transcript from the audio-visual recording of the proceedings in the above-entitled matter.

AFFIRMATION

I affirm that this transcript does not contain the social security or tax identification number of any person or entity.

KRISTEN LUNKWITZ
INDEPENDENT TRANSCRIBER

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DISTRICT COURT

CLARK COUNTY, NEVADA

* * * * *

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.,	)	CASE NO. A-19-792978-B
Plaintiff,	)	DEPT. NO. XXVII
vs.	)	
UNITED HEALTHCARE INSURANCE COMPANY, ET AL.,	)	**Transcript of Proceedings**
Defendants.	)	

BEFORE THE HONORABLE NANCY ALLF, DISTRICT COURT JUDGE

ALL PENDING MOTIONS

TUESDAY, JUNE 9, 2020

APPEARANCES:

For the Plaintiff:	PATRICIA K. LUNDVALL, ESQ. AMANDA PERACH, ESQ. KRISTEN T. GALLAGHER, ESQ. (All Via Video Conference)
For the Defendants:	D. LEE ROBERTS, JR., ESQ. COLBY L. BALKENBUSH, ESQ. (All Via Video Conference)
RECORDED BY:	BRYNN WHITE, DISTRICT COURT
TRANSCRIBED BY:	KRISTEN LUNKWITZ

Proceedings recorded by audio-visual recording; transcript produced by transcription service.

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FRIDAY, JUNE 5, 2020 AT 1:34 P.M.

THE COURT: All right. This is the Judge. I'm recalling the case of *Fremont Emergency Services versus United HealthCare*, A792978. Appearances, please. I assume it's Ms. Lundvall, Ms. Perach, and Ms. Gallagher for the plaintiffs. Is that correct?

MS. LUNDVALL: Yes, Your Honor.

THE COURT: And for the defendants would it be Mr. Roberts, Mr. Balkenbush, and Mr. Luellen [phonetic]?

MR. ROBERTS: This is Lee Roberts, Your Honor, and Mr. Balkenbush is also on the line. That's I believe that's it for us.

THE COURT: Okay. Thank you. I think we're ready to hear the continued opposition to the Motion to Dismiss by the plaintiff. Ms. Lundvall.

MS. LUNDVALL: Thank you, Your Honor. And thank you for the luxury of a little bit of time. I think we've got an echo that may require some folks to mute. We thank you for the luxury of a little bit of time in which to present our opposition to this Motion to Dismiss.

There's a couple of the issues that have been raised by United in their moving papers and in their Reply that aren't particularly commonplace in our jurisdiction and, therefore, I think that they do require a little bit

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of explanation. I know when I started looking at these issues about three or four years ago I -- it took me a little while to get -- wrap my arms around it. So, therefore, what I've tried to do then is to synthesize things into something that's simple and understandable.

As to the 12(b)(5) issues that have been raised by the Motion, respectfully I think they're a bit old had in our jurisdiction and that they don't require as much analysis but I intend to present on.

There's two points that I'm gonna ask the Court to indulge me on a little bit to verify across the course of argument, particularly on the preemption arguments. Those two points concern the type of the case that is before you. I think it's important to understand that the claims that are at issue that are being advanced by the healthcare providers are all claims that have already been deemed payable by United. In other words, United has already looked at the plans and they've already decided that these claims are payable. So, it doesn't require any type of a review of the plans.

Under the caselaw, the preemption caselaw, the courts differentiate these types of cases then between right of payment cases and rate of payment cases. They use it as kind of a shorthand way to be able to explain then some of the preemption arguments.

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The rate of payment cases, in particular, they focus not on the plan that's at issue, but they focus on the relationship between the provider, which in this case is the Healthcare Provider, and the insurer, which is United. It does not focus on the relationship or the plan documents or anything of that nature between the insurer, which is United, and the individuals who are the insureds who carry plans. And, so, that's the difference with the distinction between the right of payment cases and these rate of payment cases.

In the cases that we cited to the Court, there are a number of cases that embrace this distinction as a shorthand way of deciding preemption arguments, particularly the complete preemption arguments. We cited a whole series of these cases and I think a couple of these bear a little bit of mention. One is the *Sobertec versus UnitedHealth Care Group* case. In other words, this is a case in which that United was then involved in directly in which the complete preemption was not found by the Court.

And it turned upon it -- I'm gonna quote then from that decision:

> If the defendants acknowledge that their arguments have been rejected in cases that involve express or implied agreements to pay benefits that were independent of the terms of the ERISA plans at issue

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and the Court finds such a situation applies here.

There's another case that states this much more bluntly and it's the *Premiere Impatient Providers* case. And I'm going to quote from that and it is:

> The rate of payment and the right of payment distinction is dispositive on the issue of complete preemption.

And, so, the second point then that -- I'd like the Court to kind of keep in the back of their -- of your mind, as we go through these arguments, for this reason. This case and the tough circumstance between the Healthcare Providers and United actually arises beginning in January of 2019. That's when we began to see the erratic payments, and then the severe discounts, and then all the hardball negotiating tactics, the pressure that was placed upon some of our hospital contracts, things of that nature.

And, at that point in time, as we have alleged, set forth in pretty good detail in our First Amended Complaint, United took the position with us that there was an independent company that was dictating and determining what was a reasonable rate based upon the geographic confines of our jurisdiction in deciding what to pay. That independent company was also the one that we were supposed to go back to and to determine whether or not that we could negotiate a higher rate. In many circumstances, we did

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negotiate a higher rate of payment with them and learned that, in fact, that this rouse then that was being practiced by United. And that being that they actually owned and had an ownership and in control, more appropriately, over Data iSight. So, that's what they were telling us.

But what are they telling you? What they're telling you is that somehow that the difference is in these rate of payments have something to do with the plans that are at issue, is the exact diametric opposite of what they told us in the circumstances that led up to this case. So, the question becomes is: Why are they taking this position? And why are they taking this diametrically opposite position?

Moreover, as we alleged in our First Amended Complaint, one of the things that is quite clear from their website is that United advises its policyholders that they are not to pay in these non -- these out of network situations more than their copay or whatever their -- their contribution may be. And also advises a provider, as we alleged in our First Amended Complaint, is not to charge these folks more than the copay or what their, you know, contribution may be. But, instead, we're supposed to reach back to United then by which then to figure out then what is an appropriate rate of payment.

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So, that particular factual circumstance, that representation, underscores the idea that what is at issue here is not a relationship between the insureds and United, but it is a relationship then between the Healthcare Providers and United. And in these rate of payment cases, then, the courts have said on the complete preemption issue and related them to the conflict preemption issue, that that distinction is dispositive.

So, let me start then with the complete preemption argument that was advanced by United. And the reason I'm starting with the complete preemption argument is because it is not a proper argument for a Motion to Dismiss. As both sides have articulated in their papers, there are two forms of preemption under ERISA. One is a complete preemption and the other is a conflict preemption. And they are -- they serve two totally different purposes.

As the cases set forth that we -- that I cited at pages 16 through 19 of our brief, complete preemption is not an appropriate argument for a Motion to Dismiss because it is a jurisdictional tool for Federal Court by which to determine if, in fact, they have Federal Court jurisdiction. When, in fact, there may be state law claims that are asserted and there is a removal to Federal Court, then a Federal Court is entitled to use the complete preemption dictates and the analysis then for complete

preemption and to transmute those state law claims into ERISA claims. Those claims then are not dismissed by the Federal Court. What they are -- what happens to those claims then in the Federal Court is that, if they've gone through the exhaustion requirement, then they begin into discovery and they go then to a merit argument. And, so, to the extent that complete preemption is an inappropriate argument for a Motion to Dismiss, particularly in State Court, because what we are not looking at here is jurisdiction. What we are looking at is whether or not these claims should be dismissed as a matter of law.

Now, the complete preemption argument has already been addressed by Judge Mahan. Judge Mahan had already expressly reviewed the complete preemption argument because that was the argument that they had advanced then under -- in opposition to our Motion to Remand. What Judge Mahan did is he expressly analyzed the two-part requirement under the U.S. Supreme Court case in *Davila* and it might be pronounced *Davila*, or *Davila*. I'm probably butchering the pronunciation, but it is agreed upon by both sides then that is the U.S. -- the two-part analysis that is supposed to be reviewed then for complete preemption review.

And one of the things that Judge Mahan did is he expressly looked at and confirmed that the claims that we had plead in our First Amended Complaint were founded and

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based upon an independent duty under an ERISA plan and, therefore, they were not completely preempted.

One of the things that I think is important, if you take a close look at Judge Mahan's decision, he actually begins his analysis by articulating the differences between a complete preemption argument and a conflict preemption argument and looks at the complete preemption argument because it was the Court -- Federal Court's jurisdiction that was at issue then under that Motion for Remand.

And, so, what I'm trying to do is to underscore that these two preemption arguments, two preemption doctrines, serve two totally different purposes and that if, in fact, that jurisdiction, under a complete preemption argument, is actually found, then, in fact, those cases move forward in the Federal Court. They're not dismissed. So, it underscores the fact that on the review before you, which is a Motion to Dismiss, complete preemption is not an argument that is available then to United.

In their moving papers, United argues that Judge Mahan got it wrong. They don't tell you how or why or they don't analyze why it is that they got it wrong. They just say he got it wrong. Complete preemption does exist and Judge Mahan was wrong. And they ask you to second guess then Judge Mahan on the issue of ERISA complete preemption.

And, so, I thought, all right. So, just for kicks, let's say that United's right. Let's say that you decide that Judge Mahan was wrong. What do we end up with? We have two District Court Judges then that are making findings that are diametrically opposite. One is in Federal Court. The other is in State Court. And if, in fact, that you make a decision then that says, yes, there is complete preemption, does that allow then United to now remove this case again to Federal Court? Is your decision then on complete preemption one that prevails in this case and that you are able to trump Judge Mahan in his determination as to whether or not there's Federal Court jurisdiction on this? Is Judge Mahan then required then to review or to accept your determination? In essence, do we play a game of round robin or, you know, let's play go around the merry go around so that we then have to file another Motion for Remand, he makes the same decision, and then we're right back before you.

When you look at the practical impact of what United is asking you to do, it would be -- one begins to understand and to appreciate that, in fact, the complete preemption argument is not a dismissal issue. It is a jurisdictional issue and that jurisdictional issue has already been decided then against United.

Moreover, if you take this to the next step then,

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what Court or Courts have appellate review over the fact that you've got two District Court Judges that are making diametrically opposite decisions? Do we have the Ninth Circuit then that is supposed to sit over Judge Mahan? Or the Nevada Supreme Court that is supposed to sit, as far as appellate review, then of this Court? And, so, when you start considering the consequences of what United is asking you to do, then what you realize is that there is something wrong with their argument. And what I'd like to do then is to underscore the fact of what is wrong with their argument.

Their argument on complete preemption is not a dismissal argument. It's a jurisdictional argument. That jurisdictional argument allows a Federal Court to state -- take state law claims that have been plead and to transmute them into federal ERISA claims. Those federal ERISA claims then are subject to an exhaustion argument and, once the administrative opportunities have been exhausted, then there is discovery on those ERISA claims, there is merit determination then on those ERISA claims, and a Federal Court is making those merit determinations.

And, so, to the extent it is there where congress has said we need a uniform application of those laws and, therefore, why the complete preemption argument is one that applies so as to push these cases then to Federal Court for

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their review.

And, so, to the extent that when you take a step back and take a look at the fact that one preemption doctrine applies to determine the jurisdictional argument, but the conflict preemption argument applies in a different context. Then you begin to understand and appreciate why it is that there is actually overlap then between these two doctrines. And let me illustrate by -- what I mean by this.

There are two preemption arguments that United has advanced before you. The first is a complete preemption argument. We have cited the cases then that demonstrate that that is nothing but a jurisdictional tool. But the conflict preemption argument, both sides acknowledge that that is an appropriate determination then that can then be made by a State Court. And, so, the issue, I guess, from a practical standpoint, look at it another way, is: Why would we have two different doctrines that under United's argument accomplishes the same thing? We don't. Each one of these preemption doctrines have a separate application. That separate application has a fair amount of overlap in their analysis, but that separate application then has two different forms of review and it accomplishes two separate things.

And, so, to the extent then that we urge the Court

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on the complete preemption argument, is to look at what Judge Mahan did, to recognize that he didn't make the wrong decision. He then concluded that there was not jurisdiction then by the Federal Court so as to review these claims, transmute these state law claims into ERISA claims, and to move forward with discovery then on those in a merit determination.

Now, one of the arguments that United advances in response to ours, that complete preemption is a jurisdictional tool, not a grounds for dismissal, is that they cite to two Nevada Supreme Court cases and they contend that, well, the Nevada Supreme Court made a decision then on preemption, and, therefore, that's okay and complete preemption is what they argue that the Nevada Supreme Court did. But when you look at both the *Marcoz versus Summa* case and the *Morrison versus Health Plan of* Nevada case, which are the two Nevada Supreme Court cases that they cite, and you actually read those decisions, what you realize is that the Nevada Supreme Court was not making a complete preemption argument. It was going through a conflict preemption review.

And if you look at their analysis, what you have to do is, first and foremost, is look at the citation or the sections that they cite, and the analysis, and the factors that they review in making that determination. And

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a close review then of both of those cases, what you realize is the sections that were cited then by the Nevada Supreme Court are sections that deal with conflict preemption, not complete preemption. And probably the easiest way by which to make that determination is to look at what test that both of the Nevada Supreme Court cases employed because both United and the Healthcare Providers agree that when you are applying, or looking, or reviewing for complete preemption review that we're supposed to apply the *Davila* case. So, one would assume then the Nevada Supreme Court applied the *Davila* case, if they were looking at a complete preemption argument, particularly because one of those decisions came down after the U.S. Supreme Court issued the decision in *Davila* in 2004. Do the Nevada Supreme Court cases cite *Davila*? No. Do they do a *Davila* analysis? No.

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The sections that the Supreme -- Nevada Supreme Court looked at and reviewed then were the sections under conflict preemption analysis. And, so, therefore, that will help the Court then understand, at least in my opinion, that, in fact, those two cases are not complete preemption arguments. And if you need to go one step further to take a look at the cases then that they cited from Missouri, Texas, Illinois, and Colorado, a review of those cases as well is that each one of those decisions did

a conflict preemption analysis, not a complete preemption analysis.

And I guess I could leave that argument alone at this point in time, but what I'm going to do is to demonstrate to the Court as well that under a *Davila* analysis is actually a fairly simple analysis so the Court can confirm that there is no complete preemption argument here and that Judge Mahan was right. This is my approach, I guess, to the practice of law, a little bit of a belt and suspenders attorney, don't like to rely upon one argument when, in fact, there are two arguments that are available to us.

If you applied the *Davila*, which is the U.S. Supreme Court decision, the Court need look no further than the Ninth Circuit decisions on this point. We cited the Court then to the *Blue Cross* decision and the *Marin County* decision. The *Marin County* decision is particularly important because, in essence, it's on all fours with the case before. And in the Federal Court we had appended a copy of the Complaint that was at issue in *Marin County*. And if you look at the claims that were plead in *Marin County*, those claims -- those claims are nearly identical then to the claims that would have been plead in this Complaint. Why? We use the Complaint then as a template then in crafting our First Amended Complaint.

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And, so, to the extent that what we did is we mirrored then the claims that were at issue in *Marin County* that the Ninth Circuit said that were not completely preempted and that they were identified then as rate of payment cases. And those rate of payment cases, under the two-part *Davila* analysis, then, identifies that there is an independent legal duty that is being sued upon. And that independent legal duty then is the contract analysis that we have asserted then as our very first claim under the First Amended Complaint.

One more shortcut or one more helpful tool to be able to allow the Court then to take a look at this analysis or the complete preemption argument and it has significant overlap then with the argument that is made for conflict preemption as well. And, so, this next piece of my argument is actually where these two doctrines overlap and they look at then, in essence, the same issue. And what they're looking for is whether or not there is some type of an independent legal duty that is being sued upon. And independent in this respect is independent from any plan that is at issue.

It is our contention that there is an implied contract that exists between United and the Healthcare Providers. We have asserted that implied contract. We have set forth the factual circumstances. We have plead

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all of the elements for a breach of contract as our first claim and it's that independent legal duty, along with other state law issues, state law claims that we have plead, that provide that independent legal duty then to articulate then that that independent legal duty then is what is at issue in this case and not anything that would be conflicted then with ERISA.

Now, a helpful piece from the motion practice before the Court is that United acknowledges that if we had a written agreement or if we had an oral agreement, then this case would neither be completely preempted or conflict preempted. They make that acknowledgement in their moving papers. And they make the acknowledgement that, in fact, that -- an express contract or an oral contract constitutes an independent legal duty for both complete preemption, as well as conflict preemption. But they suggest that somehow that the implied contract that we have asserted in our First Amended Complaint is different, that it is unique, that it is treated differently under Nevada law. And, therefore, it cannot serve as that independent legal duty for preemption arguments.

But the small problem with that is that in Nevada, Nevada treats express contracts, oral contracts, and implied contracts the exact same. They have the same legal standing. They have the same standard of review. They

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have the same essential elements for their causes of action. They are treated legally the same. And we brought that caselaw then to the attention of Judge Mahan. We also incorporated that caselaw into the briefing then before this Court. Those Nevada cases that identified that all three types of contracts, express contracts, oral contracts, and implied contracts, all stand on equal footing with the law, are found in the *Magnum Opes Construction* case as well as the *Certified Fire Protection* case. The only difference between the three different forms of contracts under Nevada law is how they're proven. If you have a written contract, you've got a document. If you have an oral contract, you have spoken words. If you have an implied contract, you have the parties' conduct. And what we have asserted in our First Amended Complaint is conduct then creates the implied contract.

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And as long as Nevada then treats these three forms of contract then the same, then an independent legal duty exists. And under the admission that has been made by United, applying the *Davila* analysis as well as the conflict preemption analysis, that means that these cases are not preempted.

So, let me fairly quickly then turn to conflict preemption exclusively because this is analysis, as we indicated, that was very similar. It was actually a second

admission that I think that makes the Court's analysis a little bit easier on the conflict preemption argument that has been advanced by United. United contended at -- in their Motion, and it's found at page 2, lines 1 to 2, and they suggest that -- and I'm gonna quote here now:

> No court has allowed state law claims like the one Healthcare Providers are asserting to escape conflict preemption.

Okay? So, what I would ask the Court to do is to take a look at the whole series of cases that we actually did cite to the Court because their statement is a false statement. What you will find is there is a predicate then, a factual predicate, that is nearly on all fours of the factual predicate that is before this Court. If you look at the *Glastein versus Aetna* case, look at the Morris B. Silver versus International *Longshore*, look at the *Meadows versus Employers Health Insurance*, look at *Aetna Life Insurance Company versus Huntingdon Valley*, *Jewish Lifeline Network versus Oxford Health Plan*, *In Re Manage Care*. All of these cases we cited in our Opposition papers and each one of those cases deals with an out of network provider that was bringing claims, state law claims, that are similar to the claims that we have asserted in this case, that the courts have found were neither completely preempted nor conflicted preempted.

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So, then I got a little curious and I thought: Well, if they say that no case has -- we could cite, which was actually a false statement to try to avoid conflict preemption, what I tried to do then is to find a case that said -- that they had cited that identified that the claims that we had asserted were actually conflict preempted. And there's one that they cite. It was found, as far as in their Reply brief, and it was that was urged then by counsel for United in his oral presentation. It's the *Torrent versus Ramos* [sic] case. And if you pull that case up then on Westlaw, what you learn is it's an unpublished, Florida Federal Court decision and if you read that case then, in total, you learn that it's a complete preemption argument. It's not even a conflict preemption argument. But, more importantly, it was a decision that was handed down before *Davila*, which is the U.S. Supreme Court that identified then the two-factor test that was supposed to be reviewed. And also what you see is it's been criticized then by other cases in its own district and has been declined to be followed.

So, there was only one case then that United was able to bring to the Court's attention that, in fact, even arguably then dealt with this issue and it stands in stark contrast to the multitude of cases then that we've cited to the Court where other courts had similar claims, like those

that have been asserted by the Healthcare Providers, as not being conflict preempted.

The analysis starts for conflict preemption first with a clause that United entirely ignores in their moving papers. That clause is what's referred to as the savings clause. The savings clause identifies that -- and I'm gonna quote here:

That claims are saved from preemption for any -- quote:

> Any law of any state that regulates insurance, banking, or securities.

In the caselaw, this is referred to as the Section 14 -- 514 analysis or the savings clause and it functions to preserve, then, a State Court's power, regulatory power, over insurance, banking, and securities, quite obviously. That savings clause begins the framework of a conflict analysis and I think that when the Court looks at our facts in total that we had set forth in our First Amended Complaint, and the type of conduct then that United is being -- is practicing at against the Healthcare Providers, you can see what state, including Nevada, what to look at. It might be interested then in the regulation of the type of adverse conduct it is practicing against providers, such as the Healthcare Providers in this state.

So, the actual analysis then is found in a U.S.

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Supreme Court decision and it's one that deals with -- it's called *Gobeille* and it identifies two categories of cases. Those category of cases are, number one, cases that rely exclusively on ERISA plans, or state laws that govern a central matter of plan administration. As to that first factor or the first set of cases, that's where you find the overlap with the complete preemption analysis versus the conflict preemption analysis. That's where you find that if there is an independent legal duty, that independent legal duty then separates these claims from ERISA.

And, so, there -- hopefully there should be no question then about United's position and that is dealing -- and I'm gonna quote now from their brief that is at page 6, lines 5 through 8:

> United acknowledges, -- and I quote: 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.

And then they go on and articulate what they think is that stark difference. They identify then that we don't have a written agreement, nor did we have an oral agreement, and they suggest that somehow that the implied agreement then is not enough to be an independent duty. But that implied agreement, when we go back then -- specifically then and look at what Nevada Supreme Court has

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said then about implied in fact contracts, under our state law they all stand on equal footing, whether they're a written agreement, oral agreement, or implied agreement. And, so, in Nevada, as long as all three are on equal footing, they all three stand on equal ground, that, in fact, that constitutes an independent legal duty and it means that that factor, then, under *Gobeille* takes us out of it.

So, I may try to see if I can't fast-forward a little bit as far as in the -- this outline.

[Pause in proceedings]

MS. LUNDVALL: All right. So the second factor then under the *Gobeille* is whether or not it deals with plan administration. As we had articulated, there is nothing to do with plan administration here. In fact, that United has already acknowledged that these claims are payable. It's only a rate of payment case and that those are the lines of demarcation then to help the Court then to understand that these claims are neither conflict preempted, nor are they completely preempted. Both doctrines serve two different purposes. There is overlap between the two doctrines. But that overlap then continues to underscore the fact that there is no preemption. There doesn't need to be any need then for these claims to be somehow either kicked over to Federal Court and -- or --

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and/or dismissed in total.

So, let me turn then to the 12(b)(5) arguments that had been advanced by United in their moving papers. And what I'm going to try to do is to hit the high points, rather than to articulate and identify all of them.

Two notable high points is that they do not challenge on 12(b)(5) grounds either our claim number 5, which is violation of Nevada's pay statute, or claim number 7, which was our claim for declaratory relief. They -- so, on 12(b)(5) grounds, I'm going to begin then with our first claim, which is our breach of contract claim.

A breach of contract claim then requires a party to assert then that a contract exists, a breach occurred, damages have been sustained, and that there's been a demand for payment. Those are the basic essential elements for a breach of contract claim. What United has done, under their 12(b)(5) argument, is to challenge the sufficiency of our factual predicate so as to contend that we do not have an implied in fact contract. But we brought to the attention of the Court that, in fact, because these implied in fact contracts are all very fact specific, that it's an inappropriate analysis for the Court to make such a determination on a Motion to Dismiss. And we cited to the case that even under Federal, the more stringent review then on a Motion to Dismiss that's applied by the Federal

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Courts, the Federal Courts are quite clear that looking at the sufficiency of facts for an implied in fact contract is not the function of a Motion to Dismiss.

And, so, if you take a look at the allegations that culminate then in Paragraph 197 of our First Amended Complaint, we contend that they're more than sufficient to have stated the essential elements of an implied in fact contract.

The next argument that they advance, and this is an argument that they advance even though it's not -- if you look at the *Recrion* case, *Smith versus Recrion*, they cited that case by suggesting that somehow that payment for past services do not constitute a promise to pay for future services. But one of the things that when you look at their *Recrion* case is that the Court -- our Nevada Supreme Court was very careful to articulate that that was a case that dealt with services that were unsolicited by the party against whom the party was sought. In other words, if there had been a solicitation of the services from the Healthcare Providers, then they're completely outside the parameters of *Smith versus Recrion*. And, in this circumstance, you've got the insureds that are coming to the emergency departments that the Healthcare Providers staff and they're asking then for services. They are soliciting our services. They are asking us to treat them.

They are asking us to take care of the emergency that has brought them to the emergency room in the first place. And, under the law, we are obligated then to provide that service to them without any review of their ability to pay, or of their availability of insurance, etcetera. And, so, to the extent that the *Smith versus Recrion* case then offers them no help, we would ask the Court then to find as sufficient then our first claim for breach of contract.

The second claim that we have asserted is a tortious breach of the implied covenant of good faith and fair dealing. It's claim number 2. The *Martin versus Sears, Roebuck* case then sets forth the essential elements and we have included those essential elements then in our First Amended Complaint. Such a claim is actually fairly simple. You have to assert breach of a contract claim coupled with a special relationship.

The Nevada Supreme Court decision in *Insurance Company of the West versus Gibson Tile* identifies when, under a fact specific analysis, that a special relationship may exist. And it is specifically characterized by circumstances involving issues of public interest, on contracts of adhesion, or when there is a fiduciary responsibility that is owed by one party to another. So, if you look at those three factors, let's begin then with the issue of public interest.

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Both our federal government as well as our state government has said that it is in the public's interest to compel providers of emergency services to treat anyone that walks through its doors and to provide stabilizing healthcare for them without any regard to whether or not that they can pay, without any review of whether they can pay, without any opportunity to screen of whether they can pay, or whether they have insurance, or any other review. It is one of the most unique private industry circumstances, I think, that exists in our society today. It is a compulsion then for somebody to provide professional services based upon the public interest and the public desire that any human being that is within our nation, that they can walk into an emergency room with a healthcare problem and to be able to receive emergency healthcare stabilizing services.

So, that is the public interest that is at issue. If you look at then as far as with whether or not that United contends that this was a contract of adhesion, it is. They take the position themselves that this is a contract for which that they get to dictate what the terms of payment, that they get to dictate the amount that is paid, and that there is no input then that the Healthcare Providers can have in that. And, so, under their own recitation of this contractual relationship between them it

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is a contract of adhesion.

Also, you can see the multitude of cases that have identified then where an insurance company stands in a fiduciary-like capacity then and is obligated to deal in good faith then with the parties with whom that they contract. And, so, the factual predicate, the factual analysis of this case that we have set forth in the First Amended Complaint then indicates that this is a type of a relationship that may be a special relationship, which is a label that is applied only after looking at the factual predicate and that factual predicate is inappropriate then for review on a Motion to Dismiss.

I suppose one last point on this particular issue is that United sits in a superior position where in fact that it wields an immense amount of power then over these Healthcare Providers. We have learned of circumstances where United, taking their hardball tactics that's even driven practice groups similar to our own out of business because of the way that they have decided to apply these discounts and the pressure that they have exerted against the hospitals.

United knew that they had us in a vice and United knew that that vice was one that was only going to be tolerable for a period of time. And, so, to the extent that it kept squeezing and cranking on that vice then in an

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effort to try to coerce into a contract that provided them terms that they had dictated and that were only beneficial to them and that were harmful to us. And, so, under the factual circumstance that is before the Court then, we believe that we have sufficiently alleged in the special -- that a special relationship exists, so as to [indiscernible] a tortious breach of the implied covenant of good faith and fair dealing.

Our third claim is a claim for unjust enrichment and there's one simple argument then that United advances and they contend that somehow that an indirect benefit is insufficient so as to serve as a predicate to an unjust enrichment claim. And they brought in a number of cases to the Court's attention, but, notably, none of them were from Nevada. In Nevada, an indirect benefit is sufficient so as to serve as a foundation then for an unjust enrichment claim and that's the Nevada Supreme Court decision in *Topaz Mutual versus Marsh* and, therefore, then, our Nevada Supreme Court, under the very argument then that United advances, has acknowledged then that argument fails.

Next claim is claim number 4, which is our allegations of unfair insurance practices found under Chapter 686A of our Nevada Revised Statute. Nevada articulated -- or United articulates and relies upon *Gunny*, the decision in *Gunny*, to suggest that somehow there's not

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a private right of action. But in the *Gunny* decision, the Court emphasized that there wasn't a contractual basis then between the claimant and the insurance company. Well, we have asserted a contractual basis between the Healthcare Providers and United. And, given that contractual basis then, that is the predicate then to all of our claims, but we have sufficiently then plead this claim then so as not to subject ourselves to dismissal then under *Gunny*.

Our next claim is claim number 6, which is Nevada Deceptive Trade Practices Act. And one of the things that United argues regarding this claim and why it should be dismissed is that they say that it is a fraud claim that must be plead with particularity under Rule 9(b). Well, in our jurisdiction, there is a case that has been tried to three separate juries and has been the subject of three separate decisions from our Nevada Supreme Court. I'm well familiar with that case because I've tried two of those cases and handled two of the appellate arguments then for the Nevada Supreme Court. It is the *Betsinger versus DR Horton* case. And in *Betsinger versus DR Horton* case, in the first decision, what people refer to as *Betsinger 1*, the Nevada Supreme Court said that a Nevada -- the Nevada Deceptive Trade Practices Act is not a fraud claim that must be proven by clear and convincing evidence. And, therefore, by analogy, if you don't have to prove the claim

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by clear and convincing evidence as a fraud claim, then yo9u don't have to plead it as a fraud claim. And, so, therefore, that we're outside then any pleading parameters.

However, once again, as to that belt and suspenders component, we have plead this claim with sufficient particularity and we also particularly, as challenged then by United, have demonstrated that we are victims as defined then by the Nevada Trade Practices Act. There's a decision called *Igbinovia* [phonetic] that gives a definition then of what a victim is sufficient then by which to bring yourself within the four corners of this particular claim.

In our moving -- in our opposition papers, we identified then how that we are passive victims who do not provide voluntary services then to these insured, but, because both state law and federal law mandates that we provide these emergency medical services, then it's that compulsion then that puts us outside the parameters then of any type of voluntary participation that -- so as to fall within the definition that [indiscernible] provides under a passive victim.

There was another case that was cited by -- *Winnemucca Farmers* -- or that was cited by United as contending it was supportive of their Motion to Dismiss and actually it's another one of my cases as well. *Winnemucca*

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Farms versus Eckersell, it's a case that I will never forget, given its timing. But, in that case, if you look at the decision that was issued by Judge McQuaid, Judge McQuaid said it is -- was an issue of fact on a Motion for Summary Judgment as to whether or not a party could -- like the Healthcare Providers, could be a victim, so as to fall within the definition and the protection then of the Nevada Deceptive Trade Practices Act. And, so, any issues then of fact that would need to be resolved, they can't be resolved on a Motion for Summary Judgment, then surely they can't be resolved on a Motion to Dismiss.

We sufficiently alleged everything from false representations to the statutory violation dealing with sale of goods and services. We alleged the coercion, duress, and intimidation, and also that we acknowledge then about the knowing misrepresentation of legal rights and remedies to a transaction.

Now, what I want to do then is to turn to -- I think that this is where they actually have included an argument in their oral presentation that somehow we had not sufficiently alleged detrimental reliance. And what they did is they contended, well, we would have treated these insureds anyway. Why? Because we had both the federal and state law obligations by which to do so. And, therefore, we couldn't sufficiently have alleged or asserted

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detrimental reliance. But what they failed to acknowledge though and recognize is that based upon the implied in fact contract and the course of dealing that the parties had, that the Healthcare Providers had with United, that set the foundation for the entry of contracts that we had at the hospitals. It also set the foundation then for the entry of contracts that we have with our own employees. We relied upon the representations of United as far as -- and the transparency, and how that we were going to be paid, and the course of conduct, and how we were going to be paid. Developed a business model upon that. We, you know, bid for contracts then with the hospitals based upon those.

Also, as far as -- went out and sought employees then to be able to man those contracts. That too is a form of detrimental reliance and that is at issue then in this circumstance. So, as to be sufficient then to address then any contention or any argument there has not been detrimental reliance.

So, let me turn quickly then as far as to the last claim that we had plead and that's our RICO claim. I think it's important to know that United is not only asking you to second guess Judge Mahan, but United is also asking you to second guess Judge Ferenbach, who also looked at the sufficiency of our pleading to determine whether or not that we could assert a claim, a RICO claim. When we were

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in Federal Court, they opposed our Motion for Leave and the principal ground that they opposed our Motion for Leave was a futility ground. That futility ground advanced, you know, essentially the same arguments that they have advanced here on a Motion to Dismiss standard. And Judge Ferenbach, well, had indicated that, yes, we've had sufficiently plead the RICO claim and allowed us then to amend and to file our First Amended Complaint.

All right. So, as a general overview, I think that one of the things that people suggest that somehow that RICO claims are particularly exotic or they require some type of fancy pleading so as to be eligible then for treble damages. There are many, many instances under state law that our state Legislature has articulated circumstances wherein fact the treble damages are appropriate.

Currently I'm handling a pro bono case on behalf of a woman who purchased a home where there were misrepresentations made on her Seller Disclosure Form. Those misrepresentations serve as a predicate then for getting treble damages as well as attorneys' fees. Same thing as far as under a RICO claim. They're not particularly unusual or out of the ordinary in our jurisdiction. They're what our Nevada Legislature has identified as beings sufficient then so as to be eligible

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for certain types of remedies and it is our Nevada Legislature then that has identified what are the claims that had issue.

And if you take a look at our Nevada Supreme Court's review of those claims, what our Nevada Supreme Court has continued to identify is *Siragusa versus Brown* remains the pleading standard and that decision was handed down back in 19 -- I think it was 1991 *Siragusa* was handed down and it remains the pleading standard today. And we have to allege no more than what was asserted in our Nevada statute and it's notwithstanding the fact that we did go above and beyond in the pleading in our First Amended Complaint.

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So let me specifically address the contentions that were made then by United. United began by -- in their papers they're contending that we had not met a proximate cause allegation. In their oral presentation they transformed that into a butfor argument and that butfor argument suggested that we had not sufficiently alleged the detrimental reliance of contention. Once again, going back to the issue of -- we would have provided services to these insureds anyway.

Once again, they ignored the fact that but for their conduct that we wouldn't have entered into hospital contracts or contracts with our own employees or that we

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wouldn't have engaged in this course of conduct then with them as we have done across the period of time that's at issue in this case.

But, equally important is that there is caselaw that identifies what one needs to address so as to assert either proximate cause or but for causation. And, if you look at Paragraph 148, 187 to 88, 102, 107, 108, 109, 113, 114, 115, and 148, they all identify and articulate then the proximate cause as well as the but for causation between the scheme that was put together by United and the enterprise that was thoroughly described then as being between United and Data iSight. We identified the link to that scheme. We also identified that there's no risk of double recovery since we are the only ones that are seeking recovery for the emergency room services that were rendered and we underscored the fact that, particularly as it relates to proximate causation, that this is a fact -- that proximate causation is a factual determination that's inappropriate for a Motion to Dismiss.

In addition, we -- when we identified in the fraud-based claims that were related to racketeering meet the recognized pleading standards of *Siragusa versus Brown*. If you look at both the moving papers as well as the Reply papers, they do a relatively decent job of articulating what the standards are. But what they entirely did is they

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didn't do any analysis of our Complaint to determine whether or not that we fit within those requirements. And, in fact, that the Court looks then at our First Amended Complaint, the only way that their argument has any merit is if the Court would ignore almost 100 separate paragraphs that set forth the who, the what, the why, the context, the representations that were made, by whom, to whom, etcetera. It would require the Court to also ignore the basic scheme that we identify at Paragraph 115, as well as what was said and when it was said that was found between 1120 -- Paragraphs 128 and 188.

The false statements deal everything with transparency, defensible and market tested representation, and geographic adjustment representations. And I think this is where I want to focus the Court's attention just a touch. We went into great detail about how -- that the three different types of representations that were being made by United to explain why it is that the differing rates of payment began to be applied and how the discounts that were being unilaterally applied by United. They all dealt with issues of transparency, that these rates then were defensible, and that they were market tested, and also the representations dealing with geographic adjustment. And there's not one single one of those representations that deal with anything that's suggesting that somehow the

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variances are because of individual plans that are at issue. They all focus upon the fact that there was supposedly some new independent third party that was giving United better advice and better information on what was the market tested and what was the geographic adjustments. But, as our Complaint alleges, each one of those representations was demonstrated to be false.

Finally, they challenge whether or not that we had alleged an intent to deceive. That was found at Paragraph 115. And if you look at 128 and 188, it also identifies how the enterprise engaged in such an intent to deceive.

The last challenge that United makes then to our RICO claim is an interesting one and I think it -- it's a fun little argument in that it requires one to look a little bit at Nevada's history and actually what Nevada's statute is. If you look at the statute under NRS 207.360 subsection 36, it identified what is defined as involuntary servitude in the state of Nevada. Nevada has a very specific statute and it has a very specific definition of what is involuntary servitude. It's not based upon common law. It's not based upon what some other state has said involuntary servitude is. It's not based upon what every state and what every court in another state has looked at as though what the common law may or may not have applied. But our assertion of involuntary servitude was based upon

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this specific definition that Nevada has embraced in defining what an involuntary servitude is.

And I'm going to, in relevant part, quote then:

It's a person who knowingly subjects another person to forced labor or services by abusing or threatening to abuse the law or legal process.

So, break this down. And think back then to the arguments that were made by both counsel for United, how that they underscored the fact that the Healthcare Providers are required by law to provide emergency healthcare services to everyone who walks through the door. And they said that was a legal duty by which that they had to perform and that that was independent of anything that Untied was doing or they could have done. But what have we alleged? We've alleged then, in fact, that United is abusing that law. They know that we are compelled and forced to provide services. And what they're trying to do is to dictate unilaterally what they believe are the value of those services and when, in fact, that we would not succumb then as far as to their coercion, their intimidation, the duress that they tried to apply by trying to get us into an in-network contract. They then turn the screws on us to take advantage of the fact that we were compelled to provide these services.

So, what does that do? It puts you square within

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the four corners of Nevada statute, puts you square within a person, United, who knowingly subjects another person, that is the Healthcare Providers, to forced labor or services, that they are knowingly subjecting us to -- compelling us to work by abusing or threatening to abuse the law or legal process. What United is doing is that they are compelling work through a threat then of trying to abuse or threaten to abuse the EMTALA, which is the federal law then that requires us to provide healthcare services and the state law counterpart.

And, so, to the extent then that we have fit them within the four corners of Nevada statute in defining involuntary servitude and therefore have sufficiently plead this as a predicate act that has been practiced by United, along with the other predicate acts that we have articulated then in our Complaint.

So, in sum, Your Honor, there is no complete preemption that is available here. That's a jurisdictional tool to determine whether or not that the Federal Courts have jurisdiction. There is no conflict preemption here because there's an independent legal duty that we have asserted. And, therefore, as long as we have an independent legal duty, then we are not conflict preempted.

And, as to each one of the contentions, or each one of the arguments that they have advanced under 12(b)(5)

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grounds, we've also then been able to articulate why that those grounds are insufficient then to support a Motion to Dismiss. And we would ask the Court to deny, in full, their Motion to Dismiss and allow us then to start moving toward discovery in this case.

Thank you.

THE COURT: Thank you. And without holding you to it, how long do you anticipate the reply will take, Mr. Robertson [sic]? Mr. Robertson [sic], you'll have to unmute.

MR. BALKENBUSH: I think you may be muted [indiscernible].

THE COURT: Mr. --

MR. ROBERTS: I apologize for that, Your Honor. My best guess is 25 to 30 minutes.

THE COURT: All right. We had a lunch here in the courtroom today. We need a five-minute break. We'll call back in about 2:45. Thank you.

MR. ROBERTS: Thank you, Your Honor.

[Recess taken at 2:39 p.m.]

[Hearing resumed at 2:45 p.m.]

THE COURT: Okay. And Mr. Roberts -- and I apologize. I called you Mr. Robertson. That was just an error. Mr. Roberts, your reply, please. You and Mr. Balkenbush.

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[Pause in proceedings]

THE COURT: So, Mr. Roberts, are you ready to present the reply argument?

MR. ROBERTS: Yes, Your Honor. I am. Thank you.

So, Your Honor, as an introductory matter in addressing the allegations and arguments that have been made by plaintiffs, I think one thing that the Court needs to think about is the framework of Nevada law in which these allegations occurred. The Nevada Legislature authorized companies, like the defendants, to implement managed care policies and programs. NRS 695G.040 defines managed care as a system for delivering healthcare services that encourages the efficient use of healthcare services by using employed or independently contracted providers of healthcare.

So, what United was doing in attempting to negotiate network agreements was completely -- not only permitted, but encouraged by Nevada law. The defendants' job as manage care organizations, is to try to lower healthcare costs and lower healthcare premiums for the people of Nevada. And there is nothing inherently nefarious about seeking to enter into in-network agreements with providers of healthcare at favorable rates which allow it to charge lower policy premiums. The Court can take judicial notice that under the Affordable Care Act there

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are limits on profits. If medical costs are less, it's passed on directly in the form of lower premiums to the people of the state. It's United's job to negotiate for lower rates.

And there is absolutely no right to have a contract with United by these plaintiffs at a favorable rate. This is a matter of arms' length contracting. United is offering a contract price. That's what they allege. They don't like that contract price. So, they specifically allege that no contract was entered into because they rejected the rates that United was offering them for a contract.

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And I'll get back to that as I address some of the additional arguments, Your Honor, but I believe there is agreement among the parties as to several key elements of the caselaw.

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First of all, with regard to this rate of payment versus right of payment dichotomy urged by the plaintiffs, they talked about the *Blue Cross* case and I'm assuming that's *Blue Cross of California versus Anesthesia Care Associates Medical Group*, 187 F.3d 1045, a Ninth Circuit case from 1999. And, in that case, the Court held: The dispute here is not over the right to payment, which might be said to depend upon the patients' assignments to the providers, but the amount or level of payment -- and I

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quote:

Which depends on the terms of provider agreements.

And that is at page 1051.

So, what this case says, and what we've pointed out to the Court, is that where there is an independent legal duty to pay a different rate than the plans might provide for, where the Court can decide how much the provider is owed without reference to the terms of the plan, then there is no preemption. Therefore, Your Honor, we agree that whether or not there is preemption here, both conflict or complete, is whether or not they have adequately alleged an independent duty to pay a particular amount under Nevada law, completely independent of the plan.

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And the *Marin General Hospital* case, which they quoted, is not contrary to that point of view. In that case, 581 F.3d 941 at page 950, the Ninth Circuit found:

The question under the second prong of *Davila* -- or *Davila* -- is whether the Complaint relies on a legal duty that arises independently of ERISA. Since the state law claims asserted in this case are in no way based on an obligation under an ERISA plan, and since they would exist whether or not an ERISA plan existed, they are based on other legal duties within the meaning

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of *Davila*.

And that quote there, Your Honor, is exactly what the defendants are arguing in this case. And that is that if you get right down to it, if the ERISA plans did not exist, if these persons seeking treatment from the plaintiffs were not insured under one of our plans, there would be no legal obligation. There would be no basis for a legal obligation. I believe that plaintiffs would acknowledge that every person -- every claim that they're seeking payment for from this Court is from someone with a United plan, 90 percent of which are more or less ERISA plans.

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So, *Marin*, if you get right down to the allegations in the Complaint, which they apparently modeled in this case, is irrelevant on this point because that would have to be based on a California state law claim and whether it's adequately plead.

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In this case, Your Honor, we agree that whether or not there is complete preemption and conflict preemption all comes down to whether they have sufficiently alleged a duty completely independent of any ERISA plan and for conflict preemption, which they can assert and the Court can determine how much they're owed on, without reference to the plan. And that's where this Complaint fails.

Ms. Lundvall mentioned *Certified Fire Protection*

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in her argument. And that is a case dealing with implied contract under Nevada law and that was Supreme Court case 128 Nevada 371. And that case is very important because what it says is that a contract -- and this is at Headnote 10, page 379 going on to 380:

> A contract implied in fact must be manifested by conduct. It is a true contract that arises from the tacit agreement of the parties. To find a contract implied in fact, the fact finder must conclude that the parties intended to contract and that promises were exchanged. And the general obligation must be sufficiently clear. It is at that point that the party may invoke quantum meruit as a gap filler to supply the absent term.

Now, we agree that Nevada's a notice pleading jurisdiction. We agree that it might not be necessary to always plead in detail every single fact that might ultimately be needed to prevail on a breach of contract implied in fact claim. However, when the parties choose, when the plaintiffs chose to plead in detail and they plead allegations, which the Court must assume are true, and those allegations are inconsistent what a contract implied in fact as defined by the Nevada Supreme Court, then this Court has to dismiss at that point.

An implied contract in Nevada is still a true

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contract that arises from the tacit agreement of the parties. And where the parties expressly refuse to contract, when they expressly allege that we failed to reach an agreement on the key terms of a contract, where they failed to allege that we exchanged a promise with them, then this Court is left with no choice. You have to dismiss that claim.

And what is the gap filler that this Court is being asked to insert? It's the price, the very term that caused the parties to be unable to reach an express contract.

With regard to preemption, I go a step further. The *Certified Fire Protection* case also talks about unjust enrichment. In that case, the unjust enrichment element would have to be proven: How much is United enriched?

Now, -- and I apologize for jumping around just in trying to get through this quickly, Your Honor, but with regard to unjust enrichment, we're not citing those out of cases -- state cases for the point that an indirect benefit is not enough. I believe if you go back and read the cases that we cited to you on this issue, you'll find that these out of state cases said that a provider treating an insured does not constitute any benefit to the insurer. So, United received no benefit from the fact that they treated our plan member.

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But let's assume that they're right. Let's assume that there is an indirect benefit because they -- if they had not treated our patient, that patient would have gone to an in-network provider, that we would have then paid the -- a contracted rate for or gone to another out of network provider. Here's the hitch, Your Honor. What is unjust enrichment? In this case, it could only be the difference between what we were required to pay under the terms of our insured's plan versus what we actually paid to them. You could not determine the amount that we had been unjustly enriched without reference to the term of the plan, which is what conflict preemption comes down to.

Think of it this way, in the extreme, to highlight the argument, Your Honor. Let's assume that we wrote a plan and the employer was trying to get the rates down. And, so, we negotiated plan provisions with an employer that said emergency room treatments are not covered by the plan. Well, in that case, if one of our insureds went to the emergency room and received treatment, we wouldn't receive any benefit. There would be no unjust enrichment because we had a negotiated agreement with our insured that emergency room treatment was not covered by the plan. Similarly, if our plan says we'll reimburse you 150 percent of Medicaid if you visit the emergency room, an out of network provider. Well, you can't determine what the

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unjust enrichment would be without determining how much we were obligated to pay under the plan versus how much we actually paid Fremont. It simply is a calculation that the Court cannot do without reference to what our obligation is through our insureds under the plan.

In addition, Your Honor, with regard to the implied contract, they attempt to distinguish the *Recrion* case by saying there was a solicitation of services. It was by the patient. It was by our insured. The fatal flaw with that argument, Your Honor, is that they do not allege anywhere in the Complaint that our insured members were acting as our agents when they sought care. In fact, it would be United's preference, and most of our plans encourage people to seek treatment from in-network providers where we have negotiated agreements in fulfilling the managed care obligation we have to try to negotiate and keep prices down.

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Our insureds may have solicited services, but none of the defendants solicited any services from these providers.

In addition, with regard to the contract implied in fact, Your Honor, I'd ask the Court to look at the provisions of the Complaint, including, in particular, Paragraph 104. And, in Paragraph 104, they state that Mr. Schumacher [phonetic] advised in a phone call that

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defendants planned to cut the rates over three years if the Healthcare Providers did not formally contract them at a rate dictated by defendants. Well, a rate dictated by defendants is nothing more than the offer, which is part of a contract formation. And the Complaint here, in this paragraph, specifically alleges that we gave them notice before we reduced their reimbursement rates.

Overall, Your Honor, I understand that if you read these provisions of the Complaint they sound bad. They sound like there should be a remedy, that United was being a bully, but, ultimately, United was offering a contract which they did not accept. Therefore, what is their remedy? And they have one. The fatal flaw here, Your Honor, is United has no power to do what has been argued here to you today, to subject these plaintiffs to involuntary servitude, to make them perform services at rates which we solely dictate. And the -- because the fatal flaw is that these are all plans. They have assignments of benefits from our insured members, which we have demonstrated to the Court by attaching them to our Motion to Dismiss. They stand in the shoes of our members. And, frankly, Your Honor, there is no support for any allegation anywhere in these pleadings that under our plans we have the right to unilaterally pay whatever we want to for services received by our insured members. The plans

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themselves set the terms. And it is not unjust enrichment for United to only pay the amounts which it's obligated to pay under the terms of its plan.

And if they choose to -- they can go through the ERISA appellate process, they can appeal the rate for which they have been paid, and if they don't like the outcome of that, they can bring suit under ERISA to compel us to fairly pay in accordance with the terms of the plan. And that is the appropriate remedy here. And that is what they're trying to use artful pleading to avoid. They don't want us to pay what we're contractually obligated to pay under the policies that we have negotiated with our insures. The amounts we are obligated to pay is a matter of contract negotiation, which results in a premium. It's based on that plan and our obligations under that plan. And they're trying to circumvent that.

The remedy here is not some slippery slope bouncing back and forth from jurisdiction to jurisdiction. The remedy here is for them to plead that we haven't paid what the ERISA plans require us to pay and take an appeal of that. And the Court would have jurisdiction to hear it -- the Federal Court would certainly have jurisdiction to hear it. They wouldn't dismiss it. The only reason they dismissed this case is based on a misunderstanding of a bare allegation of state law, which this Court is not bound

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to.

And, by the way, Your Honor, the difference between the remand decisions and any findings made in remand and this Court is decisions this Court makes are appealable by both parties. Over in Federal Court, we could not appeal to the Ninth Circuit from the remand and the strong presumption against federal jurisdiction. There is no remedy to appeal and it's because of that that courts usually -- State Courts usually don't provide deference to any findings in a remand order because they're not the law of the case the way an appealable decision would be the law of the case.

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Their remedy here is to assert the actual rights they have, the only rights they have against us, which are those arising out of the assignments of plan benefits from our insured members.

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There is no contract implied in fact stated here because they chose to be specific with the allegations of the Complaint and they have specifically plead allegations which are inconsistent with the ability of this Court to find that United tacitly agreed to pay them more than our contract plans require. And that's what they're trying to get by in this Court with this pleading as it's now plead.

Deceptive Trade Practices Act, we've covered that in the brief. Ultimately, we've cited caselaw saying that

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unfair trade practice claims are preempted by ERISA, but if they're not preempted by ERISA, once again, you need an independent contract obligation, which they have insufficiently alleged here an implied contract under Nevada law.

I'm skipping a few things here, Your Honor.

So, ultimately, Your Honor, I'm going to shorten my argument because I do believe that although we've raised many appropriate arguments and some of these things are very complex, I believe that this Court can reach a decision based on the law that we've now pretty much agreed to with the plaintiffs. And that is: Have the plaintiffs adequately plead an implied in fact contract with the defendants under Nevada law which entitles them to payment even if the ERISA plans did not exist?

And, Your Honor, I would respectfully submit that the allegations of the Complaint, where they specifically admit that the parties discussed the contract and United expressly refused the contract with these plaintiffs at the rates that they're alleging they are entitled to reimbursement for in this lawsuit, shows that there can be no implied contract under Nevada law. And that if not for the existence of ERISA plans, United would have no obligation whatsoever to pay these plaintiffs anything. And, therefore, it doesn't really matter whether or not

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this Court does it on complete preemption or conflict preemption, because both would require an independent obligation under state law, which they have inadequately alleged here.

But, I must mention, Your Honor, that the Nevada Supreme Court has specifically affirmed the dismissal, not summary judgment, but has specifically affirmed the dismissal of preempted ERISA claims on a Motion to Dismiss. And that is the *Marcoz* case, 106 Nevada 737. Counsel for plaintiffs argued to this Court that that case did not analyze the *Davila* decision, the *Davila* factors. But, obviously, this was 14 years before the *Davila* case was decided and they would not have been analyzing those factors.

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If the Court will read this case and get down to the end and to the conclusions, under preemption of non-ERISA benefits, page 749, quote:

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

So, regardless of what counsel wants to argue the Court decided, the Nevada Supreme Court chose to use the

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words complete preemption in affirming the dismissal of claims based on preemption, including preemption of non-ERISA benefits. So, there is precedent for this Court to dismiss these claims based upon complete preemption. But it's unnecessary for the Court to do so because the lack of an independent, adequately plead remedy under state law, which the Court can rule on without reference to the terms of the ERISA plan to determine the damages, compels conflict preemption in any event.

And, with that, Your Honor, I will turn it back over to Mr. Balkenbush to briefly address the RICO claim.

THE COURT: Thank you.

Mr. Balkenbush?

MR. BALKENBUSH: Thank you, Your Honor.

To start out, I'd like to go back to an argument that Ms. Lundvall ended on at the last hearing when she had about 10 or 15 minutes to rebut our initial arguments on RICO. And what we argued initially at that hearing, at the outset, is that this Court should be especially skeptical of the RICO claim. And we cited to a number of Nevada Supreme Court cases, including the *Hale v. Brurkhardt* case, which said that district courts need to, quote:

Guard against the overzealous use of RICO.

And the response to that argument that this Court should be especially skeptical of the RICO claim here, the

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response was that: Well, Your Honor, we've alleged in the Complaint that this isn't the first time. It's not beyond the pale that, you know, United could be seemed as a criminal syndicate because they've done this before and we've alleged that in the Complaint. And they have alleged -- they have alleged prior bad acts in the Complaint. But, in particular, it's paragraph 70 to 75 of the Complaint. But the issue is, Your Honor, that the Court should not even consider those allegations. In fact, those allegations should be considered inadmissible under NRS 48.045, which prohibits using character evidence to prove that a defendant acted in conformity with bad character based on prior bad acts. And, also, based on NRS 50.095, which prohibits the introduction of prior bad act evidence unless the -- it's evidence of a conviction within the last 10 years and the conviction is punishable by death or imprisonment for more than one year.

If you look at the allegations in their Complaint regarding this prior bad acts by United, -- alleged prior bad acts, you'll see that they're from 2009 and they involved two cases that United settled. These aren't convictions. They aren't even criminal proceedings. So, there's no question that, one, these allegations shouldn't even be considered in assessing whether or not they have stated a RICO claim. And, two, there's no question that,

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most likely, United will have grounds to bring a Motion to Strike these allegations under Rule 12(f), given that they are redundant and immaterial to the claims at issue. And, then, we probably also have grounds to bring a Motion in Limine to preclude any evidence regarding these prior bad acts.

So, -- and another issue I want to raise with that, Your Honor, is if you look at the prior bad acts they allege, they're only against three specific United entities from 2009. These prior bad acts aren't against the -- all of the defendants that are listed in the Complaint here. There's no allegations of prior bad acts by Oxford Health Plans or by Health Plan of Nevada. And, so, we would request that the Court disregard these prior bad act allegations in assessing whether or not a RICO claim is appropriate here.

Moving on to some of the arguments that Ms. Lundvall made to today in her rebuttal. Today, for the first time, we heard a response to the argument that we have been emphasizing all along in regard to the RICO claim. That is, our argument is that they cannot allege but for causation here because they were required to treat these patients regardless of their ability to pay or insured status. And, so, for the first time in the briefing, they actually only responded to this in a

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footnote. And they kind of alluded that you don't have to allege direct causation as long as there's some relationship and they cited to the three proximate cause factors in the Holme -- in the U.S. Supreme Court's *Holmes* decision. But they never really wrestled with the merits of this argument. But, today, Ms. Lundvall did actually address the merits of the argument. And the response was that Fremont and the Healthcare Providers, that they detrimentally relied on the alleged false representations of United by contracting with hospitals at particular rates, by agreeing to particular compensation agreements with doctors and other medical providers, and that that is the detrimental reliance, that is the causation link that shows that regardless of the state and federal laws that require them to treat patients, that shows that they have alleged causation and they can meet the RICO causation element.

Well, the problem is, Your Honor, there's a reason they didn't raise that issue in the papers. That allegation is nowhere in their First Amended Complaint. There is -- there's an allegation in their Complaint that they were damaged. They were damaged by our false representations. But there is no -- no specific allegation that they detrimentally relied on our alleged false representations by altering their business model, by

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entering into specialized contracts with hospitals based on, you know, some representation about the particular rates of imbursement that would be issued. That's simply not in the Complaint.

And, so, I guess, what I would encourage the Court to do is to read through the Frist Amended Complaint and see if there's an allegation in there that actually says we changed our business model, we entered into specific contracts with hospitals based on United's alleged false representations about the rate of reimbursement. Not there, Your Honor. And, so, we would, again, contend that the RICO claim should be dismissed for the sole reason of the fact they have failed to allege but for causation.

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The Healthcare Providers also raised another issue in their rebuttal and that is that this idea that we somehow transformed our proximate cause argument in the Reply and that we -- this is something we never raised before. And we never raised a but for causation issue. That's incorrect, Your Honor. If you look at page 4 of our opening brief, we cite to both the Nevada Supreme Court's *Allum* decision and we quote it, noting that it states that there must be a, quote:

> Direct causal connection between the harm alleged and the damages alleged.

And we also cite to the U.S. Supreme Court's

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Holmes decision, which the Healthcare Providers also cited to, and that decision specifically states that but for causation is a required element of any RICO claim.

Now, I want to also address the involuntary servitude claim that the plaintiffs have addressed in their rebuttal. The argument regarding involuntary servitude claim that they make is that the Court should disregard the federal cases that United cites that essentially state that this is a RICO predicate crime that is limited to instances of physical coercion, essentially limited to things like forced labor camps or African slavery, and that Nevada has a special statute for involuntary servitude and has different elements than are required under a federal RICO involuntary servitude claim.

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Again, I would just encourage the Court to read the *Allum* decision, to read the other RICO decisions that we cited. The Nevada Supreme Court has specifically stated that Nevada's RICO statute is patterned on the federal RICO statute. And the only reason Nevada has involuntary servitude listed as a predicate RICO act is because it's also listed as a predicate RICO act under the federal RICO statute. So, the federal cases interpreting involuntary servitude and essentially stating that it's only -- you can only allege it in very limited circumstances such as forced labor camps and things of that nature, those are persuasive

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and the Court should follow those decisions in this case, especially given that there is no Nevada Supreme Court case law directly on point dealing with an involuntary servicing claim in the context of a RICO civil claim.

And, finally, Your Honor, I'll just close briefly with the preemption issue for the RICO claim. Ms. Lundvall cited to the *Gobeille* decision and what she focused on was the first prong of that decision, which says that a state law is only preempted if it references a -- if it references an ERISA plan. What we focused on in our briefing and we want the Court to focus on is the second prong of the *Gobeille* decision, which says if a state law impacts a central matter of plan administration, it must be deemed preempted. That is the fact that ERISA -- or, excuse me. The fact that Nevada's RICO statute does not reference the federal ERISA scheme does not mean that their state law RICO claim escapes preemption.

If their RICO claim is essentially seeking to force United to pay rates that are different than the rates set forth in the plan, then the RICO claim is impacting essential matter of plan administration. ERISA expressly requires -- and this is 29 U.S.C. Section 1104, subsection (a), ERISA expressly requires planned administrators like United to administer the plan, quote:

In accordance with the documents and instruments

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governing the plan.

Therefore, any state law claim that seeks to force United to pay out something different, to pay a different rate of payment than the rate of payment called for by the plan's terms, must be preempted.

And, so, we would request that the Court also find the RICO claim is both completely preempted and conflict preempted. Thank you, Your Honor.

THE COURT: Thank you both. But, unless anyone has anything else to add, the matter is submitted and this is the ruling of the Court. This is a preemption issue on an ERISA argument and it's a request to dismiss the Complaint. I'm going to deny the Motion to Dismiss for a number of reasons.

First, I realize that ERISA section 5.14(a) says that all state laws that relate to an employee benefit plan will be preempted. However, I just don't find that this is the relationship that is intended by this statute. The ERISA deals with plans and their members. And, here, it's a provider and the insurer. So, I don't find that the preemption doctrine is implemented. I started on the -- when my analysis on the presumption that it was preempted, I read the necessary cases, but I don't find that the test is met here, either for complete or conflict preemption.

There's also a presumption that federal laws do

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not preempt an application of state and local laws, regulating the matters that fall within traditional powers of the state, including health and safety matters. And that weighed heavily in my decision. I read *Davila*, or *Davila*, and looked at both tests. I found that they didn't apply here. I found Judge Mahan's remand very persuasive because he already ruled that part of the claim was not preempted.

I analyzed every single cause of action under Nevada law to determine whether or not the facts were sufficient and the cause of action existed. And I found that it did. So, the allegations in the Complaint were sufficient. And all of the causes of action, taking the Complaint as true, relief could be granted in favor of the plaintiff if in fact the proof and the determination at trial is made.

Now, with regard to the particularity, I do find that all of the causes of action were appropriately plead -- or, sufficiently plead, not appropriately, sufficiently plead under the Rules of Civil Procedure. And I recognize that various rules apply to different causes of action. I do find that every element was met. And there's a lot of argument by the defendant on reliance. But, reading the Complaint as a whole, it was that change in the reimbursement rates and the reliance that they had on the

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prior reimbursement that I found persuasive in the Complaint.

With regard to the contract and tort claims, I went through each one and they were sufficiently plead in a manner under which relief can be granted. The plaintiff will be directed to prepare Findings of Fact and Conclusions of Law. They should be consistent not only with my ruling here today but, also, with the Opposition papers to the Motion to Dismiss. And that includes the supplement.

That takes us to the second motion, which is the Defendants' Motion Requesting That the Court Decline to Recognize the Pre-Remand Federal Court Filings. Mr. Roberts and Mr. Balkenbush, please.

MR. ROBERTS: Sorry. Your Honor, I believe that that Motion was resolved by agreement at the last hearing where, ultimately, --

THE COURT: I thought so, too. But, if I was wrong, I wanted to give you a chance to argue.

MR. ROBERTS: No. Your Honor, that was primarily directed to the Amended Complaint that was filed in Federal Court. The plaintiffs refiled that Amended Complaint and we addressed it, which I believe eliminates the need for any immediate relief on that Motion.

To the extent that there is any other issue, I

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believe the plaintiffs have agreed that the discovery plans and orders entered by the Federal Court would not apply. I think the Motion for Leave to Amend has now been mooted. So, I can't think of any reason why we need the Court to rule on that Motion today.

THE COURT: Okay. Ms. Lundvall, do you wish to comment?

MS. LUNDVALL: Yes. Now that I've unmuted my mic, I agree with Mr. Roberts that that Motion has been resolved by an agreement. I would imagine that the Court, from a technical standpoint, needs to make a determination or enter a determination up on the record and would agree with Mr. Roberts that that could be indicated as being resolved by agreement, then, that the Motion to Decline Recognition, then, the Federal Court findings, then, has been resolved against them.

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THE COURT: Good enough. So, it would be my intention, counsel, just to vacate the hearing from today's docket based upon a stipulation of this file. Any objection to that? It's the Defendants' Motion. Mr. Roberts, then Ms. Lundvall.

MS. LUNDVALL: No, Your Honor.

MR. ROBERTS: That --

THE COURT: Okay. Then we --

MR. ROBERTS: Your Honor, that would be acceptable

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to United. I think I was muted again. And that the hearing on that can be vacated and the Motion could be noted as withdrawn on the minutes of the Court.

THE COURT: Ms. Lundvall?

MS. LUNDVALL: Yes, Your Honor. We would agree.

THE COURT: Okay. That takes us to the third motion, which is the Plaintiff's Motion to Compel the Defendants to Meet and Confer Participation and Related Action on Order Shortening Time. Given the ruling on the Motion to Dismiss, which will trigger under the rules an Answer, and, then, a Rule 16, JCCR Rule 16 meeting. Is it necessary for us to go forward on the Plaintiff's Motion at this point?

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MS. GALLAGHER: Your Honor, this is Kristen Gallagher on behalf of the plaintiff. Good afternoon.

So, it is our position that I would like to at least discuss the Motion to Compel. There has been some activity on it and with respect to some of the pieces that were identified in the Motion to Compel, it was resolved by agreement. However, there has been some subsequent activity that I think it's important to lay the groundwork for in connection with a Rule 16 conference.

And, if I may ask the Court, does the Court intend on proceeding with a Rule 16 conference today? It was my understanding that we would be discussing a discovery plan

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today as well.

THE COURT: We put it on the calendar for today. And I realize that may be premature at this point because the defendant has not known if they even had to respond to a pleading. So, I'm willing to consider this as a preliminary mandatory Rule 16 conference. But I do think we need to have some agreement that you need -- still need to do initial disclosures, you still need to meet and file a report, and I can bring you back for a status after that occurs.

So, may I have your response to that? And, then, I'll hear from Mr. Roberts and Mr. Balkenbush.

MS. GALLAGHER: Yes, Your Honor.

So, as you know, our Motion to Compel was intended to move forward two pieces of discovery that had actually started while we were in Federal Court. That was we had sought a meet and confer with respect to defendants' responses to discovery because they had indeed provided responses that we felt were not sufficient. So, that was the first point that we raised in our Motion to Compel.

And the second piece was a subset of the same discovery, asking for United to produce documents that it had promised to do so before Magistrate Judge Ferenbach. And we had identified those as responses to RFP numbers 11, 12, 13, 21, 27, 37, and 44. And, so, if Your Honor recalls

on the May 15th subject, due to the party's stipulation, the Court entered an order compelling those documents to be produced. And I wanted to raise with the Court today the issues that continue, and realize that perhaps this is preliminary, but would like to lay the groundwork for where we are on that, Your Honor. Because it was an order of the Court, we took it to mean that United would respond with respect to those requests for production that I've identified.

But what we saw on June 1st in connection with the agreement was that united only produced a series of agreements with MultiPlan, also known as Data iSight, in connection with an affiliate company. And that document was redacted throughout with information that United has indicated is irrelevant, and proprietary, and therefore entitled to redaction. So, in an effort to move that piece forward, Your Honor, we requested a meet and confer. Initially, it was not responded to by United in a favorable manner. But we did meet this morning. And, so, I think it's important to understand what sort of responses we're getting from United, which is consistent with what we've seen before, which is an agreement to perhaps to meet with us and to discuss an issue. And, then, when we actually meet, United's counsel doesn't have a substantive availability to discuss.

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So, I'll give you an example, that happened this morning, Your Honor. With respect to RFP number 13 and 27, we had asked for documents relating to negotiations and discussions about out of network rates and United had proposed a few benchmark pricing programs. And, so, initially, prior to remand, United indicated that it was in the process of collecting responsive documents. And I call this phraseology out because it's something consistent that we see prior to remand and, then, after remand, that this type of phrasing doesn't actually commit United to any particular position or agreement. It more serves as a placeholder, a meeting to, then, regroup again and meet and confer on the same issue a second time and, in some cases, a third and a fourth time.

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So, this is evidence by the supplement that we received on June 1st. United now has said that it couldn't locate any additional documents relating to out of network negotiations, an issue that we find to be concerning because we think that there are a number of e-mails that would have been discussing that sort of negotiation.

In response, what we're hearing is perhaps a reclassification of where these e-mails or where these discussions may be and United characterizing it as being within the administrative record. And if Your Honor is familiar with an administrative record from an ERISA

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proceeding, it's very specific. It includes explanations of benefits, it includes Healthcare Provider remittance forms, and, then, United has defined it as including some other documents that it is now indicating that will include any communications about a specific claim.

And that's important in this case because what we heard today is that United has not undertaken any review or collection of the administrative record because it's claiming that it is too burdensome. And they have submitted a declaration indicating what that -- what they think that burden is. But it's important to understand that the Healthcare Providers have tried to move this ball forward since February by making an offer of compromise for discovery-related matters that would substantially narrow the data points that underlie the dispute about how much was billed and how much United has paid. And we have been endeavoring to reach an agreement on that particular point, like I said, since February. And the recent discussions and subsequent meet and confers on those issues have not yielded us any further response from United, only that it continues to look into those particular points.

And, so, I raise this point, Your Honor, as we go down the road of meet and conferring. I think it's an -- it's going to be perhaps a mantra that we hear several times and wanted to have the opportunity to lay that

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groundwork for Your Honor.

With respect to the Rule 16 conference that was for today, we did meet and confer in advance of today's hearing on that particular point. And I do have a proposed discovery plan that I would be interested in setting forth, if Your Honor is open to that. Regardless of whether or not there's an Answer on file, we would ask, as we've been asking since we filed our status report, that discovery continue and that there not be any further delay in terms of further document production, meeting and conferring, issuing subpoenas that may be available to third parties that we can go forward with.

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As I mentioned, the parties had conducted discovery and has done initial disclosures in the federal case and we think it would be appropriate to go forward. So, if Your Honor is open to the proposal that we've discussed and communicated to United, I'd be happy to explain that to Your Honor.

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THE COURT: All right. Let me hear the response from the defendant before we get there.

MR. BALKENBUSH: Thank you. And this is Colby Balkenbush. I'll respond on behalf of the defendants since I was on the call with Ms. Gallagher this morning. Okay.

So, let me start with there's a lot of different issues raised in the plaintiff's response there. So, the

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Motion to Compel they brought, we understood as well that that had been resolved by the parties' joint agreement by the stipulation. What that Motion to Compel essentially sought was, one, the production of documents that United had promised to produce by a particular date and its discovery responses that were submitted in the Federal Court proceeding. And two was that motion sought an agreement by United that they would meet and confer with the plaintiffs on some discovery issues. We -- United has done both of the things that the Motion to Compel asked. It supplemented its discovery responses on June 1st and produced additional documents. And we have been meeting and conferring with the plaintiffs on these issues. We haven't been refusing to take their phone calls or meet with them.

Now, what Ms. Gallagher referred to as there is now a dispute between the parties over the sufficiency of the new supplemental response that United submitted that was required by the stipulation. And we had a meet and confer call this morning on that. Ms. Gallagher pointed out some things with our responses that she believes are inadequate. And what we said is: You know, look, there was no -- we never received an e-mail or outline of these issues before the call, or says we'll look into these issues. We're -- we've already contacted our client to

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start getting their view on, you know, if there's any other documents out there, anything was left out. A lot of these issues are sort of an argument by the plaintiffs that, well, they think that there must be more out there. And, so, what we've said is: Well, let us contact our client, let us, you know, see if there's more out there. And, you know, if there is, well, we can -- you know, we'll get back to you and we will -- we'll supplement. And, so, we agreed to meet and confer again this coming Monday on that issue.

So, -- and I guess I should say, too, is I just generally -- I don't think it's appropriate to get into a tit for tat over what was said and who admitted or argued what on a meet and confer call -- or a discovery that's supposed to bring good faith. But, in any case, certainly, I disagree generally with some of the characterizations Ms. Gallagher made about what was said on the call. And I think that this matter, as far as the sufficiency of the supplemental discovery responses, is premature at this point, given that we already have another meet and confer call scheduled for next Monday.

And, as the Court pointed out, we haven't even had the Rule 16 conference yet. So, our view is that let's try to resolve this without court action if we can. We're still in the meet and confer process. We literally just had our call this morning. So, I don't know that it's

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appropriate at this point in time to essentially bring what is an oral motion by the plaintiffs over the sufficiency of supplemental responses.

THE COURT: Okay. And do you object to the discovery plan? And do you have any objection to me hearing it?

MR. BALKENBUSH: No, Your Honor. We are prepared to discuss a discovery plan at this point. We agreed to participate in a Rule 16 conference, even though we had not filed an Answer yet. We have a little different discovery plan than -- a little different idea of how discovery should proceed than the plaintiffs do. But if the Court is prepared, we are prepared to go forward and have a Rule 16 conference today. We did meet and confer with the plaintiff on that.

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THE COURT: Good enough. All right.

So, Ms. Gallagher, your response, please?

MS. GALLAGHER: Sure, Your Honor.

So, the Healthcare Providers would like to have a 90-day period of fact discovery that is followed, then, by 120 days of expert discovery. That would, then, put discovery completely to close by December 10th. The 90-day fact period would close September 3rd of this year with expert discovery closing on January 4th of 2021. The interim deadlines, Your Honor, are initial expert report

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deadlines on October 5th, 2020. Amending pleadings and adding parties would be closed on October 6th. Rebuttal expert report deadline on November 4th. And, then, the expert deadline and completion of all discovery -- expert discovery, January 4th, 2021. And that puts dispositive motions, then, in early February 2021.

So, I think it's important for me to explain why we think that this can be met. This seems to be a shortened timeline, given what United has indicated is a very large document ask of them. They have protested through a declaration of undue burden, that it's going to take them quite a bit of time in order to pull things like explanations of benefits, provider remittance forms, and other documents that they are describing as part of the administrative record, although I will indicate to you that I don't have further information on what specific documents that that may entail. So, although United has protested that it will take upwards of three years of constant document production, on the first hand, we think that that is not supported. We have submitted a declaration indicating that we think those documents can be collected in much less of a time frame.

But, even more important than that, when it gets down to it, really what the dispute is with respect to the specific individual claims is: How much did we bill and

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how much did they pay? And, so, when you get down to that, you can eliminate a lot of the rest of the information. So, we proposed, like I mentioned earlier, in February, that we submit to a protocol that would then negate the ability of -- or, the requirement of United to have to pull explanation of benefits and provider remittance forms. In exchange, Fremont and the Healthcare Providers would not have to pull each HCPA form. And if Your Honor is familiar with those forms, those include information about how much was billed, the patient, the date of service, and that sort of information.

We have already in the course of this case produced a list of all of the at issue claims. And, so, United has had those data points and those dates of service and their members' information for quite some time. And we have supplemented that information recently.

And, so, what we proposed is that they match our spreadsheets. In other words, they pull their information and if there are any particular points of data in terms of adjust relating to the amount billed and the amount paid, which is the crux of the underlying breach of the implied contract claim, then that would be where we have the discussion. So, United would then have a period of time to respond. Any items that don't match, we would then be able to further have a discussion on and whittle that down. So,

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that takes away a lot, Your Honor, of what is at issue in terms of United's view of needing a long time to be able to pull documents for discovery.

Part of that compromise includes some additional points. Because we are specific to the Data iSight and the MultiPlan relationship, we are looking for information on that. And it also included an agreement to exchange a market file relating to what some rates are being paid among providers in this market.

So, we have endeavored to drastically reduce the scope that we think is well within a 90-day fact discovery period, and, then, followed by the expert period. So, we would ask that Your Honor consider that in terms of Rule 16, subsection (c)(2)(A) for formulating and simplifying the issues, as well as under (c)(2)(D), which allows the Court to avoid unnecessary proof and cumulative evidence, which we think that those EOBs, PRAs, and the HCFA forms would be if the parties simply agree on the data. Because they both have sophisticated document management systems and that this information should be relatively easy to be able to call and be able to sift through in terms of what matches or what doesn't match.

So, I think it's important that I reiterate that we've had these discussions with United since February. We have been told recently in the meet and confer that was

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part of the May 15th stip and order that United was indeed interested in a compromise of such nature. However, since then, we have not had any substantive conversation about what that might be, other than United indicating that they're not sure whether or not point 2 with regard to Data iSight would really negate the rest of it. But I would encourage Your Honor to consider, as part of the Rule 16, ordering the parties to identify ways to be able to just meet -- identify the data point so that it's unnecessary for the parties to have to pull the underlying documents.

I do want to make one point, though, clear, is that today I heard some discussion that United is characterizing this as not a need to pull the administrative record, which United's counsel has indicated includes communications and e-mails that would be part of that record. I want to make it clear that is not something that the Healthcare Providers would be interested in in terms of not receiving e-mails and communications that United's counsel today indicated would necessarily be part of an administrative record and not part of any Outlook or other e-mail program. So, I just want to make that distinction clear with information that is sort of new to me today in terms of the language during the meet and confer.

So, I guess I'll turn it over to Mr. Balkenbush in

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terms of their discovery plan. But, Your Honor, I think there is sufficient information and ability to call this down.

And, then, one piece that I'll also just leave for the end is the status of the protective order that's I'd like to address after Mr. Balkenbush has a chance to discuss.

THE COURT: All right. So, rather than hearing again from Mr. Balkenbush, it seems that this situation has evolved since the time the papers was -- were filed. You are still negotiating. It seems premature to me to grant the Motion to Compel at this point. You guys have raised things that have occurred since I read the papers. So, my suggestion would be that I'll set a deadline for a JCCR. If there are competing discovery plans, you should address those. My thought is July 17th, with a Rule 16 conference on July 23rd at 10 a.m. And, based upon what I hear at the Rule 16 conference, I'd be prepared to set trial at that point. Responses, please? First from the plaintiff and, then, the defendant.

MS. GALLAGHER: Your Honor, during that interim period, would it be fair to say that discovery that is in progress may continue and that plaintiff may issue discovery, perhaps Rule 45 subpoenas and related items?

THE COURT: Well, if -- I don't know if you guys

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are aware, but our Chief Judge has done a series of administrative orders and all deadlines imposed in discovery will extend for 30 days after we get back to work. And we're not there yet. So, I'm not prepared to enter any type of order that would be contradictory to an administrative order of the Chief Judge.

MS. GALLAGHER: But it -- if I may clarify, Your Honor? In terms of issuing discovery, then, that necessarily wouldn't contradict with the administrative order, --

THE COURT: Issue --

MS. GALLAGHER: -- would that be your sentiment as well?

THE COURT: Issuance is one thing; response time is tolled for 30 days after we get back to work. I can't change that.

So, Ms. Gallagher, if you have a response? And, then, I'll hear from Mr. Balkenbush, please.

MS. GALLAGHER: So, Your Honor, with respect to the Motion to Compel, we had asked that Your Honor compel defendants' participation because these were issues that were in progress. And, because the case has not been dismissed and that we are moving forward, we would like to take advantage of this time between the parties to be able to iron out these issues. What we have been seeing in

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Federal Court and currently is kicking it down the can -- kicking the can down the road, meaning we meet on an issue and we don't get a substantive move, we get something with: I'm going to have to talk to me client. And, then, the next time we meet, I don't have anything additional to move the case forward. So, we would ask Your Honor to allow the discovery that is in progress at a minimum to continue. And, then, perhaps to allow the issuance of such because some of the subpoenas that may be issued may not have jurisdiction in Nevada, they may be outside of the state, and those states may have different administrative orders governing that type of response, Your Honor. And, so, we would ask that we don't be continued to have -- not moving the case forward in terms of discovery.

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THE COURT: Thank you.

Mr. Balkenbush?

MR. BALKENBUSH: So, I guess, first, Your Honor, a few things, too. As far as the July 16th, I think, date the Court gave for the Joint Case Conference Report and the July 23rd date for the Rule 16 conference, I'm open on those dates. And I'll defer to my colleague, Mr. Roberts, to confirm that he is. But I believe we're open on those dates.

And, then, the fact that the issue is with this request for additional discovery, we're just not in a

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position right now to agree to, you know, whether the -- to serving additional subpoenas or additional written discovery without conferring with our client. And, so, we're just hesitant to make an agreement here at the spur of the moment without first having a conversation with our client about this issue. We didn't expect this particular issue to arise. So, that's -- I guess I'll leave it at that.

THE COURT: All right. So, let me clarify for both of you, the Motion to Compel, the Meet and Confer Participation, etcetera, is denied without prejudice. The -- we've held an initial Rule 16 conference today. Discovery may begin. However, I can't change the deadlines if there are not prompt responses. And that's just in compliance with our Chief Judge. I have set a deadline, it's Friday the 17th of July for the JCCR. And the Rule 16 conference will be held on July 23 at 10 a.m.

Now, is there anything else we need to do today? It's on the record that the second motion was vacated. The Motion to Compel is denied without prejudice. And I'll direct Mr. Balkenbush to prepare that Order. Ms. Gallagher, do you wish to approve the form of that Order?

MS. GALLAGHER: I do, Your Honor.

THE COURT: Okay. And, so, --

MS. GALLAGHER: And if I may raise the issue of

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the protective order that remains outstanding?

THE COURT: You may.

MS. GALLAGHER: So, we have had several exchanges with United with respect to the protective order. I had hoped to have a final response from Mr. Balkenbush today. But one of the things I'd like to propose is that if we don't have an agreed upon version by the end of the week, that the Court enter the prior version that was entered in federal court, the one that was submitted in connection with our status report as Exhibit 4.

THE COURT: You know, --

MS. GALLAGHER: And the reason for that is we are seeing a lot of edits that go beyond what we had anticipated. We were trying to better define AEO designations. We were trying to address trial preparations and other indications of whether or not AEO designations would be appropriate -- bless you. And outside of the scope of what would be appropriate. And, so, what we'd like to do is get this protective order on file as soon as possible. I'm hoping Mr. Balkenbush will get back to me. But, if not, we would ask that the Court go ahead and enter Exhibit 4 by the end of the week if the Court hasn't seen a protective order submitted.

THE COURT: Mr. Balkenbush? Or Mr. Roberts.

MR. BALKENBUSH: Sure. And the issue with the

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protective order, Your Honor, is that there's been a number of red line revisions and going back and forth with plaintiffs on them. First, they suggested some significant revisions. They significantly changed it from the version that had been issued in Federal Court. We then proposed some additional revisions and some changes to their revisions. And the issue is that each time -- our client is very hands on with this case. And, so, each time we get new additional revisions from them, we have to go and discuss with our client and run those by them. And I just got, I think it was yesterday, we got the most recent revisions from the plaintiffs to that protective order. We're not trying to stall getting it entered, it's just that we have to consult with our client before we can agree to any additional changes to it.

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As to the issue of just entering the prior version that was issued in Federal Court, one, we think that Order should be somewhat modified so it mirrors Nevada's requirements, as the other Order was issued in Federal Court. And, two, we don't think there's an urgency to have it entered immediately, given that the party's stipulation expressly states that any documents produced in the interim, that is any documents produced between now and whenever we actually agree on a State Court protective order, that those documents will be produced pursuant to

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the provisions of the prior Federal Court protective order. So, I don't think there should be a concern by either party that if, you know, a document is produced, let's say next Monday, that that document won't be subject, you know, attorney's eyes only protection or confidentiality protection. Because the parties agreed in their stipulation that until we get on a finalized State Court order, that the Federal Court order's terms will still protect those documents from, you know, disclosure to third parties or disclosure for improper purposes.

So, we would just request additional time to go over the changes with our client and try to iron out State Court protective order here and the Court just unilaterally entering the Federal Court order with no change.

THE COURT: All right. So, Ms. Gallagher, it's not necessary for me to hear your reply on this. I've already denied the Motion without prejudice. I'm happy to sign a protective order when both parties to agree to it. If they're -- you're continuing to negotiate, there's still open issues, I'm not going to impose one on the parties on this point. If you can't agree on the terms of it, then tee it up. I'll put it on calendar with one of these other deadlines or get you in the court before then so that that the matter can be resolved. But, while you're still negotiating, it's improper for me to impose a protective

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order on the case.

Now, is there anything else?

MS. GALLAGHER: No. I understand your position, Your Honor. I appreciate the opportunity to bring it to your attention if we can resolve this.

THE COURT: Good enough.

Mr. Balkenbush, Mr. Roberts, anything further?

MR. BALKENBUSH: Nothing else, Your Honor.

THE COURT: All right. You guys, stay safe --

MR. ROBERTS: No, Your Honor. That's perfect. Thank you for all your help.

THE COURT: Who's there?

MR. ROBERTS: No. Nothing further. Thank you for your time, Your Honor.

THE COURT: Very good. All right. You guys, stay safe, stay healthy, and see you next time.

MR. ROBERTS: Thank you, Your Honor.

MS. LUNDVALL: Thank you, Your Honor.

MS. GALLAGHER: Thank you, Your Honor.

MR. BALKENBUSH: Thank you, Your Honor.

PROCEEDING CONCLUDED AT 3:58 P.M.

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CERTIFICATION

I certify that the foregoing is a correct transcript from the audio-visual recording of the proceedings in the above-entitled matter.

AFFIRMATION

I affirm that this transcript does not contain the social security or tax identification number of any person or entity.

KRISTEN LUNKWITZ
INDEPENDENT TRANSCRIBER

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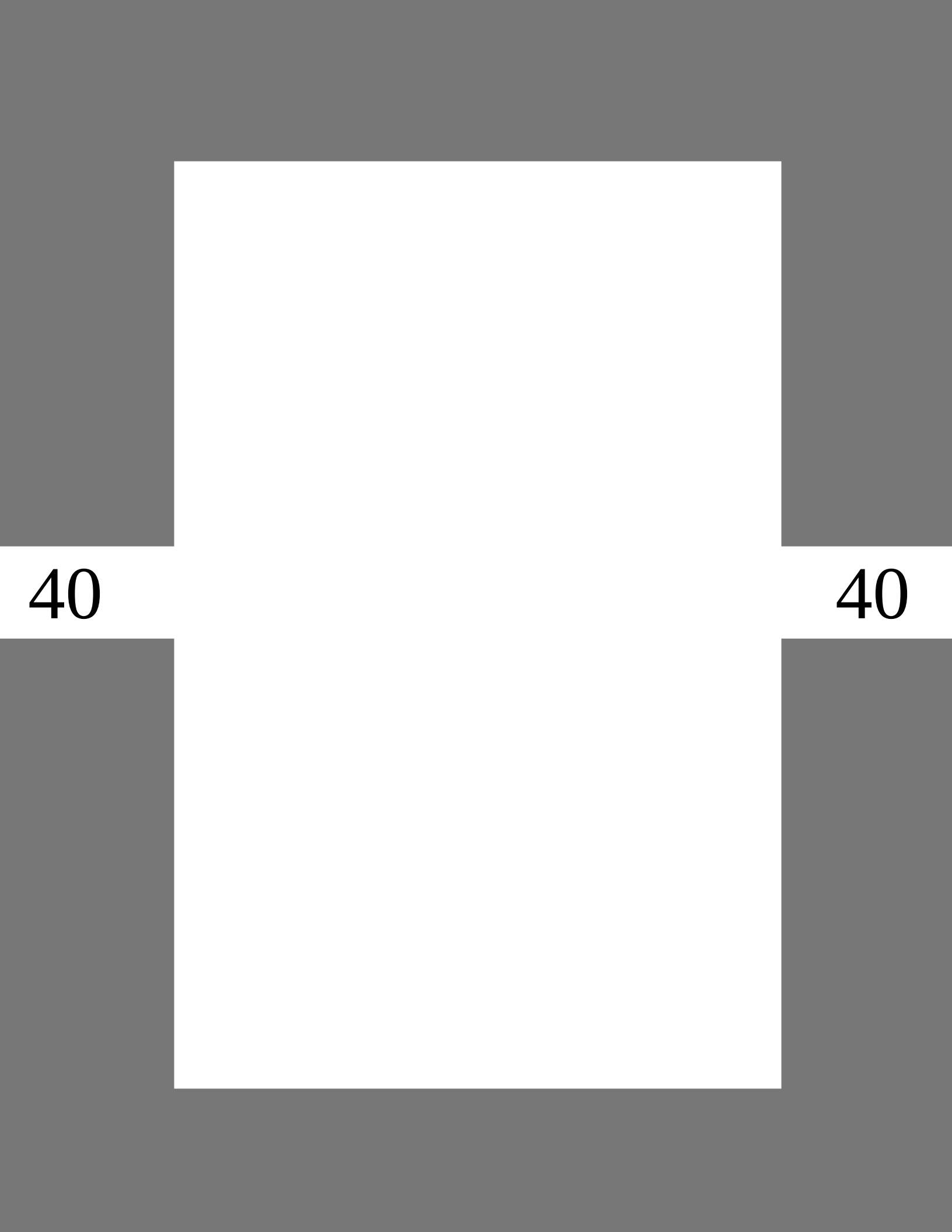
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DISTRICT COURT

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

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

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PLEASE TAKE NOTICE that an Order Denying Defendants' (1) Motion to Dismiss First Amended Complaint; and (2) Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief was entered on June 24, 2020, a copy of which is attached hereto.

DATED this 24th day of June, 2020.

McDONALD CARANO LLP

By: */s/ Kristen T. Gallagher*

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 24th day of June, 2020, I caused a true and correct copy of the foregoing **NOTICE OF ENTRY OF ORDER DENYING DEFENDANTS' (1) MOTION TO DISMISS FIRST AMENDED COMPLAINT; AND (2) SUPPLEMENTAL BRIEF IN SUPPORT OF THEIR MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT ADDRESSING PLAINTIFFS' EIGHTH CLAIM FOR RELIEF** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: A-19-792978-B Dept. No.: XXVII **ORDER DENYING DEFENDANTS' (1) MOTION TO DISMISS FIRST AMENDED COMPLAINT; AND (2) SUPPLEMENTAL BRIEF IN SUPPORT OF THEIR MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT ADDRESSING PLAINTIFFS' EIGHTH CLAIM FOR RELIEF**

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

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

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

FINDINGS OF FACT RELEVANT TO THE COURT'S DECISION

Procedural History

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Relevant Allegations Concerning the Relationship Between the Parties and the Dispute

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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reimbursed providers - a drastic and unjustified discount from what Defendants have been paying the Health Care Providers on their non-participating claims in these plans, and an amount materially less than what Defendants were paying other contracted providers in the same market. FAC ¶ 94.

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

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

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

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

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

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

k. Data iSight is the trademark of an analytics service used by health plans to set payment for claims for services provided to Defendants' Members by non-participating providers. Data iSight is owned by National Care Network, LLC, a Delaware limited liability company with its principal place of business in Irving, Texas. Data iSight and National Care Network, LLC will be collectively referred to as "Data iSight." Data iSight is a wholly-owned subsidiary of MultiPlan, Inc., a New York corporation with its principal place of business in New

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York, NY. MultiPlan acts as a Rental Network "broker" and, in this capacity, has contracted since as early as June 1, 2016 with some of the Health Care Providers to secure reasonable rates from payors for the Health Care Providers' non-participating emergency services. The Health Care Providers have no contract with Data iSight, and the Non-Participating Claims identified in this action are not adjudicated pursuant to the MultiPlan agreement. FAC ¶ 101.

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

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

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

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

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

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

r. As further evidence of Defendants' scheme to use their market power to the detriment of the Health Care Providers and other emergency provider groups that are part of the TeamHealth organization, in August 2019, UHG advised at least one Florida medical surgical

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facility (the "Florida Facility") that Defendants will not continue negotiating an in-network agreement unless the Florida Facility identifies an in-network anesthesia provider. The current out-of-network anesthesia provider is part of the TeamHealth organization. Defendants' threats to discontinue contract negotiations prompted the Florida Facility's Chief Operating Officer to send TeamHealth a "Letter of Concern" on August 14, 2019. Defendants' threats and leverage are aimed at intentionally interfering with existing contracts and with a goal of reducing TeamHealth's market participation. FAC ¶ 108.

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

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

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

27. The Health Care Providers further allege:

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

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

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

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

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

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

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

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

i. As stated on Defendants' website (https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits) for non-participating provider claims, the relevant United Health Group affiliate will "in many cases" pay the lower of a provider's actual billed charge or "the reasonable and customary amount," "the

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usual customary and reasonable amount," "the prevailing rate," or other similar terms that base payment on what health care providers in the geographic area are charging. FAC ¶ 79.

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

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

CONCLUSIONS OF LAW

ERISA Preemption

ERISA Overview

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

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

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

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

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

Complete Preemption

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conflict Preemption

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NRCP 12(b)(5) Legal Standard

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

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

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

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

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

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

The Health Care Providers' Claims

Breach of Implied-in-Fact Contract

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Alternative Claim for Unjust Enrichment

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

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

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

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

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

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

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

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