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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time. And, you know, this thing here. This guy was the president, okay? This is the email that we have. This is the email that we have. We got to kind of peek under the kimono, if you will, with just a couple of these emails. And this is really a telltale sign of what's really going on behind the scenes in this company. This is a Fortune 5 company. The only companies bigger than this company are Apple, Walmart and a couple others.

This is number five on the Fortune 500, okay? And this is the behavior. They're going to pile on TeamHealth. Nice splash. And why is that? Because their greed is utterly, totally uninhibited and unhinged. They brag about it in their business plans. Two simple strategies: Get more people to sign up and make more margin. Margin being the difference between the amount you're going to charge and the amount you're going to pay. Those are their goals.

Now, this is part of the -- you know, brainwashing is a strong word, but that's exactly what they're doing. That is exactly what they're doing. And so what do they say? They use the buzzword that gets most people to jump, which is, oh, premiums are going to go up. Overpaying providers causes higher member cost and higher premiums for customers. That is going to hook people and get them to be sympathetic to their cost. But what we know is that there were reductions in the charges during those three years.

This is Haben, and this is before they cleaned him up and they brought him back and they got him to clarify. Right? And here's what we know about charges are going down, premiums are going up.

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And make no mistake about it. Regardless of what you do, they are going to raise the premiums. They can't help themselves. Now, if you do what I'm going to recommend you do, it may change their mind. And I'm going to get to the amount in just a minute here.

Okay. How does this relate to the State of Nevada? Now look, I've been here about two and a half months, okay, and I've gotten to know this place pretty well and I've met a lot of great people here. And it is unfortunate that this is the state that they brag about in this plan that they put in place in 2014 as leading the pack for this Fortune 5 company at how much they're going to make. This and the State of California. Right? The best financial performers, the most margin in the West was California and Nevada.

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And Haben, he says, "I'm not a finance person" -- except he has a degree in accounting. "I did not write it". That's their favorite thing. If it hurts, oh, three monkeys. Haven't seen it, haven't heard it, haven't spoken it. Right? And we saw that a little bit today. I mean this lady knew she was coming here more than a week ago. And these are very, very skilled lawyers. They knew exactly what we were going to ask, and that's the best that you got today.

Okay. So per member per month, per member. The margin, we talked about this, skyrockets. Why? Well, because the people of this state. Because they're able to get away with it until now. Until now. So this is -- this is Mr. McManis' chart. He went to one of those fancy schools, so I don't know what that means. I know this. This is for UMR, and they have different names for their so-called programs. But they

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were doing the exact same thing that the other subsidiaries were. The exact same thing. They were cutting reimbursements so they could make more money.

And whether it's on the fully insured or whether it's being a third-party administrator, the goal was always the same: Continue to grow the margin. Because there is no enough. There is no enough. Right? And here's where we are now. This is where we are now. $177, okay? Now, listen. If you don't whack them on these punitives using the two factors we're talking about, this ain't changing.

MR. BLALACK: Objection. Argumentative, Your Honor, given the issues we raised with the Court outside the presence of the jury.

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MR. ZAVITSANOS: Your Honor, I'd like to respond.

THE COURT: I'm going to overrule the objection.

MR. ZAVITSANOS: Because the only thing they understand. The only thing they understand is money. Just like the ancient Athenians, they only thing they understood was the privilege to live in what was then the most advanced civilization in the world was the loss of their liberty for 10 years. This group, I mean, they're not going anywhere. They're not going to lose any license. They're going to continue operating here. But if their language is dollars and cents, that's it.

And I don't know if you remember this. This was day eight of Mr. Haben. We did this calculation where we laid out -- and this isn't theoretical; this is in fact what's happening. They're making more per

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visit than the doctor is on just the shared savings. This does not include the PMPM fee. This is on top of that. The doctor's getting 300, they're getting 385 on top of the PMPM fee. Because to them, doctors are like grains of sand.

This was Mr. Ziemer. This was Mr. McManis questioning him. He got asked a question, "Whose job is it to treat the patient that saves lives? Who do you think deserves more?" "I don't know how to answer that question". I mean, this is their favorite answer when they get caught in a spot. I don't know, I can't answer that. That wasn't me, it's not my department, I'm a vice president. I got all kinds of stock options, but I don't know what the stock's trading at. Come on.

And we looked at this. I mean, I'll tell you. The companies that you should hit the hardest are these two United companies based here in Nevada; Sierra and The Health Plan of Nevada. Because -- and I'm going to use their word right now -- their reimbursements are utterly egregious. They pay the same amount regardless of the code, regardless of the facility. And they're all over the place, totally random.

And then, of course, their favorite tagline during the trial was, well, we have to follow a plan. The plan says we can't pay more, we can't pay more. The problem is -- and this is the kind of extreme version of it. If it says you can only pay a nickel, well, we can't pay beyond what it says. The problem is we don't have the plans, right? We don't have the plans. And how do we know that these plans actually say the opposite of their little rehearsed presentation during this trial? How do we know that? Because internally, this is what they were saying.

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This is from Scott Ziemer. This is UMR 2018. "Recently, we proposed CRS Benchmark to a very large customer". Now, that means, you know, we want to pour it on and take savings. And despite millions in savings, they did not want to live with the potential member disruption due to balance billing. Look, believe it or not, there are some companies that actually do care about their employees. And they don't want their employees getting harassed about balance billing because if that happened and you're a good worker, they may lose that person to go to another company that has better benefits. Right?

This is what is going on within United. Now, do we have this document? No, we don't. But yet, they have the nerve to get up on the stand over and over again and say, the customer drove this. We made these changes because of the customer.

Now, this was the instruction that Her Honor just read to you, okay? And this, I will tell you, just like punitive damages and just like ostracism 2,600 years ago, this is very rare. You don't see this very often. In fact --

MR. BLALACK: Objection, Your Honor. Talking about other litigation.

THE COURT: Objection sustained.

MR. ZAVITSANOS: The Court just instructed the previous instruction regarding presumed relevant evidence that was not produced is adverse to the Defendants is still in effect. Now, I want you to think about this for a second. We've been gone a week. Everybody went home. Everybody went to their office. The lawyers met with their

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clients. And you would think since we came back and we put on additional evidence, maybe they would show up with some of this evidence to say, okay, you know, we understand what you did in phase one. We made an honest mistake; here they are.

Didn't truly -- didn't do it. Why? Because they're counting on those seeds that they planted 10 years ago or whatever it was -- 2014, 8 years ago -- to take hold. The fear that premiums are going to go up, that somebody's getting rich, that the lawyers are going to take a cut, that the doctor's not going to get it or will get it. They want you thinking about those things rather than following the instructions.

And so now, we are here. It's still in effect. And this is what the original inference said, right? And this was multi paragraphs, but this is the -- this is the key part. The Court concluded the Defendants' conduct was willful. Now, we're talking about reprehensibility, the first prong of how much to assess against them, right? And this was the other part of the adverse inference, okay? If you believe that they've not rebutted the evidence, then you are required to presume that the evidence was adverse to the Defendants. That was for phase one. And now, Her Honor has instructed you that this remains in effect. And they did not rebut it. They did not.

Now, look at this. 2019, these are the Sierra and The Health Plan of Nevada. Okay. You could stub your toe, or you could have your guts spilling out in the emergency room from getting shot twice, and they're going to pay the same. It's $185. Okay. And they ain't stopping. They're going lower. They're going lower.

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Now, I know I mentioned this last time, but I want to do it again. Okay. Because this, this is the height of arrogance. This is the minimum wage standard that is contained in Plaintiffs' Exhibit 295 where they clearly understand what they have to pay. And internally, these are the Nevada companies, okay? These are the Nevada companies, and this is why the rates are lower.

Internally, they changed the language of the law. I mean, it's the equivalent of saying the speed limit is 55 or 70 miles an hour; screw it, the speed limit's now 120. That's literally what they did. They changed the language and got rid of usual and customary, and put something in called eligible medical expense. And by the way, you'll notice in phase one, they never responded to this. They didn't say one word about this.

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Now, this is the patient share under the insurance policy. The copay and the patient responsibility. And they put on a whole dog and pony show that if they cut the rates, the patients are going to pay more. Right? And yet, the reality is patients are now paying in Nevada 18 percent of the bill as opposed to what it was back in 2017 before they began this aggressive descent.

This is your fellow citizens in this state where they have an 80-percent market share in this county. Okay. Eight out of 10 people in this county have one of the United insurance policies. Eight out of 10. 8 out of 10 people in this county are now paying almost 20 percent when they used to pay 1 percent. But somehow, their position is we're the problem; Dr. Scherr is the problem.

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That's Exhibit 89. Sierra United membership totaling 80 percent of the Clark County market share. Okay. There's a game that has that word; it's called Monopoly where you control the market.

MR. BLALACK: Objection, Your Honor. There's no evidence about market power or monopoly in this case.

THE COURT: I'm going to overrule it only because it's -- I don't find it improper.

MR. ZAVITSANOS: Eighty percent. Okay, this is their internal analysis, I'm not making this up.

Okay, so second. The amount which will punish and determine. Now, look, here's the thing. The most common denominator that we've heard begins with a B, right? Billions. But if you want to curb this behavior, you have to hit them with at least, at least $100 billion. At least that. Dr. Scherr thinks it out to be a bill one year of revenue. They're not going to change unless you give them a number that is going to be material.

Look at this. 455. Now, here is the key thing about this. This is 2020. 2020. By this point they have cut us to the bone, and we didn't -- I didn't talk about this during the first phase, and I don't think anyone has talked about this during the first phase. There is Ms. Paradise, January 15, 2020, okay? Look at this. They're instructed to go find -- go find another almost $300 million of additional income. This is after they've cut us to the core. It's not enough.

So when you get there and one of you says -- and look, I know one of you will. I can't believe Mr. Zavitsanos suggested at least

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100 million. And it needs to be at least 100 million. Okay? You consider the fact that after they've cut us to the bone to $175, they're -- Ms. Paradise, who seems to have forgotten everything while she was on the stand today -- is told to go find another $280 million.

Now, that is very, very recently, right? January 2020. And that's the plan. Application of OCM to TeamHealth. It's 47 million in 2019. And they're saying that they couldn't be competitive. We talked about this. They're making more than twice as much as the competitors.

And this is Mr. Haben, Day 6. By 2023, you want to continue counting out-of-network reimbursement by three billion. Look, this we're going to evaluate, we're going to think about it, we heard the jury. You want them to hear you, you got to talk a little louder. Okay? Because that's what's going to happen.

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Now, if you talk with a whisper, I'm sorry, you have wasted a month and a half of your lives. Plaintiffs' 519. A 20 percent increase in cashflow. $22.2 billion. Now, look, in fairness, that's the parent company, but the main subsidiary that is a defendant in this case makes up 90 percent of that. So let's call it 19 billion. A 20 percent increase. I -- listen, Dr. Scherr, I mean, I love this guy. I've really gotten to be very good friends with him. I mean, he was screaming at me this morning that he wanted me to suggest to you all [indiscernible]. You know, I -- believe it, they'll hear you if you do that.

Now, okay. If you have 100 shares of stock in the market, and they're at $10, okay? And we get rid of half of those shares, so now we only have 50 shares; those shares are now worth $20 because there

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are less shares, right? And so you're going to take the enterprise value and apply it to the number of shares.

Now, I want it to sink in on what this company is doing. They're going out to the market to buy back their shares to drive up the share price of the executives at United who are going to benefit from this.

MR. BLALACK: Objection, Your Honor. That evidence is not in the record.

THE COURT: Objection is sustained.

MR. ZAVITSANOS: They are going out to the market to buy back shares. I mean, look at this. It's $10 billion of share buyback to drive up their share price. Okay? I mean, this one you've got to -- and they're bragging about it to their shareholders.

Now, United Healthcare Services; that's the one that I said makes up 90 percent of the numbers we just saw. That's their net worth. And look, it's a lot of fancy accounting, but essentially, you take the assets, and you subtract the liabilities, and that's your net worth, right? You take the value of your house, you subtract the mortgage, okay? And that's the net value of your house. Here, this company is worth nearly $86 billion. That's one of the defendants. United Healthcare Insurance Company, 7.6 billion. The medical loss ratio. This is money they have to give back. They are required to give it back because they made too much.

MR. BLALACK: Your Honor, there is no evidence in the record about medical loss ratios.

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MR. ZAVITSANOS: Your Honor, 1002 is in evidence.

MR. BLALACK: No testimony whatsoever.

THE COURT: All right. Overruled.

MR. ZAVITSANOS: Medical loss ratio. I mean, you could fill the pail while you're milking the cow, but if it starts overflowing, you've got to give some of it back or you gotta give it somewhere else. Okay? And they're required to give it back. In 2020 over $320 million. They literally made too much.

Sierra -- now, listen, I think Sierra deserves to get hit for at least 100 million just themselves because this is all about the people of this county and the people of this state. They are worth 3.3 billion. They made too much too. There is [indiscernible] for $29 million. That's a federal [indiscernible]. Health Plan of Nevada; over 300 million.

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Now, why is this happening? Why was this happening? This 246 -- and by the way, the 246 includes all of the defendants, right? If it's just the Nevada companies, this is 175. Okay? That's what they paid other ER doctors; that's what they pay us. Well, because they want to weaken us. And why? Because they want to be a one stop shop. They want to be on both ends of the deal. And that's fine. There's no --

MR. BLALACK: Your Honor, objection. There's zero testimony about Defendant's motives for any --

THE COURT: I'm going to overrule that simply because it did come up in some answers.

MR. ZAVITSANOS: This was Mr. Almost Doctor Deal. This was his answer. It's always better if you're going to buy something, you

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buy less expensively. And we know they buy things. You've just gone through their 10K. They're gobbling up doctor's practices all over, and they are here in Nevada with Sound Physicians, right?

Now, you think about when you think about somebody in this county, they get shot, they have a stroke, they have a heart attack, and they get taken to the ER. Do you want them being treated by someone that ultimately reports to an insurance executive whose job it is to cut costs, or do you want them being treated by someone whose Chair of the Board took the Hippocratic oath -- also Greek by the way -- right? To save lives.

What do you think the insurance company is going to say? He doesn't need that test. Don't do that. Why do you think they're gobbling up doctor's practices? They're here now.

MR. BLALACK: Same objection, Your Honor. None of this is in evidence.

THE COURT: Sustained. You need to move on.

MR. ZAVITSANOS: Okay. Now, here's the verdict form. Now, look, here's the thing. Her Honor instructed you all that you can fill this out and you can award any amount you think is appropriate. I'm not going to pretend to tell you how much you need to break it down. Okay? There's 15 lines -- I mean, listen, the one thing both sides figured out; you all are good at math, right? I mean, we -- the amount of precision that you gave the first form.

So I'm sure you all -- you obviously have the intelligence and the information to be able to fill this out. But again, I -- this is about the

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two factors we talked about. Reprehensibility and deterrence. Okay? And when Ms. Paradise was on the stand today and she was asked will she even make a recommendation; that was her answer.

Now, Mr. Blalack is going to get up here and tell you, well, the TeamHealth guy said the same thing. No, he didn't. He committed to you all that he's going to -- and I get it, they're a big company. You can't make the change in a week. But she would not even commit to making a recommendation. And let me tell you, this -- this case -- the significance of this case, the materiality of this case, the impact of this case; you can bet your bottom dollar this is all they have been talking about over the last week over at United. But she doesn't have a recommendation. You all need to light them up.

THE COURT: Does the Defense --

MR. BLALACK: We are. I am, Your Honor.

DEFENDANTS' CLOSING ARGUMENT

MR. BLALACK: Now, ladies and gentlemen, you're almost there. I appreciate the time and attention and commitment you've shown, particularly having to come back here after a week. I know that was not easy, and I thank you and our clients thank you.

Now, I want to start as I have done every time we have spoken by reminding you of an admonition the Court gave because I think in this case it's particularly important.

You'll see in Instruction Number 47 that you will get a copy of when you start deliberating where the Court advises you you'll be hearing arguments of counsel to help you in the verdict. And it goes on

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to remind you, however, it says but whatever counsel may say, you will bear in mind that it is your duty to be governed by your -- in your deliberations by the evidence as you understand it and remember it. And I'm going to urge you and ask you again as I've asked you the prior times we've spoken to focus on the testimony you remember in your notes and the documents that were admitted into evidence that went back with you.

You heard testimony from a lot of Defense witnesses in this case, and if you added up the substantive testimony of all of those witnesses, the person who testified the most about my client's conduct is sitting right there because what he did was he would put a document up on the screen, he would pull up one quote -- one line out of 60 pages, show it to a witness who hadn't seen it, had no role in writing it, maybe not even received it or ever known about it, and then it would be characterized to the witness and the witness would then be asked to explain why it doesn't mean what he says it means. That's not evidence. That's lawyers talking. And we got another glimpse of that today in this recitation in his closing.

So I'm going to urge you, before I get into my presentation -- I'm not going to take you back through all the evidence in case. You heard lots of arguments before and weeks of evidence. I'm not going to do that to you.

I'm going to focus on the questions the jury is being asked to deliberate on in this phase of the trial. But I am going to ask you not to be distracted by lawyer talk and focus instead on documents. Read them

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yourself. Don't trust what you've been shared and the little snippets that you've been shared. You yourself look at your notes and hear testimony to help inform your deliberation.

Now, last week, the jury rejected TeamHealth's demand for more than $10 million in billed charges. My clients understand and they respect the jury's decision that higher payments should have been made to these three plaintiffs.

Now, my clients believed that they had reimbursed the disputed claims at a reasonable rate, and you all obviously disagree. And my clients hear you loud and clear. And there's no shouting that's needed. No lighting people up. None of that incendiary language. Your verdict does, in fact, have profound implications for my client's operations here in Nevada. And contrary to what my colleague and friend, Mr. Zavitsanos said, you did hear a lot of testimony from Ms. Paradise today in response to their questions regarding what the implications of that verdict are.

And as she pointed out, it's not about the 2.65 million. That's obviously a healthy chunk of money, but nobody from my side is going to stand up and say that for United Healthcare and United Healthcare Insurance Company that the $2.65 million is the key point.

The point is you found based on hearing the evidence that my client's reimbursements for these claims were underpaid. And that has very significant implications for how they run their business.

Now, she described for you some of those implications. She talked -- you know -- this is -- we've got a -- we've got thousands of

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disputed claims that are no longer disputed. You guys have resolved them. So those --

MR. ZAVITSANOS: Your Honor, this is improper argument. It goes to who ultimately pays.

MR. BLALACK: I'm not talking about who ultimately pays, I'm describing what her testimony to the jury was.

THE COURT: Overrule the objection.

MR. BLALACK: So she described in response to Mr. Ahmad's questions that this is going to require -- we've got to go back and look at --

MR. ZAVITSANOS: Your Honor, I'm sorry.

MR. BLALACK: -- [indiscernible].

MR. ZAVITSANOS: I'm looking at the third bullet point. That is a direct violation.

THE COURT: That is. Take it down and approach.

[Sidebar at 12:08 p.m., ending at 12:09 p.m., not transcribed]

MR. ZAVITSANOS: Your Honor, the Court's ruling?

THE COURT: I sustained an objection.

MR. BLALACK: Now, and then in addition to addressing the disputed claims, this paragraph also describes that it would be necessary to go back and review the out-of-network program reimbursement methodology that are implicated by your verdict. Now it was nice of Mr. Zavitsanos to acknowledge that it's not reasonable to expect my clients to have a fully formed plan of action that's been implemented and is being rolled out in the last week.

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But the truth of the matter is what she said was the company has no choice but to undertake this analysis based on your verdict, and that's a big deal. That's a real big deal. That really gets to the heart of it, which is that there's not many things that Mr. Zavitsanos and I agree on, but I think we do agree that your verdict is a big deal, and it has significant implications for my client's business operations in this State. That's one reason, ladies and gentlemen. That's not the only reason, but it's one reason that the jury should reject TeamHealth's request for a huge punitive damages award, which is what they're doing.

Now the jury should also reject their baseless request for $100 million in punitive damages or frankly anything close to it, because such an award is not even remotely proportional to the actual damages the jury is looking at here. Now Mr. Zavitsanos said that's not something you're going to be instructed on and that's true. But as a matter of fairness and justice, the harm here is you will be instructed, I'm going to assure you that you were instructed, and I'll show you the instruction in a moment, your measurement of punitive damages has to be tied to the injury caused to the Plaintiff in this case, and proportionality is an important feature in that analysis.

Now the jury has already awarded millions of dollars to TeamHealth in this case to make them whole, and punitive damages, as he noted, are intended to punish. And while the jury clearly found that my clients acted improperly, I respectfully submit that the evidence doesn't justify the most severe sanctions, which is what they're asking for.

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Fremont offered no -- I'm sure a lot of talk from lawyers. But Fremont offered you no evidence that my clients' conduct caused any personal injury to any patient. They offered you no evidence that any hospital or emergency room was closed or that it suffered any financial hardship --

MR. ZAVITSANOS: Your Honor, again I'm going to object to that last bullet. That is an improper argument, and frankly it's also untrue.

MR. BLALACK: They referenced it in their own closing.

MR. ZAVITSANOS: Your Honor I --

THE COURT: I sustain the objection.

MR. BLALACK: And they also presented no evidence that the compensation of a single ER doctor was reduced, or that a single ER doctor left Nevada because of Defendants' reimbursements. I want to focus on those, because you heard a lot of talk in opening and in the trial closing about those points, no documents, no data, no evidence, no witness testimony talking about any of this.

Ladies and gentlemen, the evidence here shows that this was a payment dispute between the opponents. That's what this is. Here, the jury concluded that my clients underpaid TeamHealth when they reimbursed the Plaintiffs at 164 percent of the Medicaid rate. You all said that's not enough. We hear you, and we get that. But the jury also rejected TeamHealth's contention that the Plaintiffs were owed their full bill charges, as the evidence from their own expert confirmed and equated them more than 760 percent of Medicaid. In fact, the amount

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the jury awarded was far closer to the amount my clients paid on the disputed claims and the bill charges that the TeamHealth Plaintiffs requested in this lawsuit.

And remember ladies and gentlemen Mr. Briscoe testified in his first visit with you that the original list of disputed claims in this case had almost 23,000 at issue [indiscernible], and the Plaintiffs receiving way more than $10.4 million in damages back then. And by the time we got to trial, they had dropped half of those claims, all the way down to 11,563 and all the way down to $10.4 million in alleged damages.

Now the jury of course did find that my clients didn't pay the proper reimbursement rate on those 11,563 claims that were at issue by the time we got to you. But from my client's perspective, look at how TeamHealth's demands for payment kept changing. I submit that under the circumstances, the moving target should be a mitigating factor in the jury's decision about how much my client should be punished for underpaying these claims.

And again my clients fully understand the jury's decision. But ladies and gentlemen respectfully, you should not punish my clients for refusing to pay TeamHealth's full bill of charges, when the jury found that the Plaintiffs were only entitled to just over 40 percent of those charges. Now you've been shown a comparison supposedly of an average rate of reimbursement for the TeamHealth claims for my clients in an average rate of reimbursement from other providers. Do you remember that discussion?

And remember what that is. It's not like some rate schedule

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that says out-of-network reimbursements equals [indiscernible]. What that is is when you have all of the reimbursements from all of the providers in the market, it produces an average. Some are higher, some are lower. So the notion that like there's some bulletin board that has that number on it that everyone knows is supposed to be reimbursed, that's just not accurate. Now awarding TeamHealth $100 million in punitive damages --

MR. ZAVITSANOS: Objection, Your Honor. TeamHealth is not a party and it's not an award to TeamHealth.

THE COURT: Objection sustained.

MR. BLALACK: Awarding the -- I'll revise. Awarding the TeamHealth Plaintiffs $100 million in punitive damages would be, I submit, an obscene windfall. They're the largest ER staffing company in the country. They are asking for such a large amount for a cynical reason. They hope that by asking for such a monstrous award you will opt for an equally absurd amount simply because it seems small by comparison to what they're asking for. Go high and hope you'll go somewhere in the middle.

But don't be fooled. It would be unjust to give such a large payment damages award to TeamHealth on this evidence. A fair and just punitive damages award must be tied to the evidence, should be tied to the evidence about these 11,563 claims. That's what this lawsuit's about. Under the law, as instructed to you by the Court, the punitive damages award must be based on the conduct at issue in the case. The conduct at issue in this case relates to the disputed claims submitted by

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these three Plaintiffs to these five Defendants. That's what the case is about.

And I want to show you and ask you to focus on in your deliberations this instruction. This is Instruction No. 44. Remember Mr. Zavitsanos telling you there's only two standards? That's true with respect to defining what you should focus on, but this is equally important in deciding what you can consider and evaluate when awarding punitive damages. In the Court's instruction I'm highlighting -- the first sentence just makes the obvious point that to the extent my clients have done any injury to anyone else, they have legal rights to bring claims just like the TeamHealth Plaintiffs.

This case is about the TeamHealth Plaintiffs and my clients, and as the Court instructed you and you must follow, it says "In determining the amount of punitive damages that is necessary for punishment and deterrence, you may only consider the wrong done to the claimants in this case." They've worked mightily to try to distract you with allegations of wrongdoing of everybody else. This case is about these three staffing companies and their claims for 11,533 I think to my clients. An analysis of punitive damages is the amount of punitive damages necessary for punishment and deterrence, considering only the wrong done to these plaintiffs. You may not award any punitive damages for the purposes of punishing their business conduct towards anyone else or any conduct outside of the State of Nevada.

So when you're in deliberations, if one of your peers says what about that thing that happened somewhere else, or what about

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other doctors, remember this instruction.

MR. ZAVITSANOS: That's a misstatement of the instruction.

MR. BLALACK: I'm reading directly from the instruction.

MR. ZAVITSANOS: He actually --

THE COURT: I'm going to overrule that.

MR. BLALACK: Now we talked about there were 11,563 of these claims. The Defendants disputed around 2.4 million. You already found that that was an underpayment, that an additional 2.65 million should have been paid. That means that the total amount that the jury found was reasonable value for these disputed claims was about 5.5 million. That translates to just over 40 percent of the Plaintiffs' charges. You heard my questioning of Mr. Briscoe on that issue.

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Now ladies and gentlemen, I submit to you under the Court's instructions, these numbers set the reasonable boundaries of what a fair punitive damages award could be. It should guide your deliberations, not irrelevant sums cited by TeamHealth in the financial statements, and I'm going to talk about the financial statements in a minute. This is what the case has been about for weeks. Based on the instruction that the Court read you, this needs to be the focus of your deliberations. I'm not going to presume to suggest a number to you. You all will come to that judgment.

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But what I will ask you to do is follow the law and the instruction as you've been given, and focus on the conduct that you found wrongful, that was focused on this case, and that was the underpayment of these claims.

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Now with respect to the financial statements, they showed you financial statements that are not focused on just the State of Nevada, the profit and loss in Nevada. They didn't focus on just the profit and loss related out-of-network programs. They didn't focus on just the profit and loss related to ER services. They didn't focus on the profit and loss tied to just TeamHealth, much less the profit and loss of these plaintiffs.

They gave you the financial statements of the consolidated enterprise worldwide, that have nothing to do with the focus on the issues in this case. The only reason to do that was to put a bunch of huge numbers in front of you and try to incite you to punish my clients because of their sizing alone. That's the only reason to do it.

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And ladies and gentlemen, Instruction No. 45, which the Court gave you and which you have in front of you, specifically says "The wealth of a defendant does not diminish is entitlement to all the protections of the law on which you have been instructed." Ladies and gentlemen, the law for my clients, how big they are, whether they're Fortune 5, whether they're Fortune 15, whether they're Fortune 20, whether they're not fortune anything is not relevant to the question of the conduct you found wrongful and the dispute around these underpayments, and there's an effort to try to distract you from your duty.

Now I want to briefly address this reference to MLR rebates. This is the first time it came up in the entire trial after weeks. All of a sudden they want to [indiscernible]. Just so that you know, in case

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anyone asks, and you look at the documents, an MLR rebate is a rebate under the law that's a premium back to customers. So what those numbers are examples of where my clients are sending premiums back to their customers, because their costs relative to the premium they're taking in were not as high as they expected.

That's not a bad thing, that's a good thing, because that's a sign of my clients' goodwill and compliance with rules and requirements governing their business. And the fact that it's been thrown in at the last minute just sets an example of the kind of distraction that the Plaintiffs are [indiscernible]. Now I also want to address quickly this adverse inference question, which Mr. Zavitsanos mentioned numerous times.

This is Instruction 46. He focused, he reminded you that that instruction which you heard in the first phase of trial is still an effective [indiscernible]. We haven't had any new evidence to offer about missing records, and the part he didn't show you, the critical part that I urge you to review, what the Court read to you is the very first sentence. It reads "You may not award punitive damages to punish defendants' conduct in litigation."

So even if you accepted this conclusion, that my clients' litigation conduct was improper, that could not form a basis under the law as instructed to you by the Court for the award of punitive damages that you're going to be deliberating. To the extent any juror suggests otherwise, I request and urge you to pull up Instruction 46 and review it.

Now for the same reason the financial statements were a distraction, I want to urge you to remember that it would be unfair to

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punish the Defendants and their clients simply because they're a large company.

MR. ZAVITSANOS: Judge, I'm going to object to "and their clients." Their clients are not defendants. They're not responsible for any portion of this.

MR. BLALACK: It would also be unfair --

THE COURT: Sustained. No speaking objections, just rephrase.

MR. BLALACK: It would also be unfair to punish the Defendants simply because they are large companies that could pay a punitive damages award. The issue here, ladies and gentlemen, we're not standing up here and saying that our clients couldn't pay the $100 million damages, punitive damages award that Plaintiffs are requesting. That's not the question.

The issue is whether that is a just and fair result given the evidence and the law you've been instructed, and the Court's instruction on assessing punitive damages, the very first one, 43, says -- this is the one that Mr. Zavitsanos referred to, and it has an important qualifier. It says "The law provides [indiscernible] standards as to the amount of punitive damages, but leaves the amount to the jury's sound discretion" -- here's the key phrase. That's [indiscernible] without passion or prejudice. Now they want a lot of passion, and they want a lot of prejudice in your deliberations. That would be disregarding your duty under the law as instructed.

What does that mean? It means the jury cannot let bias

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against insurance companies like my clients color your deliberations. You all may remember, do you remember many weeks ago when we started this journey together from Mr. Roberts, when he was conducting jury selection? He asked each of you whether you could be fair to health insurers even if you had had a bad experience yourself, or someone you knew had had a bad experience with an insurance company?

And my memory and I recall that none of you had any difficulty assuring Mr. Roberts that your deliberations would be free of bias, hostility to insurance companies in general. So as you're deliberating, please keep that commitment you made in mind, as you weigh and balance the evidence you've heard in this trial.

Ladies and gentlemen in closing, I urge you to reject TeamHealth's baseless requests for a windfall award. Instead, I urge you to select an amount of punitive damages that you think is fair based on the testimony and documents related to these disputed claims. Quite frankly, anything else would be unfair and unjust and most important, would disregard the Court's instructions on the law.

Thank you for your time and attention. I appreciate it.

THE COURT: Thank you. And is there a rebuttal argument?

MR. LEYENDECKER: Just a few minutes, Your Honor, please.

[Pause]

PLAINTIFFS' REBUTTAL CLOSING ARGUMENT

MR. LEYENDECKER: The conduct at issue in this case. In Nevada, that's the conduct at issue in the case. Two forty-six for us out-of-network, five hundred and twenty-eight on average all other

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emergency room doctors here in Las Vegas and other parts of the state. That's the conduct at issue in the case.

Ms. Paradise today couldn't commit to making any recommendations but will digest and evaluate. We, number one, must talk to our employer clients and, number two, we must -- hang on, I wrote it down -- revise our reimbursement methodologies. Now, I want you all to think about why are they telling you they must talk to their employer clients and why they must revise the reimbursement methodologies and ask yourself the methodologies that led to them paying everybody 528 a claim, those have to be revised? Is that why they paid us less than half?

I don't think so. Because if they've got methodologies and you guys have voted on whether you think the -- what those average amounts should look like. We get that. Appreciate that. But the idea that they have to go talk to their employer clients and change their methodologies because they pay us less than half of what those methodologies pay everybody else? I don't think so. The conduct is not about the Walmarts of the world, or Caesars. It's about the decisions the Defendants made during this period to pay us a fraction of what they pay everybody else. That's the conduct at issue in the case.

Now, you know, at first blush, it might seem like, okay, we've only known this for a week. But honestly, that's a little disingenuous because everybody in this courtroom has been thinking about the result for quite some time. And what it would mean to them. And so for any witness to suggest in this chair, well, it's just fresh on my mind, I don't

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really know what we're going to do, when for months, I can assure you she and all of her colleagues have been focused on okay, the jury says we owe more money, what are we going to do about it? And so for the person who's in charge of that for these United entities, some of them, to say, well, I don't really know. I'll digest and evaluate.

Well, sometimes people communicate in texts and emails with all caps, and they mean to shout. Now is your time to communicate in all caps about the conduct at issue in this case. And make no mistake about this, whatever you decide in this case does not under any way, shape, or form come out of anybody's pockets but these Defendants.

Is this an accident? My good friend and colleague Mr. Ahmad asked Ms. Paradise. "Well, I don't know what you mean by an accident." This is the conduct at issue in this case in Nevada. Mr. Bristow told you all what Ms. Hare would not as it relates to what the Defendants pay in Nevada versus everywhere else. Now is your time to communicate in all caps. Thank you.

THE COURT: All right. Come on up.

[The Clerk swore in the Officers to take charge of the jury during deliberations]

THE COURT: Thank you. All right. So I will now ask that the jurors go with the marshal and my assistant Karen to the jury deliberation room. They will bring in the verdict form for you and you may take your notes and your instructions and your notebooks with you. And then, send out a note as soon as you have a decision.

And be careful over here. We've got some wires.

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[Jury retired to deliberate at 12:35 p.m.]

THE COURT: Someone please let me know when the room is clear.

MR. ZAVITSANOS: Yes, Your Honor.

[Outside the presence of the jury]

THE COURT: All right. Please be seated. We need to take up the objections during the close. Plaintiff?

MR. ZAVITSANOS: Your Honor, I think there were several references to who is ultimately going to pay this and the suggestion that employer clients of the various United entities, the ASO clients, would be responsible for this. I mean, that was the clear implication. The Court, I understood, did sustain the objection, so I don't really have anything more to add than that, Your Honor.

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THE COURT: Good enough. And would you like to reply?

MR. BLALACK: I do, Your Honor. I take issue with the characterization that the statement of the slide said that. The slide did not talk about employers being responsible for the payment of any damages associated with the verdict. What it referred to was the change in relationship, business relationship, between those employers and clients and the Defendants in a world where the out-of-network payment methodologies that are present in this case are changed.

That is not about any damages in this case. That is a natural consequence of the verdict in a world where those kinds of methodologies changed. And I wasn't talking out of something that wasn't in the record. Ms. Paradise testified to that exact point in

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response to questions from Mr. Ahmad.

So that's why I dispute the suggestion from opposing counsel that the statement on the demonstrative said that.

THE COURT: Well, unfortunately for you, that was the first thing I thought. I took that same inference when I saw it.

MR. BLALACK: And I understand, Your Honor. I just -- I think the plain language of the -- I think that it'll speak for itself in terms of what it said. I don't think it said that, so that's the reason I --

THE COURT: Good enough.

MR. BLALACK: -- presented it.

THE COURT: Now, it is 12:37. You guys have been at it all morning. You have something else to put on the record?

MR. KILLINGSWORTH: Yes. Real quick, Your Honor. There was a few exhibits that were admitted today and my understanding, and according to the Court's staff, that --

THE COURT: They need to go back.

MR. KILLINGSWORTH: -- could not submit them electronically and so we had to send paper copies back and provide them to opposing counsel to okay them. They've reviewed them. And so I just want to provide those to you.

THE COURT: Good enough. Because I do need to go back, also.

THE CLERK: Those four exhibits?

THE COURT: Two -- the four?

MR. KILLINGSWORTH: It's six. So it's those four --

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THE CLERK: Okay. Wait a minute.

MR. KILLINGSWORTH: And then 89 and 519.

THE CLERK: Oh, 89, I have on -- and 519. I don't need those. Those were on the disc.

MR. KILLINGSWORTH: Oh, okay.

THE CLERK: It's just that these were going to --

MR. KILLINGSWORTH: Okay.

THE CLERK: Okay. Thank you.

THE COURT: All right. So you can get those marked and let us know. Now, I know you needed to make an offer of proof. I'm going to ask how you can -- you know, what -- how you want to proceed. They have lunch back there. They have lunch back there, right?

MR. ZAVITSANOS: It's outside here, Your Honor.

MR. ROBERTS: No. I think it's outside.

THE COURT: Oh. Oh. There's already a note. Okay. Come on up.

MR. BLALACK: No objection from the Defendants, Your Honor.

MS. ROBINSON: Sure. Do you need an additional copy, Your Honor?

MR. ZAVITSANOS: We agree, Your Honor.

THE COURT: We have a machine down the hall. Although our machine -- we regularly buy lemons. It has a -- yeah. Well actually, if you can easily do it, sure. Thank you.

MS. ROBINSON: I think I can.

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THE COURT: So Karen, we can't leave them alone. We can't leave them alone. Somebody has to be with them. Hang on just a second. Too much noise.

So with regard to the jury question about each getting instructions, the Plaintiff is going to make those available. Yeah. But do you have any objection to the Plaintiff making those copies?

MR. BLALACK: Not at all, Your Honor.

THE COURT: Because otherwise, we would go down the hall.

MR. BLALACK: Okay. That's fine, Your Honor. We'll make them, and we'll confirm, and then we'll be ready to go.

THE COURT: Thank you. So now, Defendant, how would you like to make your offer of proof?

MR. BLALACK: Your Honor, I'll take some guidance from you. We don't have any -- it's not important as long as we make the record. I think we have two pieces of evidence to offer. And if we could do it in a written submission like we did in the first case.

THE COURT: Why don't you outline it for the record so that we have at least something now?

MR. BLALACK: That's fine, Your Honor. The offer of proof in our case, in this that the Court had not already ruled in their case about the questions of door being open, we would have offered into evidence the deposition testimony which we provided designations to opposing counsel last night from the following witnesses: Mr. Bristow, Mr. Murphy, Ms. Harris, Rena Harris, Mr. Greenberg, and Mr. Kline. And we

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have those designations, which we provided to the other side. We would intend to actually today put them in a written submission as part of what would have been offered into evidence from those cases.

And then, that would have been -- and the associated exhibits, Your Honor, as a part of those. And then, there would be two witnesses, live witnesses that we would have called. One is J.C. Jefferson (phonetic), who is a employee from the Sierra Health Plan of Nevada. And the other is Shaun Schoener, who's an employee of UnitedHealthcare. They're both Nevada residents and we would have called them live.

They all would have addressed -- all of this testimony and evidence would have addressed the same topics, which was the prior network agreement between the parties and what the rates were in those agreements, the termination of those agreements by TeamHealth, the subsequent motivations for TeamHealth's termination of those agreements, the subsequent negotiations between the parties of renewing those agreements and what rates TeamHealth indicated it would accept and agreed were reasonable.

And then in addition to that, subsequent communications between executives of UnitedHealthcare and TeamHealth regarding the costs of providing these services to TeamHealth as well as the rates that TeamHealth received from our competitors for the same type of services, particularly the Blue Cross Blue Shield ones. So I'm broadly summarizing, Your Honor, but we will put all of that in a written submission for the offer of proof.

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THE COURT: Thank you. Is there any response?

MR. ZAVITSANOS: No, Your Honor. Not anything beyond what we identified earlier.

THE COURT: Okay. I would ask that you guys stay close. And I know that you have people here who want to be involved, but I'm afraid we're over the 41-person, and that has nothing to do with COVID. It's the fire marshal.

MR. BLALACK: Understood.

THE COURT: So I'll ask if you could be really careful. And because some of your folks can still watch online.

MR. BLALACK: I understand that. Thank you.

THE COURT: So I'll let you know as soon as --

MR. BLALACK: We'll be close. And I think you all have our contact information.

THE COURT: I'm sure they do. So before I leave the bench, I never have any idea what the result will be. But what a beautiful job on both sides. You gave dignity to your clients, you brought out the very best in every witness. Both of you did that equally. And so best wishes to both sides.

MR. BLALACK: Thank you, Your Honor.

MR. SMITH: Your Honor? Could I? I'm sorry, just for the --

THE COURT: Yeah. Sure.

MR. SMITH: If I may make one addition to this. Obviously, we didn't want to interrupt with a speaking objection through the argument. But --

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THE COURT: Yeah.

MR. SMITH: -- Mr. Roberts reminded me about point one, as we discussed, and I understand Your Honor overruled us in the -- during the [indiscernible] conference. We objected to, you know, to them presenting a number to the jury that would have been inconsistent with the factors of a *BMW v. Gore*. Obviously, under that one of the factors is the ratio to compensatory damages, the argument was that they could disregard that, disregard the compensatory damages. Now, obviously, the number they suggested was grossly inconsistent with *BMW v. Gore*. So we objected to that.

The second point has to do with the instruction on the adverse inference. And this is what we were afraid of is they went over the line, you know, of even though Your Honor, I believe, tried to craft an instruction that basically just said the instruction is still in place. And we wanted the instruction that no, the adverse inference no longer applies when you're talking about punitive damages. What happened is exactly what we hear, which is they invoked the presumption from phase one to say that that was a part of the reprehensible conduct, the fact that we didn't produce these plans and that we didn't produce the plans within the week between compensatory damages verdict and today, and that that was a proper basis for awarding punitive damages. That was the problem. Thank you.

THE COURT: Is there a response for the record?

MR. ZAVITSANOS: Your Honor, just the record is obviously clear. At no point did I suggest that the number was tied to the adverse

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inference. I was underscoring the fact that they could have offered evidence this week and that the adverse inference was still in effect. I never tied the two together.

THE COURT: Okay. Anything else?

MR. ZAVITSANOS: No, Your Honor.

MR. SMITH: I think the point stands, Your Honor, that when we're in closing arguments on the amount of punitive damages, to harp on the Yale study, to harp on the claim documents that we didn't produce, didn't say, and you have this instruction, you know, bringing up the whole -- linking the concept of willfulness in the adverse inference to reprehensibility in the amount of punitive damages I think crossed the line and was a violation of the Court's instructions. Thank you.

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THE COURT: Okay. Anything else?

MR. ZAVITSANOS: No, Your Honor.

THE COURT: All right. If you get to eat a lunch, I hope you can enjoy it.

MR. BLALACK: Thank you.

[Recess from 12:45 p.m. to 3:20 p.m.]

THE COURT: Everyone, please remain seated. We're ready to bring in the jury?

MR. BLALACK: Defendants are, Your Honor.

THE COURT: Thank you.

MR. LEYENDECKER: Plaintiffs are ready. Your Honor, I think we just heard that maybe on BlueJeans they can't hear. I don't know.

THE COURT RECORDER: I'm going to have to restart it again

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because --

THE COURT: We've told. Stop Andrea until we get back on. So let us know when you're ready. And we'll hold up Andrea bringing the jury in.

[Pause]

THE MARSHAL: All rise for the jury.

[Jury in at 3:23 p.m.]

THE COURT: Thank you. Please be seated. So Ms. Foreperson, has the jury arrived at a decision?

THE FOREPERSON: Yes, we have.

THE COURT: Will you please give it to the marshal? Okay. The clerk will now read the verdict out loud.

THE CLERK: District Court, Clark County, Nevada, Fremont Emergency Services, Mandavia, LTD, a Nevada professional corporation, Team Physicians of Nevada, Mandavia, PC, a Nevada professional corporation, Crum, Stefanko and Jones, LTD. d/b/a Ruby Crest Emergency Medicine, a Nevada professional corporation, Plaintiffs, v. UnitedHealthcare Insurance Company, a Connecticut corporation, UnitedHealthcare Services, Inc., d/b/a UnitedHealthcare, a Minnesota corporation, UMR, Inc., d/b/a United Medical Resources, a Delaware corporation, Sierra Health and Life Insurance Company, Inc., a Nevada corporation, Health Plan of Nevada, Inc., a Nevada corporation, Does 1-10, Roe Entities 11-20, Defendants, case number A-19-792978-B, Department Number XXVII.

Special verdict form.

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We, the jury in the above-entitled action, answer the questions submitted to us as follows.

The amount of money that should be awarded to Fremont Emergency Services against the following Defendants for punitive damages is:

UnitedHealthcare Insurance Company, answer, $4,500,000.

UnitedHealthcare Services, Inc., $4,500,000.

UMR, Inc., answer, $2 million.

Sierra Health and Life Insurance Company, Inc., answer, $5 million.

Health Plan of Nevada, Inc., answer, $4 million.

Number two. The amount of money that should be awarded to Team Physicians against the following Defendants for punitive damages is:

UnitedHealthcare Insurance Company, answer, $4,500,000.

UnitedHealthcare Services, Inc., answer, $4,500,000.

UMR, Inc., answer, $2 million.

Sierra Health and Life Insurance Company, Inc., answer, $5 million.

Health Plan of Nevada, Inc., answer, $4 million.

Number three. The amount of money that should be awarded to Ruby Crest Emergency Medicine against the following Defendants for punitive damages is:

UnitedHealthcare Insurance Company, answer, $4,500,000.

UnitedHealthcare Services, Inc., answer, $4,500,000.

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UMR, Inc., answer, $2 million.

Sierra Health and Life Insurance Company, Inc., answer, $5 million.

Health Plan of Nevada, Inc., answer, $4 million.

Dated December 7, 2021. Signed by Jury Foreperson Cindy Springberg.

Ladies and gentlemen of the jury, is this your verdict, as read?

THE JURORS: Yes.

THE COURT: Do either of the parties desire to have the jury polled?

MR. BLALACK: Defendants do, Your Honor.

THE COURT: Okay.

MR. ZAVITSANOS: Yes, Your Honor. Thank you.

THE CLERK: Nerissa Gonzaga, is this your verdict, as read?

JUROR NUMBER 1: Yes.

THE CLERK: Cindy Springberg, is this your verdict, as read?

JUROR NUMBER 2: Yes.

THE CLERK: Katelyn Landau, is this your verdict, as read?

JUROR NUMBER 3: Yes.

THE CLERK: Catherine Ross, is this your verdict, as read?

JUROR NUMBER 6: Yes.

THE CLERK: Dina Hortillas, is this your verdict, as read?

JUROR NUMBER 7: Yes.

THE CLERK: Elizabeth Trambulo, is this your verdict, as

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read?

JUROR NUMBER 8: Yes.

THE CLERK: Michael Cabrales, is this your verdict, as read?

JUROR NUMBER 9: Yes.

THE CLERK: And is it Iris Wynn?

THE COURT: It's Isis Wynn.

JUROR NUMBER 11: No, Isis.

THE CLERK: I'm sorry. Isis Wynn, is this your verdict, as read?

JUROR NUMBER 11: Yes, it is.

THE COURT: Okay. So we've come now to the end of the trial. And I hope now that you have seen justice in action that you realize what a basic and fundamental service our system of justice provides for this community. It's the right of every civil litigant to be judged by a jury of their peers, to be fair and impartial.

And unfortunately, jury service is something people don't really want to do, and I saw that look on some of your faces during jury selection. But I hope that if you -- even if you weren't enthusiastic, I hope that you now see what an important service you've provided to the community.

You are now released from all those admonishments about not talking about the case. The marshal will take you back to the jury deliberation room. I will be there in a few minutes to give you my personal thanks. And so thank you again for your service.

And Marshal, can you just move that to make it easier for

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them?

THE MARSHAL: Yes, ma'am.

THE COURT: Thank you. And I'll be down there in just a few minutes. Thank you again for your service.

THE MARSHAL: All rise for the jury.

[Jury excused at 3:30 p.m.]

THE COURT: Let me know when the room is clear.

MR. ZAVITSANOS: Now, Your Honor.

[Outside the presence of the jury]

THE COURT: Thank you. I know that didn't go the way you wanted. It had nothing to do with any lack of skill by the lawyers. You guys did a tremendous case.

MR. BLALACK: Thank you, Your Honor.

THE COURT: Now -- yes, of course.

MR. POLSENBERG: I have two motions, Your Honor.

THE COURT: Yes.

MR. POLSENBERG: First of all, I'd like to have a stay of execution pending the resolution of those judgment motions.

THE COURT: Well, you can put that in writing. We don't even have a judgment yet. And I'm more than happy -- and I almost always grant stays, as you know.

MR. POLSENBERG: Right. And before the judgment is entered, I would like to brief and have you decide the application of the punitive damages cap.

THE COURT: And you can brief that, and I'll be happy to do

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that.

MR. POLSENBERG: I'd be happy to brief it. I just probably want to have a hearing date, and I would suspect would want to have one sooner rather than later.

THE COURT: I know we loaded up the 15th and 16th with thinking things would be quiet at the end of the year with my six-month statuses. So I am going to ask you guys to confer about a date. I'll see if I can accommodate that on a non-motion calendar day so that you have the time you need.

MR. POLSENBERG: Very good. Thank you very much.

THE COURT: Work with my office.

Now, in this jurisdiction, very often, the lawyers like to go back and talk to the jurors. I will go back first to make sure everybody is okay. Sometimes people disagree. I don't want to let anybody leave here being upset about anything.

MR. ZAVITSANOS: We have no objection, Your Honor.

THE COURT: So stick around in case they are willing to talk to you. I have a security plan in place for them with regard to media and security. And I want to talk to them about that, as well.

But congratulations.

MR. LEYENDECKER: Thank you, Your Honor.

MR. ZAVITSANOS: Thank you, Your Honor.

MR. ROBERTS: I did have one request, Your Honor.

THE COURT: Sure.

MR. ROBERTS: Especially since it came up that the jurors

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would be allowed to be escorted out the back and it may be a madhouse out front --

THE COURT: Well, do you really want to put that on the record right now?

MR. ROBERTS: My request was that the jurors be given an opportunity to provide their phone numbers to the parties if they are willing to do so --

THE COURT: I have the court Public Information Officer on her way. Oh, she's here. Marianne, come on back with me. Thanks. So the court PIO is here, and she and I will talk.

MR. BLALACK: Thank you, Your Honor.

THE COURT: Anything else before I leave? Good enough. Because next time I come back is without the robe.

MR. ROBERTS: Nothing. Thank you, Your Honor.

THE COURT: Okay.

[Proceedings concluded at 3:32 p.m.]

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio-visual recording of the proceeding in the above entitled case to the best of my ability.

Jessica B. Cahill

Maukele Transcribers, LLC
Jessica B. Cahill, Transcriber, CER/CET-708

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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.

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

MOTION TO SEAL DEFENDANTS' MOTION TO SEAL CERTAIN CONFIDENTIAL TRIAL EXHIBITS

[CHAMBERS HEARING REQUESTED]

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; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation,

Defendants.

Defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services, Inc. ("UHS"), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Co., Inc. ("SHL"), and Health Plan of Nevada, Inc. ("HPN") (collectively "Defendants"), by and through their attorneys, hereby move to seal, pursuant to Rule 3(1) of the Nevada Supreme Court Rules Governing Sealing and Redacting of Court Records ("SRCR"), Defendants' Motion to Seal Certain Confidential Trial Exhibits.

This Motion is made and based upon the papers and pleadings on file herein, the Declaration of Brittany M. Llewellyn, and the following memorandum of points and authorities.

Dated this 15th day of December, 2021.

/s/ Brittany M. Llewellyn

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DECLARATION OF BRITTANY M. LLEWELLYN IN SUPPORT OF MOTION TO SEAL DEFENDANTS' MOTION TO SEAL CERTAIN CONFIDENTIAL TRIAL EXHIBITS

1. I am an attorney licensed to practice law in the State of Nevada, a partner at Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC, counsel for Defendants in the above-captioned matter.

2. This Declaration is submitted in support of the instant Motion to Seal Defendants' Motion to Seal Certain Confidential Trial Exhibits.

3. I have personal knowledge of the matters set forth herein and, unless otherwise stated, am competent to testify to the same if called upon to do so.

4. Defendants' Motion to Seal Certain Confidential Trial Exhibits contains documents and summaries of documents that have been designated as "Confidential" or "Attorneys' Eyes Only" under the Stipulated Confidentiality and Protective Order ("Protective Order") entered in this matter.

5. The Protective Order sets forth that documents designated as "Confidential" or "Attorneys' Eyes Only" must be filed under seal.

6. Defendants file the instant Motion to Seal in accordance with SRCR 3(1), as there are sufficient grounds to seal the Confidential Material under SRCR 3(4).

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

DATED: December 15, 2021.

/s/ Brittany M. Llewellyn
Brittany M. Llewellyn

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Defendants move this Court to allow the filing of their Motion to Seal Certain Confidential Trial Exhibits under seal, pursuant to Rule 3(1) of the Nevada Supreme Court Rules Governing Sealing and Redacting of Court Records ("SRCR"). The Motion to Seal Certain Confidential Trial Exhibits contains documentary exhibits that have been designated as "Confidential" or "Attorneys' Eyes Only" under the parties' Stipulated Confidentiality and Protective Order ("Protective Order"), as well as summaries of those documents.

There will be no prejudice to Plaintiffs because the parties' Protective Order mandates that documents designated as "Confidential" or "Attorneys' Eyes Only" must be filed under seal, and Plaintiffs' counsel has full access to the Motion to Seal Certain Confidential Trial Exhibits and any Confidential Material therein. Defendants respectfully request that the Court permit the filing of the Confidential Material under seal.

II. LEGAL ARGUMENT

Pursuant to SRCR 3(1), "[a]ny person may request that the court seal or redact court records for a case that is subject to these rules by filing a written motion . . . ." A court may order that the records be redacted or sealed provided that "the court makes and enters written findings that the specific sealing or redaction is justified by identified compelling privacy or safety interest that outweigh the public interest in access to the court records," which includes a finding that "[t]he sealing or redaction furthers. . . a protective order entered under NRCP 26(c)" or "[t]he sealing or redaction is justified or required by another identified compelling circumstance." SRCR 3(4)(b), (h).

On June 24, 2020, pursuant to a stipulation by and between the parties, this Court entered the Protective Order. The Protective Order provides that a party may designate a document as "Confidential" if it "reasonably and in good faith believes [the document] contains or reflects: (a) proprietary, business sensitive, or confidential information; (b) information that should otherwise be subject to confidential treatment pursuant to applicable federal and/or state law; or (c) Protected Health Information, Patient Identifying Information, or other HIPAA-governed

information." Prot. Ord. at §2(a). The Protective Order also provides that a party may designate a document as "Attorneys' Eyes Only" if any portion of it contains material, testimony, or information that the party "reasonably and in good faith believes contains trade secrets or is such highly competitive or commercially sensitive proprietary and non-public information that would significantly harm business advantages of [the Party]…and that disclosure of such information could reasonably be expected to be detrimental to the [Party's] interests." *Id.* at §2(b).

The Protective Order further provides that the parties will file a motion to have confidential / sensitive discovery material filed under seal, including any portion of a court paper that discloses confidential / sensitive discovery material. *Id.* at 20. Consistent with the parties' agreement contained in the Protective Order, Defendants move to file their Motion to Seal Certain Confidential Trial Exhibits under seal. The Motion contains documents which have been designated as "Confidential" or "Attorneys' Eyes Only" under the Protective Order, as well as detailed summaries of those documents.

Based on the Protective Order and the confidential nature of these documents, SRCR 3(4) provides a sufficient basis to order sealing Defendants' Motion to Seal Certain Confidential Trial Exhibits. The Motion has thus been filed temporarily under seal and should remain under seal until such time as this Court has had an opportunity to rule on the instant Motion, and in perpetuity unless this Court finds otherwise.

III. RELIEF REQUESTED

For the foregoing reasons, Defendants respectfully request that the Court enter an Order sealing Defendants' Motion to Seal Certain Confidential Trial Exhibits. Defendants further request that the Confidential Material remain under seal until such time as this Court has had an opportunity to rule on the instant Motion, and in perpetuity unless this Court finds otherwise.

Dated this 15th day of December, 2021.

/s/ Brittany M. Llewellyn

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CERTIFICATE OF SERVICE

I hereby certify that on the 15th day of December, 2021, a true and correct copy of the foregoing **MOTION TO SEAL DEFENDANTS' MOTION TO SEAL CERTAIN CONFIDENTIAL TRIAL EXHIBITS** 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.

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

MOTION TO SEAL DEFENDANTS' SUPPLEMENT TO MOTION TO SEAL CERTAIN CONFIDENTIAL TRIAL EXHIBITS

[CHAMBERS HEARING REQUESTED]

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Defendants.

Defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services, Inc. ("UHS"), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Co., Inc. ("SHL"), and Health Plan of Nevada, Inc. ("HPN") (collectively "Defendants"), by and through their attorneys, hereby move to seal, pursuant to Rule 3(1) of the Nevada Supreme Court Rules Governing Sealing and Redacting of Court Records ("SRCR"), Defendants' Supplement to Motion to Seal Certain Confidential Trial Exhibits.

This Motion is made and based upon the papers and pleadings on file herein, the Declaration of Brittany M. Llewellyn, and the following memorandum of points and authorities.

Dated this 15th day of December, 2021.

/s/ Brittany M. Llewellyn

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DECLARATION OF BRITTANY M. LLEWELLYN IN SUPPORT OF MOTION TO SEAL SUPPLEMENT TO DEFENDANTS' MOTION TO SEAL CERTAIN CONFIDENTIAL TRIAL EXHIBITS

1. I am an attorney licensed to practice law in the State of Nevada, a partner at Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC, counsel for Defendants in the above-captioned matter.

2. This Declaration is submitted in support of the instant Motion to Seal Defendants' Supplement to Motion to Seal Certain Confidential Trial Exhibits.

3. I have personal knowledge of the matters set forth herein and, unless otherwise stated, am competent to testify to the same if called upon to do so.

4. Defendants' Supplement to Motion to Seal Certain Confidential Trial Exhibits contains highly detailed summaries of documents that have been designated as "Confidential" or "Attorneys' Eyes Only" under the Stipulated Confidentiality and Protective Order ("Protective Order") entered in this matter.

5. The Protective Order sets forth that documents designated as "Confidential" or "Attorneys' Eyes Only" must be filed under seal.

6. Defendants file the instant Motion to Seal in accordance with SRCR 3(1), as there are sufficient grounds to seal the Confidential Material under SRCR 3(4).

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

DATED: December 15, 2021.

/s/ Brittany M. Llewellyn
Brittany M. Llewellyn

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Defendants move this Court to allow the filing of their Supplement to the Motion to Seal Certain Confidential Trial Exhibits under seal, pursuant to Rule 3(1) of the Nevada Supreme Court Rules Governing Sealing and Redacting of Court Records ("SRCR"). The Supplement to the Motion to Seal contains highly detailed summaries of documents that have been designated as "Confidential" or "Attorneys' Eyes Only" under the parties' Stipulated Confidentiality and Protective Order ("Protective Order").

There will be no prejudice to Plaintiffs because the parties' Protective Order mandates that documents designated as "Confidential" or "Attorneys' Eyes Only" must be filed under seal, and Plaintiffs' counsel has full access to the Supplement to the Motion to Seal Certain Confidential Trial Exhibits and any Confidential Material therein. Defendants respectfully request that the Court permit the filing of the Confidential Material under seal.

II. LEGAL ARGUMENT

Pursuant to SRCR 3(1), "[a]ny person may request that the court seal or redact court records for a case that is subject to these rules by filing a written motion . . . ." A court may order that the records be redacted or sealed provided that "the court makes and enters written findings that the specific sealing or redaction is justified by identified compelling privacy or safety interest that outweigh the public interest in access to the court records," which includes a finding that "[t]he sealing or redaction furthers. . . a protective order entered under NRCP 26(c)" or "[t]he sealing or redaction is justified or required by another identified compelling circumstance." SRCR 3(4)(b), (h).

On June 24, 2020, pursuant to a stipulation by and between the parties, this Court entered the Protective Order. The Protective Order provides that a party may designate a document as "Confidential" if it "reasonably and in good faith believes [the document] contains or reflects: (a) proprietary, business sensitive, or confidential information; (b) information that should otherwise be subject to confidential treatment pursuant to applicable federal and/or state law; or (c) Protected Health Information, Patient Identifying Information, or other HIPAA-governed

information." Prot. Ord. at §2(a). The Protective Order also provides that a party may designate a document as "Attorneys' Eyes Only" if any portion of it contains material, testimony, or information that the party "reasonably and in good faith believes contains trade secrets or is such highly competitive or commercially sensitive proprietary and non-public information that would significantly harm business advantages of [the Party]…and that disclosure of such information could reasonably be expected to be detrimental to the [Party's] interests." *Id.* at §2(b).

The Protective Order further provides that the parties will file a motion to have confidential / sensitive discovery material filed under seal, including any portion of a court paper that discloses confidential / sensitive discovery material. *Id.* at 20. Consistent with the parties' agreement contained in the Protective Order, Defendants move to file their Supplement to the Motion to Seal Certain Confidential Trial Exhibits under seal. The Supplement contains detailed summaries of documents which have been designated as "Confidential" or "Attorneys' Eyes Only" under the Protective Order.

Based on the Protective Order and the confidential nature of these documents, SRCR 3(4) provides a sufficient basis to order sealing the Supplement to Defendants' Motion to Seal Certain Confidential Trial Exhibits. The Supplement has thus been filed temporarily under seal and should remain under seal until such time as this Court has had an opportunity to rule on the instant Motion, and in perpetuity unless this Court finds otherwise.

III. RELIEF REQUESTED

For the foregoing reasons, Defendants respectfully request that the Court enter an Order sealing Defendants' Supplement to their Motion to Seal Certain Confidential Trial Exhibits. Defendants further request that the Confidential Material remain under seal until such time as this Court has had an opportunity to rule on the instant Motion, and in perpetuity unless this Court finds otherwise.

Dated this 15th day of December, 2021.

/s/ Brittany M. Llewellyn

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CERTIFICATE OF SERVICE

I hereby certify that on the 15th day of December, 2021, a true and correct copy of the foregoing **MOTION TO SEAL DEFENDANTS' SUPPLEMENT TO MOTION TO SEAL CERTAIN CONFIDENTIAL TRIAL EXHIBITS** 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.

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

NOTICE OF ENTRY OF ORDER GRANTING DEFENDANTS' MOTION FOR LEAVE TO FILE DEFENDANTS' PRELIMINARY MOTION TO SEAL ATTORNEYS' EYES ONLY DOCUMENTS USED AT TRIAL UNDER SEAL

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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; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation,

Defendants.

YOU WILL PLEASE TAKE NOTICE that an Order Granting Defendants' Motion For Leave To File Defendants' Preliminary Motion To Seal Attorneys' Eyes Only Documents Used At Trial Under Seal was filed December 23, 2021, in the above-captioned matter. A copy is attached hereto.

Dated this 27th day of December, 2021.

/s/ Brittany M. Llewellyn

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CERTIFICATE OF SERVICE

I hereby certify that on the 27th of December, 2021, a true and correct copy of the foregoing **NOTICE OF ENTRY OF ORDER GRANTING DEFENDANTS' MOTION FOR LEAVE TO FILE DEFENDANTS' PRELIMINARY MOTION TO SEAL ATTORNEYS' EYES ONLY DOCUMENTS USED AT TRIAL UNDER SEAL** 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.

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

ORDER GRANTING DEFENDANTS' MOTION FOR LEAVE TO FILE DEFENDANTS' PRELIMINARY MOTION TO SEAL ATTORNEYS' EYES ONLY DOCUMENTS USED AT TRIAL UNDER SEAL

Hearing Date: December 21, 2021
Hearing Time: In Chambers

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; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation,

Defendants.

Defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services, Inc. ("UHS"), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Co., Inc. ("SHL"), and Health Plan of Nevada, Inc. ("HPN") (collectively "Defendants"), filed their Motion for Leave to File Defendants' Preliminary Motion to Seal Attorneys' Eyes Only Documents Used at Trial Under Seal ("Motion for Leave") on November 12, 2021. The Motion for Leave was served on all appearing parties and no opposition was filed. Good cause appearing,

IT IS HEREBY ORDERED that Defendants' Motion for Leave is GRANTED.

IT IS HEREBY FURTHER ORDERED that the hearing on Defendants' Motion for Leave set for December 21, 2021, on Chambers Calendar is VACATED.

IT IS SO ORDERED.

Dated this 23rd day of December, 2021

Nancy L Allf

Hon. Nancy L. Allf

CA9 EFC 54B5 1764
Nancy Allf
District Court Judge

Submitted by:

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DISTRICT COURT
CLARK COUNTY, NEVADA

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

AUTOMATED CERTIFICATE OF SERVICE

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

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Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation,

Defendants.

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

PLAINTIFFS' OPPOSITION TO UNITED'S MOTION TO SEAL

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This motion is only about ***admitted*** trial exhibits. The Court's position on such documents has already been made clear: "I can tell you right now that I will not seal anything that's admitted. It's not going to happen[]"; "I can tell you I won't seal any exhibit that gets admitted. I think I made that clear[]"; "[I]f . . . it gets admitted it's in the public domain." 11/1/2021 Tr. (Day 5) at 121:5–6; 122:17–18; 125:2–4.

United has offered nothing in the way of particularized, evidentiary support to overcome that presumption or to meet its burden on a document-by-document basis to 1) establish that any of the information it seeks to seal is, in fact, trade secret; 2) prove that those trade secrets have not gone stale with the significant passage of time; and 3) demonstrate that United would suffer any specific harm from maintaining the status quo—that these documents were already disclosed in a public trial, available for any and all to see. Instead, United offers two, nearly identical, generalized declarations regarding alleged harm from the disclosure of certain broad categories of information. But nowhere—not in is motion or in the declarations, does United draw a connection between those alleged harms and any particular document.

In short, United has provided insufficient evidence to overcome the presumption of an open court and open trial record and, for that reason, its motion should be denied.

The Health Care Providers submit this Opposition to United's Motion to Seal Trial Exhibits. This Opposition is based upon the record in this matter, the points and authorities that follow, the pleadings and papers on file in this action, and any argument of counsel entertained by the Court.

POINTS AND AUTHORITIES

I. UNOPPOSED REDACTIONS FOR PHI AND PII

The Health Care Providers do not oppose United's request to redact exhibits for personal health information (PHI) or personal identifying information (PII). This applies to the following exhibits: PX307; PX375;[1] PX413; PX444;[1] PX473;[1] DX4002;[1] DX4003;[1] DX4005;[1] and DX4006.[1]

[1] The Health Care Providers do oppose, for the reasons set forth herein, United's additional requested redactions to these documents beyond PHI and PII.

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II. LEGAL STANDARD

"It is clear that the courts of this country recognize a general right to inspect and copy public records and documents, including judicial records and documents." *Nixon v. Warner Comm'ns, Inc.*, 435 U.S. 589, 597 (1978) (citing, *inter alia*, *State ex rel. Nevada Title Guaranty & Trust Co. v. Grimes*, 29 Nev. 50 (1906)). The open courts presumption in Nevada is well-established. *Del Papa v. Steffen*, 112 Nev. 369, 374, 915 P.2d 245, 248 (1996) (recognizing that the public has a right to access proceedings in civil cases under state law and the U.S. Constitution). Unless otherwise provided **by law**, the "sitting of every court of justice shall be public." NRS 1.090. "Every trial on the merits must be conducted in open court." NRCP 77(b). The Nevada Supreme Court has recognized this strong policy in the Nevada Rules for Sealing and Redacting Court Records: "[a]ll court records in civil actions are available to the public, except as otherwise provided in these rules or by statute." SRCR 1(3).

Thus, as United concedes, there is a strong "policy favoring public access to court records," (Mot. at 5) and sealing is only appropriate where that presumption is "outweighed by a ***significant*** competing interest." Mot. at 10 (emphasis added) (quoting *Howard v. State*, 128 Nev. 736, 744, 291 P.3d 137, 142 (2012). To evaluate whether there is such a significant competing interest, the Nevada Rules for Sealing and Redacting Court Records set out specific circumstances where a court "may," but is not required to, issue an order sealing or redacting records. SRCR 3(4). Under these Rules, a court must use the least restrictive means and duration for any sealing or redacting order. SRCR 3(5)–(6).

III. ARGUMENT[2]

A. The public took incredible interest in this trial—that should not be thwarted.

The public took a significant interest in this trial. Two media requests were granted. At

[2] As an initial matter, during trial, the Health Care Providers never agreed that any of the information United asks to seal was entitled to protection. Rather, the Health Care Providers simply agreed that, for the subset of documents United identified as attorneys' eyes only, the Health Care Providers would not read certain information into the trial record—this compromise was solely for the purpose of streamlining trial, and not on the substantive merit of United's confidentiality claim. Any insinuation by United to the contrary (or that the Health Care Providers ever violated that agreement) is false.

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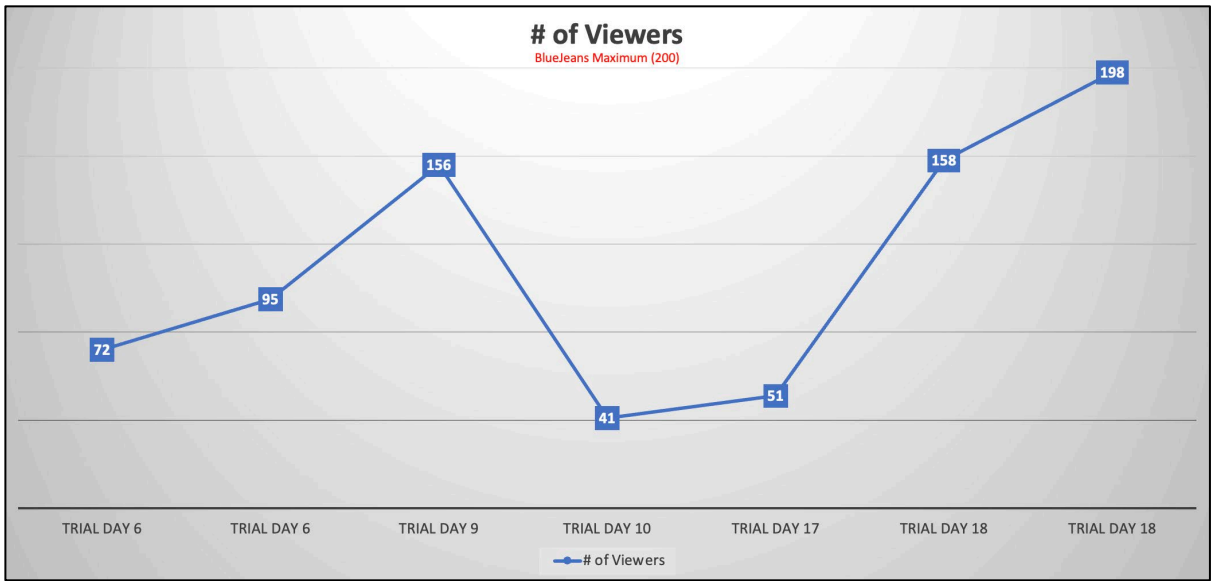
times, media members were present in the courtroom. But perhaps most significantly, the public audience on the live BlueJeans webstream, at times, stretched the software to its limit. Just based on what can be determined from the trial record, the BlueJeans audience ranged from 41 (the entire capacity of the physical courtroom, pursuant to fire marshal restrictions) to 198 (two short of the BlueJeans maximum):



See Trial Day 6 (22:15–17; 127:24–25); Trial Day 9 (97:1–3); Trial Day 10 (217:7–9); Trial Day 17 (51:18–22); Trial Day 18 (78:24; 135:20–21).

Now, United seeks to thwart that public interest by sealing documents and information (*e.g.*, allowed amounts, business plans, etc.) that were routinely described in open court, in front of in-person and internet audiences, and retroactively claim confidentiality over those materials. That post-hoc strategy, designed specifically to prevent the public from learning the basis for the jury's finding, is inappropriate and the Court should reject it. Moreover, the practical effect is that the Court would never be able to enforce the order because it has already been publicly disseminated at trial—the Health Care Providers (or anyone else who viewed the trial, for that matter) cannot be liable to United for information that has already publicly been shared in trial.

B. Throughout the case, United overdesignated information as confidential.

United produced over 61,000 documents to Plaintiffs over the course of the lawsuit; over sixty-three percent of them—38,430 of those documents—were designated as attorneys' eyes only. 11/1/2021 Tr. (Day 5) at 112:1–5. This gross over-designation led to an increase in expense

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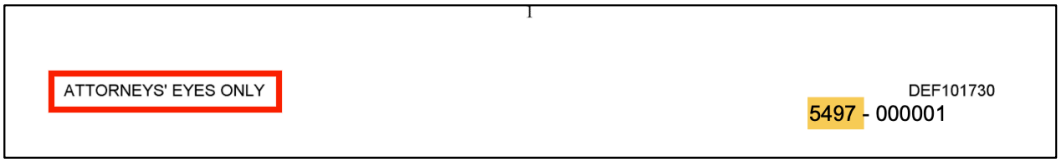
and time spent litigating confidentiality issues. By United's count, it was "four or five times" in which the parties had to resort to motion practice over United's improper designations. *Id.* at 116:21. And, as stated by United's counsel, "each time the special master . . . denied [United's] motion and de-designated the documents." *Id.* at 116:23–24. In other words, the Special Master and the Court recognized, repeatedly, that United had inappropriately sought to shroud its documents in a cloak of secrecy. Moreover, these were only the documents that United presented to the Court. On numerous other documents, United simply agreed that it had over-designated and withdrew its claim of confidentiality.

This practice continued through trial. The same day as the hearing quoted above, United added another document to its exhibit list: the June 2017 "Surprise! Out-of-Network Billing for Emergency Care in the United States" article that United assisted Zack Cooper in preparing as part of a deliberate effort to sway ***public opinion*** against TeamHealth. *See* DX5497. Despite the wide public dissemination of this article (it was published in a public journal) and its purpose of causing a public effect, United designated this trial exhibit (of a publicly distributed "research" article) "Attorneys' Eyes Only":



United's Motion to Seal is more of the same—after succeeding in its own efforts to poison the public well against TeamHealth, United asks the Court to shield the public from the documented conduct a Nevada jury found to be fraudulent, malicious, and oppressive. And, although United will likely argue that its request is reasonable, United asks for a perpetual sealing order that would apply to documents dating back fifteen years. This is hardly the least restrictive scope and duration as required by the Rules.

C. In its motion, United seeks to protect stale and outdated information.

United asks the Court to seal records that cannot possibly have any value as trade secret or proprietary because the information is stale. *See, e.g.*, *United States v. Int'l Bus. Mach. Corp.*, 67 F.R.D. 40, 46 (noting that "disclosure of ***two-and-a-half-year-old*** sales data" will not result

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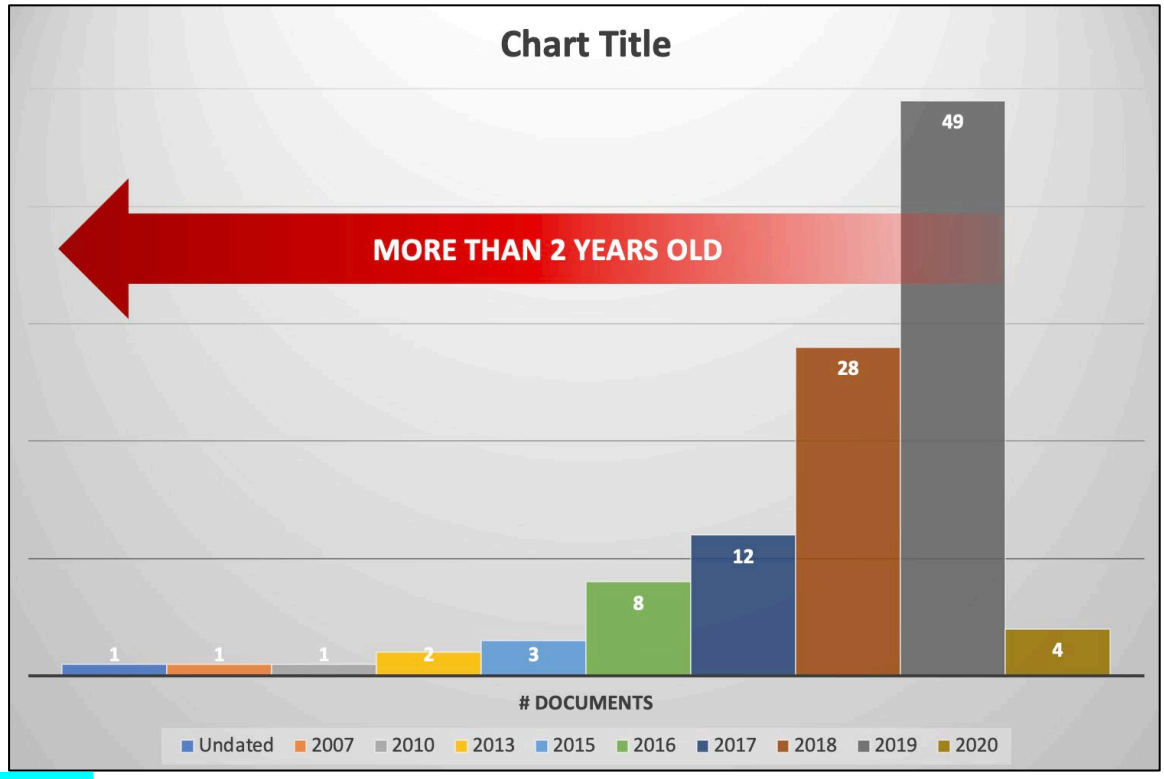
in a "clearly defined, serious injury") (emphasis added).[3] By the time of trial, the majority of these documents were well over two years old—many of them over five or even as many as fifteen years out of date:



See Ex. 1 (list of exhibits subject to United's Motion).

It is United's burden to explain "why the information contained [within these old documents] is not already so stale as to no longer be proprietary and/or harmful." *Talking Rain Beverage Co., Inc. v. DS Servs. of Am., Inc.*, No. 15-cv-1804, 2017 WL 2806831, at *2 (W.D. Wash. June 29, 2017). *See also Glob. Material Techs., Inc. v. Dazheng Metal Fibre Co.*, 133 F. Supp. 3d 1079, 1085 (N.D. Ill. 2015) (finding that the party seeking to prevent disclosure bears the burden of "establish[ing] good cause and explain[ing] with particularity why the information is not stale." Indeed, "the lapse of time" since the creation of these documents "makes it highly unlikely that any exposure" to their contents could be used to United's detriment. *Hartford Cas. Ins. Co. v. Am. Dairy & Food Consulting Lab'ys, Inc.*, No. 09-cv-0914, 2010 WL 2510999, at

[3] In some cases, even a matter of months can render information stale. *See, e.g.*, *Katch, LLC v. Sweetser*, 143 F. Supp. 3d 854, 869 (D. Minn. 2015) (information over a month old was stale or would soon become so); *Lexis-Nexis v. Beer*, 41 F. Supp. 2d 950, 959 (D. Minn. 1999) (noting that four month old information would be of little value and thus not a trade secret).

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*6 (E.D. Cal. June 17, 2010).

For example, what trade secret value could United's projection for improved revenue from implementing their Outlier Cost Management ("OCM") program in 2017 have, now that OCM has long since been implemented and the actual results have been publicly reported in SEC filings? *See, e.g.*, United's proposed redactions to PX96. And for that matter, what value can a projection for 2022 or 2023 have when that projection was made in 2019 or earlier, and subsequent projections have taken its place? United's motion offers nothing in the way of "any particularity" explaining how public access to these documents could give any competitor "an unfair advantage in the current market." *Glob Material Techs.*, 133 F. Supp. 3d at 1085. The conclusory declarations submitted by United[4] contain no information specifically identifying, on a document-by-document basis, how information dating back multiple years is relevant to today's market. *See, e.g.*, Exs. B and C to Mot. This is not enough to meet United's burden.

D. *Historical* business plans are not *current* trade secrets.

The majority of the documents United seeks to seal relate to business plans and strategies for what were, at the time of creation of the document, upcoming periods of time. That is because this information that was once forward looking has now been replaced by actual information from the relevant time period; the long-term projections have become obsolete. *See Katch*, 143 F. Supp. 3d at 868 (finding "long-term sales strategies" to be within a group of "information that has or will quickly become obsolete does not have the independent economic value to be considered a trade secret").

Even United's financial projections and other information is not confidential. United is a public company. "[M]ost of [its] financial information has been disclosed in 10-Ks, 10-Qs and otherwise." *Ayyad v. Sprint Spectrum, L.P.*, No. A121948, 2009 WL 4048035, at *4 (Cal. Ct. App. Nov. 23, 2009). Like Sprint, "[t]here is no evidence that [United] used proprietary methods

[4] A comparison of the two declarations shows that numerous paragraphs are identical, suggesting that these were likely crafted by counsel so as to provide "support" for the request, as opposed to an actual reflection of particularized business concerns relating to any specific exhibit.

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of analysis,"[5] and "[t]he results of [United's] financial decisions are public and are the subject of this lawsuit." *Id.* Moreover, because United's documents are all historical in nature, "the decisions are now several years old, suggesting that the information is now stale and no longer derives much, if any, value from its alleged confidential nature." *Id.*

The results of United's financial performance are publicly reported on a quarterly and annual basis—historical projections for that performance cannot possibly be a trade secret or cause of potential business harm, because the actual performance has already been made available. Accordingly, every United document relating to business plans and pricing that presents information for a public reporting period that has already come and gone (*i.e.*, anything through Q3 2021) is not entitled to sealing. Accordingly, for the reasons set forth in Sections IV.C–D, United's motion as to DX5504; PX1; PX3; PX8; PX10; PX5; PX16; PX22; PX23; PX25; PX26; PX34; PX53; PX66; DX4569; DX5507; PX67; PX71; PX73; PX75; PX76; PX92; PX94; PX96; PX127; PX132; PX509; DX5499; PX144; PX147; PX148; PX149; PX150; PX154; PX159; PX170A; PX174; PX175; PX178; PX193; PX212; PX218; PX220; PX229; PX230; PX231; PX236; PX239; PX243; PX244; PX246; PX254; PX256; PX265; PX266; DX5506; PX262; PX267; PX268; PX270; PX273; PX288; PX294; PX297A; PX297S; PX314; PX319; PX320; PX324; PX329; PX340; PX342; PX344; PX348; PX354; PX359; PX360; PX361; PX367; PX368; PX370; PX375; PX378; PX380; PX394; PX395; PX400; PX403; PX413; PX418;[6] PX421; PX423; PX426; PX440; PX444; PX447; PX462; PX476; PX477; PX471; PX483; DX4048; DX4478; DX4573; DX5505; PX450; PX455; PX464; and PX472 should be denied.

E. United requests sealing & redacting beyond the least restrictive means.

United attempts to keep up appearances by seeking redactions as opposed to wholesale sealing of each document. But a close examination of United's proposed redactions reveal a

[5] Indeed, much of the "analysis" consisted of a third party, MultiPlan, applying a unilaterally selected percentage of Medicare at United's direction. This is hardly a proprietary technique.

[6] United's motion describes PX418 as "a spreadsheet containing a list of providers, including personal identifying information such as addresses and TINs." Ex. B to Mot. This is incorrect. PX418 is a 2019 email from Rebecca Paradise to John Haben.

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different approach: United seeks to seal nearly every single number or percentage that appears in every one of the subject documents—regardless of whether United previously treated the document as having any confidentiality whatsoever.

Take, for example, DX4569, an exhibit which United moved into evidence and shared on the public screen without limitation:

> MR. BLALACK: Thank you.
>
> Your Honor, I move 4569 into evidence.
>
> THE COURT: 4569 will be admitted.
>
> [Defendants' Exhibit 4569 admitted into evidence]
>
> MR. BLALACK: Shane, could you bring that up, please?

11/10/2021 Tr. (Day 10) at 139:5–9. Mr. Haben then went on, in response to questions from United's counsel, and explained the document, the basis for putting it together, and the business concerns related to the email for over six pages of testimony. Now, however, despite affirmatively introducing this evidence into the public trial proceedings, United asks the Court to seal every percentage or number that isn't a date or a percentage of Medicare[7]—without any particularized explanation justifying these proposed redactions.

The same is true for DX4048, DX4478, DX4573, DX5505, DX5506, DX5507; each exhibit was moved into evidence by counsel for United without any limitation on its use or mention of any confidentiality:

[7] This is indicative of United's ongoing effort to sway public narrative. United leaves in percentages of Medicare because it fits their public messaging, but redacts all other information that cuts against their public message. A preferred public message is not a justifiable basis for seeking to seal or redact court records.

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> MR. BLALACK: Your Honor, real quick before the examination, I'm going to move for admission of Defendants' Exhibit 4048, Defendants' Exhibit 4478, Defendants' Exhibit 4529, Defendant's Exhibit 4531, Defendants' Exhibit 4573, Defendants' Exhibit 5505, Defendants' Exhibit 5506, and lastly, Defendants' Exhibit 5507.
>
> MR. AHMAD: And no objection, Your Honor.
>
> THE COURT: All right. Exhibits 4048, 4478, 4529, 4531, 4573, 5505, 5506, and 5507 will be admitted.
>
> [Defendants' Exhibit 4048, 4478, 4529, 4531, 4573, 5505, 5506, and 5507 admitted into evidence]

11/15/2021 Tr. (Day 12) at 48:9–18. Now, however, United seeks to retract that unconditional admission and redact significant portions of these documents without specifically addressing the basis for those redactions (and instead relying on the generalized affidavits, as discussed above).

In other examples, such as DX5530, United asks the Court to redact the summary of United's expert analysis as to the average allowed amounts for the claims at issue. This was testified to extensively at trial with no objection, by a number of witnesses:

> Q And you figured out, and you did all that work, did they have -- did they allow on average about -- during the claim period, $246 to the Plaintiffs?
>
> A Yes, for those 11,563 claims.

> Q And he compared it then to the amount that the Defendants allowed for disputed parts.
>
> A Yeah, 246 per claim, yes.
>
> Q On an average per claim basis?
>
> A Correct.

See, e.g., 11/17/2021 Tr. (Day 14) at 39:13–15; 11/18/2021 Tr. (Day 15) at 191:18–22. There is no basis now, after trial, to begin redacting figures that have been publicly testified to throughout the trial.

While these are just examples, they are indicative of United's entire process. And,

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because United has chosen to try and support its proposed sealing and redactions with a broad brushstrokes approach, rather than making document-specific arguments, United has not met its burden to provide the Court with sufficient evidence to parse through the variety of redactions and rule on a document-by-document basis. Instead, United's categorical redactions of numbers—without regard to whether they are publicly disclosed or if they actually merit trade secret protection—must be rejected, and the Court should deny United's motion.

F. United also asks the Court to redact data that has been widely disseminated.

In a number of the claims files, summary exhibits, and EOBs, United requests the Court seal information such as the allowed amount for each claim, the amount actually paid on each claim, coinsurance amounts, and other categories of information:

	M	N	O	P	Q	R	S	T
1	Charges	ALLOW	PMT	DEDUCTIBLE	COPAY	COINS.	TTL PMTS	IMPACT
7959	$1,428							
7960	$1,428							
7961	$1,428							
7962	$1,428							
7963	$1,428							
7964	$1,428							
7965	$1,428							
7966	$1,428							

See, e.g., United's Proposed Redactions to PX473 (emailed to the Court by C. Balkenbush on Dec. 24, 2021 at 1:22pm PT).

These allowed amounts and related categories were discussed ad nauseum at trial—without United ever *once* claiming these figures required AEO protection. This is a blatant attempt to hide United's wrongdoing behind the cloak sealed court records. United is not entitled to any protection from the public knowing how drastically it has underpaid emergency room doctors in Nevada (or across the country). These are not trade secrets, and United's historical payments cannot be the source of any competitive harm.[8]

Not only were these amounts widely discussed at trial, but they have been widely disseminated to numerous third parties. Every single patient gets informed of United's allowed

[8] United's "harm" in this instance would have to be that, if other providers knew how low United was paying, United would have to pay higher to compete in the marketplace. In other words, United would have to come closer to paying the reasonable value—exactly what the jury determined United had failed to do. It is not "harm" to be prevented from continuing misconduct.

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amount for their individual claim, as well as each and every provider. Take United's proposed redactions of allowed amounts on its EOB in PX375 for example. The allowed amount within that EOB was "calculated" by MultiPlan using Data iSight, provided to United from MultiPlan, then distributed directly to a an individual employee as well as to a provider billing department. The notion that the allowed amount somehow maintains confidentiality through that process is absurd. Any person could ask the patient and find out the information. *See Katch*, 143 F. Supp. 3d at 868 ("Similarly, the amount Katch pays its publishers is of questionable independent economic value. Katch, Sweetser, and MediaAlpha all agree that any salesperson can simply ask a publisher what it will take to move its business from one platform to another."). Accordingly, United's request to seal or redact the following exhibits should be denied: PX297A; PX297S; PX 473; PX512; DX4002; DX4003; DX4005; DX4006; DX4166; DX4168; DX4455; DX4457; DX4774; DX5322; DX5530.

G. The "irreparable harm" United alleges does not exist.

One of the "irreparable harms" United points to is that disclosure of certain documents during the trial "caused MultiPan's stock to drop six points."[9] Mot. at 4. What United leaves out, however, is that the MultiPlan stock price when the first documents were posted was $4.45 on November 4, 2021. On November 10, the MultiPlan stock price was at $3.76. But by November 22, the MultiPlan stock price had risen all the way to $4.67 (it also exceeded the $4.45 mark on December 7 and December 15). And as of December 23, the MultiPlan stock price is $4.42—a total of $0.03 less than on November 4. In other words, the "harm" is not so irreparable after all:

[9] As previously noted, all of the documents posted to the TeamHealth website were admitted exhibits. On top of that, United did not designate any of those specific exhibits as the AEO documents it had concerns with for trial.

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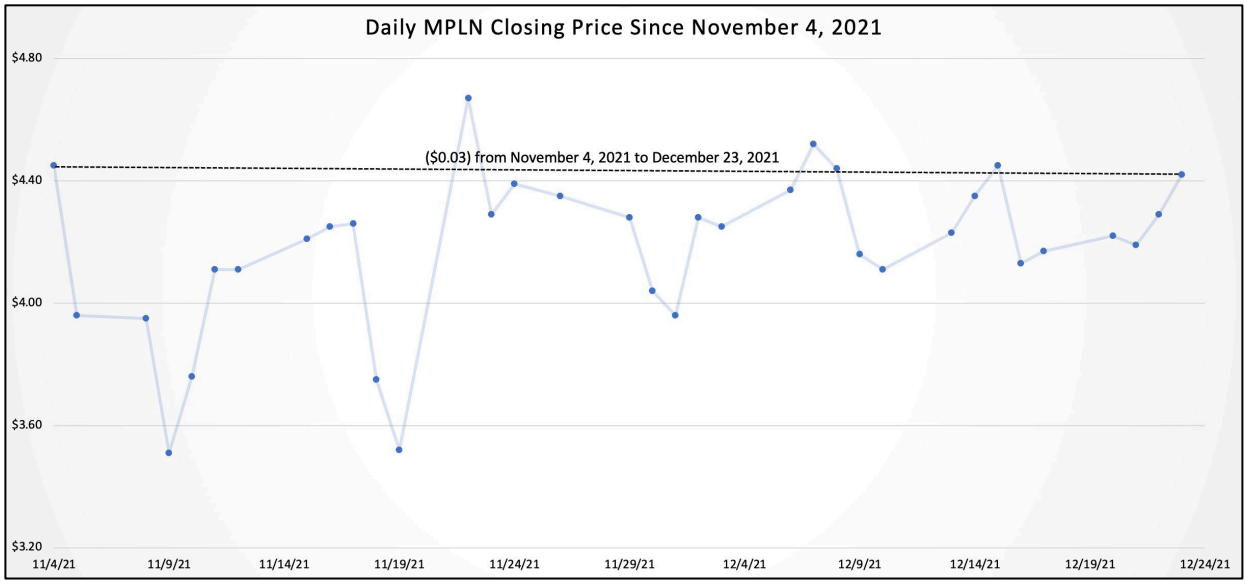

Source: https://finance.yahoo.com/quote/MPLN/history?p=MPLN.

On the contrary, these are price fluctuations that are normal in the market. And on top of that, the contents of the document—whether MultiPlan would be continuing as a vendor for United in the future—were the subject of extensive testimony from John Haben, all of which was open to the public. Therefore, this is not evidence of any so-called harm and does not justify sealing public court records.

H. United's non-sequitur accusations are inaccurate and irrelevant.

United asserts that the "parties reached an agreement that TeamHealth Plaintiffs would allow Defendants to redact certain portions of AEO documents that were shown at trial, such as particularly sensitive portions showing numbers or rates." Mot. at 9. While the HealthCare Providers did agree to allow United to propose such redactions, and not to read certain information into the record, the Health Care Providers never agreed to the scope of the proposed redactions. All of the figures were presented to the jury for all the jurors to see, all of the figures could have been seen and used in deliberations, and all of the figures are properly part of the public court record unless and until United presents a significant competing interest.

But United has no such significant competing interest that outweighs the public interest and Nevada open courts policy. Instead, United falsely accuses TeamHealth of "breach[ing] the parties' agreement" by posting admitted exhibits to the TeamHealth website. What United ignores, however, is that not a single one of the documents posted to the TeamHealth website

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was subject to the parties' agreement. Further, as soon as the Health Care Providers were informed of the information on the TeamHealth website, they pulled it down pursuant to the Court's order. No additional documents were posted for the duration of trial.

United then argues that, because the TeamHealth website says it will publish public documents after conclusion of the trial, this somehow justifies their request to seal because TeamHealth wishes to "promote public scandal" or "release trade secrets." Mot. at 17. This, again, is false. United conveniently ignores the disclaimer on TeamHealth's website, which states documents will only be made available "***subject to any limiting orders of the court***."[10] In other words, only documents that the Court rules are not confidential will be made available—hardly the "private spite" alleged by United.

This conjecture is not a consideration in the sealing analysis. But more importantly, it reveals that United wishes to live by a double standard. By suggesting TeamHealth's desire to demonstrate exactly how United maliciously, fraudulently, and oppressively treated the Health Care Providers in Nevada is inappropriate, United is asking the Court to allow United to get away with what it has done for *years*. United has tirelessly worked behind the scenes to aggressively target TeamHealth and its affiliated emergency room physician groups with controlled media efforts. United has hid its involvement in "objective" studies while calling TeamHealth out by name. United has "changed the narrative" with its media relations blitz. Now, however, when the tables are turned (only with respect to non-confidential documents), United cries foul. This is not a basis to seal otherwise non-confidential documents that do not contain trade secret information, after those documents have been fully admitted as evidence in a public trial. Thus, the Court should deny United's motion.

I. United's requested stay is designed for delay.

United's requested stay is far too lengthy. United is well aware of the issues and can be in the process of preparing the writ, if necessary, while this motion is pending. Instead, United asks for a deadline to seek as writ within thirty days from a *written* order denying its motion.

[10] https://www.teamhealth.com/protectingourhealthcareheroes/?r=1 (accessed December 28, 2021) (emphasis added).

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Given that United is likely to object to drag out the process of obtaining a final written order, this is unnecessarily extended.

Should the Court be inclined to grant a stay while United seeks a writ, United should be required to file the writ within 10 days of the Court's ruling on the motion—written or otherwise. No written order is necessary for United to seek a writ.

IV. CONCLUSION

For the reasons set forth above, the Health Care Providers request the Court deny United's motion to seal.

DATED this 29th day of December, 2021.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of Ahmad Zavitsanos Anaipakos Alavi & Mensing PC, and on this 29th day of December, 2021, I caused a true and correct copy of the foregoing **PLAINTIFFS' OPPOSITION TO UNITED'S MOTION TO SEAL** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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Exhibit 1

Year	Exhibit(s)
Undated	DX5504
2007	PX1
2010	PX3
2013	PX8; PX10
2015	PX5; PX16; PX22
2016	PX23; PX25; PX26; PX34; PX53; PX66; DX4569; DX5507
2017	PX67; PX71; PX73; PX75; PX76; PX92; PX94; PX96; PX127; PX132; PX509; DX5499
2018	PX144; PX147; PX148; PX149; PX150; PX154; PX159; PX170A; PX174; PX175; PX178; PX193; PX212; PX218; PX220; PX229; PX230; PX231; PX236; PX239; PX243; PX244; PX246; PX254; PX256; PX265; PX266; DX5506
2019	PX262; PX267; PX268; PX270; PX273; PX288; PX294; PX297A; PX297S; PX314; PX319; PX320; PX324; PX329; PX340; PX342; PX344; PX348; PX354; PX359; PX360; PX361; PX367; PX368; PX370; PX375; PX378; PX380; PX394; PX395; PX400; PX403; PX413; PX418;[1] PX421; PX423; PX426; PX440; PX444; PX447; PX462; PX476; PX477; PX471; PX483; DX4048; DX4478; DX4573; DX5505
2020	PX450; PX455; PX464; PX472

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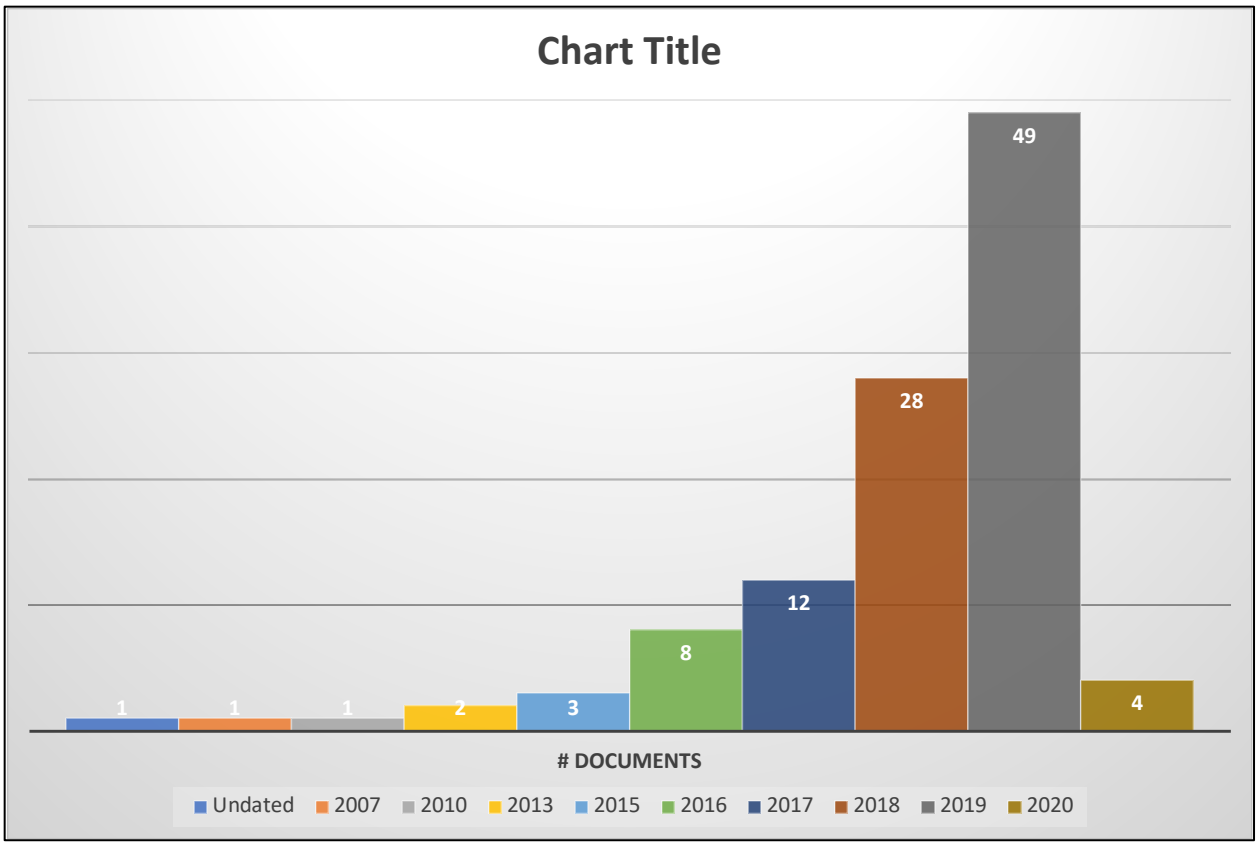
Claims Files & Summaries Spanning 2017–2020 (not included in chart):

PX473; PX512; DX4002; DX4003; DX4005; DX4006; DX4166; DX4168; DX4455; DX4457; DX4774; DX5322; DX5530

[1] United's motion describes PX418 as "a spreadsheet containing a list of providers, including personal identifying information such as addresses and TINs." Ex. B to Mot. This is incorrect. PX418 is a 2019 email from Rebecca Paradise to John Haben.



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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.,	Case No.: A-19-792978-B Dept. No.: 27 **HEARING REQUESTED**

DEFENDANTS' MOTION TO APPLY THE STATUTORY CAP ON PUNITIVE DAMAGES

Case Number: A-19-792978-B

Plaintiffs,

vs.

UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation.,

Defendants.

Defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services Inc. ("UHS", which does business as UnitedHealthcare or "UHC" and through UHIC), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Company ("SHL"), and Health Plan of Nevada, Inc. ("HPN") (collectively, "Defendants"), by and through their attorneys, hereby submit this Motion to Apply the Statutory Cap on Punitive Damages ("Motion").

DEFENDANTS' MOTION TO APPLY THE STATUTORY CAP ON PUNITIVE DAMAGES

In cases involving compensatory damages of $100,000 or more, Nevada law limits any award of punitive damages to "[t]hree times the amount of compensatory damages awarded to the plaintiff." NRS 42.005(1)(a). If the compensatory damages award is less than $100,000, then the punitive damages award is capped at $300,000. NRS 42.005(1)(b). Any judgment on the jury's verdict in this case must reflect these statutory limits.[1]

POINTS AND AUTHORITIES

After twenty-two days of trial, the jury awarded TeamHealth Plaintiffs[2] collectively $2.65 million in compensatory damages from the various Defendants, and then an additional $60

[1] Defendants expressly reserve their rights under the Due Process Clause of the U.S. Constitution and Nevada Constitution, which further limit the amount of recoverable punitive damages. Those due process limits, however, will be addressed in post-judgment motions, to the extent necessary.

[2] 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 "TeamHealth Plaintiffs").

million in punitive damages. Of course, the Court did not instruct the jury about NRS 42.005(1)(a) or (b);[3] to the contrary, they were encouraged by TeamHealth Plaintiffs to award punitive damages far in excess of those statutory limits. It is no surprise, then, that the verdict wildly exceeded statutory limits, with stratospheric punitive damages awards as high as 14,210 times compensatory damages.[4] The Court's duty now is straightforward: to enter a judgment that applies NRS 42.005(1)(a)-(b), limiting punitive damages based on the formulas set forth in the statute.

The statutory limits apply unless TeamHealth Plaintiffs plead and prove an exception under NRS 42.005(2). But they have plainly not done so here. The only exception applicable to insurance companies[5]—when they "act[] in bad faith with respect to [their] obligations to provide insurance coverage," NRS 42.005(2)(b)—does not apply for two separate and independent reasons. First, in order to evade preemption under the Employee Retirement Income Security Act of 1974 ("ERISA"), TeamHealth Plaintiffs deliberately disclaimed that they were seeking to enforce a claim for insurance coverage or to recover health insurance benefits, opting instead to plead their causes of action as third-party claims for reimbursement under various state laws. They expressly declared that their state-law claims did not depend upon the insurance coverage allegedly provided to their patients and denied that they were seeking to enforce coverage obligations through any assignment of benefits from their patients. Insurance coverage, by its very nature, only pertains to events—*i.e.*, loss of property, physical injury, or a

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[3] *See* NRS 42.005(3) ("The jury must not be instructed, or otherwise advised, of the limitations on the amount of an award of punitive damages prescribed in subsection 1.").

[4] For example, the jury awarded $281.49 in compensatory damages to plaintiff Ruby Crest against defendant HPN, but then awarded $4 million in punitive damages to the same plaintiff-defendant pairing. *See* 11/29/2021 Phase 1 Special Verdict Form Question No. 4 (compensatory damages awarded against HPN); 12/7/2021 Phase 2 Special Verdict Form Question No. 3 (punitive damages awarded to Ruby Crest).

[5] It is undisputed that TeamHealth Plaintiffs were not insureds under any applicable policy of insurance and, as shown by the trial record, some of the Defendants are not even insurers or issuers of insurance policies. *See* Brief in Support of Oral Motion for Judgment as a Matter of Law; 11/19/2021 Response to Plaintiffs' Trial Brief Regarding Applicability of Unfair Settlement Practices Act NRS 686A.020 and 686A.310 to all Defendants.

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healthcare procedure—that are payable based on the terms of an insurance policy. *Benchmark Ins. Co. v. Sparks*, 127 Nev. 407, 411-12, 254 P.3d 617, 620 (2011). Thus, the availability and extent of insurance coverage necessarily arises from the obligations imposed on an insurer under the language of an applicable insurance policy. *Id*. Here, over Defendants' objections, this Court affirmatively held that TeamHealth Plaintiffs were not seeking to recover benefits under any insurance policy. Thus, under the law of the case, the claims for relief do not seek to enforce an insurer's obligation to provide insurance coverage to an insured and, in any event, TeamHealth Plaintiffs are not insureds under any relevant insurance policy.

Second, even if it was possible to characterize their claims for relief as implicating an insurer's obligation to provide insurance coverage, TeamHealth Plaintiffs openly abandoned any cause of action based on bad faith. 11/22/2021 Tr. 310:20-22 ("We're not pursuing bad faith as a basis for punitive damages."). And, this Court did not instruct the jury on the legal requirements to find bad faith. As a result, in rendering its verdict, the jury made no finding of bad faith that could support the application of the exception to the statutory limit on punitive damages. Accordingly, when entering judgment in this case, the Court must apply the statutory limits in NRS 42.005(1)(a)-(b).

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I.
PUNITIVE DAMAGES ARE STATUTORILY CAPPED AT EITHER THREE TIMES THE COMPENSATORY DAMAGES AWARD OR $300,000, DEPENDING ON THE AMOUNT OF THE COMPENSATORY DAMAGES AWARD

Section 42.005(1) limits awards of punitive damages. If a plaintiff recovers $100,000 or more in compensatory damages, then the punitive damages award may not exceed three times the amount of the compensatory damages. NRS 42.005(1)(a). If the compensatory damages award is less than $100,000, then the punitive damages award is capped at $300,000. NRS 42.005(1)(b). Here, after applying the appropriate statutory cap, the total punitive damages award permitted by Nevada law is $10.57 million.

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TeamHealth Plaintiff	Defendant	Compensatory Damages Award	Punitive Damages Award	Punitive Damages Cap[6]
Fremont	UHIC	$478,686.26	$4,500,000.00	$1,436,058.78
	UHS	$771,406.35	$4,500,000.00	$2,314,219.05
	UMR	$168,949.51	$2,000,000.00	$506,848.53
	SHL	$1,007,374.49	$5,000,000.00	$3,022,123.47
	HPN	$23,765.68	$4,000,000.00	$300,000.00
Team Physicians	UHIC	$42,803.36	$4,500,000.00	$300,000.00
	UHS	$40,607.19	$4,500,000.00	$300,000.00
	UMR	$485.37	$2,000,000.00	$300,000.00
	SHL	$1,783.85	$5,000,000.00	$300,000.00
	HPN	$598.83	$4,000,000.00	$300,000.00
Ruby Crest	UHIC	$32,972.03	$4,500,000.00	$300,000.00
	UHS	$69,447.39	$4,500,000.00	$300,000.00
	UMR	$7,911.57	$2,000,000.00	$300,000.00
	SHL	$3,438.63	$5,000,000.00	$300,000.00
	HPN	$281.49	$4,000,000.00	$300,000.00
Total		**$2,650,512.00**	**$60,000,000.00**	**$10,579,249.83**

II.
TEAMHEALTH PLAINTIFFS ARE NOT PERMITTED TO OBTAIN UNLIMITED PUNITIVE DAMAGES BECAUSE THIS COURT HELD THAT THEY ARE NOT SEEKING TO RECOVER HEALTH INSURANCE BENEFITS

There are five exceptions to the statutory limit on punitive damages, but none of them apply to this case. NRS 42.005(2). TeamHealth Plaintiffs may attempt to rely on the statutory exception for an action against "[a]n insurer who acts in bad faith regarding its obligations to provide insurance coverage." NRS 42.005(2)(b). For the reasons explained *infra* at II.A.1-2, however, their own allegations show that this exception does not apply here. As a result, TeamHealth Plaintiffs cannot establish the applicability of the exception in NRS 42.005(2)(b), and the Court must enforce the statutory limits on punitive damages in the final judgment.

A. TEAMHEALTH PLAINTIFFS PREVIOUSLY ARGUED THAT THEY DID NOT BRING AN ACTION TO ENFORCE A HEALTH INSURER'S OBLIGATIONS TO PROVIDE INSURANCE COVERAGE TO INSUREDS

The exception to Nevada's cap on punitive damages set forth in NRS 42.005(2)(b) is predicated on a finding of "bad faith regarding [an insurer's] obligations to provide ***insurance coverage***." It is not a catch-all provision that applies to all misconduct by an insurer; by its own

[6] NRS 42.005(1)(a)-(b).

terms, the exception is limited to conduct vis-à-vis insurance coverage. Insurance coverage, in turn, only pertains to events—*i.e.*, loss of property, physical injury, or a healthcare procedure—that are payable based on the terms of an insurance policy. *Benchmark Ins. Co. v. Sparks*, 127 Nev. 407, 411-12, 254 P.3d 617, 620 (2011) ("An insurance policy" provides "financial protection from foreseeable . . . events."); *Zurich Am. Ins. Co. v. Ironshore Specialty Ins. Co.*, 137 Nev. Adv. Op. 66, 497 P.3d 625, 630 (Nev. Oct. 28, 2021) (en banc) ("Nevada law requires that the insured establish coverage under an insurance policy," *i.e.*, "'a loss . . . within the terms of the policy.'" (quoting *Nat'l Auto & Cas. Ins. Co. v. Havas*, 75 Nev. 301, 303, 339 P.3d 767, 768 (1959)). The duties of insurance coverage, then, must be found in the terms of the insurance policy. *Benchmark Ins. Co.*, 127 Nev. at 411-12. ("the duties undertaken by . . . the insurer are defined by the terms of the policy itself."). Thus, by its plain language, NRS 42.005(2)(b) only applies when insurance coverage exists and the insurer acted in bad faith regarding its coverage obligations to an insured.

Throughout the entirety of this case, however, TeamHealth Plaintiffs have argued that their lawsuit is not a coverage dispute, is not affected by any insurance policy, and is, consequently, not preempted by ERISA. *See* 4/15/2019 Complaint ¶ 1 n.1.; 5/15/2020 First Amended Complaint ¶ 1 n.1; 10/7/2021 Second Amended Complaint ¶ 1 n.1; 10/19/2021 Tr. 90:8-13 ("We do not want this case to get removed. . . . [A]n ERISA issue . . . is not our goal."). In fact, they deliberately disclaimed that they were seeking to recover benefits that could stem from an insurance policy or relief based on coverage owed to an insured. 4/15/2019 Complaint ¶ 1 n.1.; 5/15/2020 First Amended Complaint ¶ 1 n.1; 10/7/2021 Second Amended Complaint ¶ 1 n.1; **Exhibit 1**, 5/24/2019 Plfs' Mot. to Remand at 11; **Exhibit 2**, 6/18/2019 Plfs' Federal Court Opp. to Defs' Mot. to Dismiss at 2. And, it is undisputed that (1) TeamHealth Plaintiffs are not insureds under any applicable insurance policy; and (2) that they are not parties to any insurance policy between Defendants and their insureds.

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1. TeamHealth Plaintiffs' Tactics to Avoid ERISA Preemption, Including Their Representations that Insurance Coverage Was Not Disputed, Preclude the Applicability of NRS 42.005(2)(b)

Insurance coverage must be disputed for NRS 42.005(2)(b) to apply, because a jury cannot lawfully find that an insurer "act[ed] in bad faith regarding its obligations to provide insurance coverage" without evaluating the insurer's coverage obligations, which derive from the applicable insurance policy. *See United Fire Ins. Co. v. McClelland*, 105 Nev. 504, 511, 780 P.2d 193, 197 (1989) ("Liability for bad faith is strictly tied to the implied-in-law covenant of good faith and fair dealing arising out of an underlying contractual relationship."); *Zurich Am. Ins. Co.*, 137 Nev. Adv. Op. 66, 497 P.3d at 630 ("Nevada law requires that the insured establish coverage under an insurance policy."); *Benchmark Ins. Co.*, 127 Nev. at 411-12 ("the duties undertaken by . . . the insurer are defined by the terms of the policy itself"); *Pioneer Chlor Alkali Co.*, 863 F. Supp. at 1243 ("Bad faith requires an awareness that no reasonable basis exists to deny the insured's claim.").

To evade preemption under ERISA, however, TeamHealth Plaintiffs rejected any reliance on the insurance policies that provided their patients with health insurance coverage and did not claim to be insureds or even the third-party beneficiaries of the insureds' rights to coverage. 4/15/2019 Complaint ¶ 1 & n.1 (describing the nature of this action as "aris[ing] out of a dispute concerning the rate" of payment and that "there [wa]s no basis to remove . . . to federal court under federal question jurisdiction"). Defendants removed the case to federal court arguing, among other things, that ERISA preempted their state law claims because TeamHealth Plaintiffs necessarily sought to recover health insurance benefits owed to their patients. *See* **Exhibit 3**, 5/14/2019 Defs' Notice of Removal at 2-6; **Exhibit 4**, 6/21/2019 Defs' Opp. to Plfs' Mot. to Remand at 2, 6.

While in federal court, however, TeamHealth Plaintiffs reiterated their position that ERISA was inapplicable by representing that insurance coverage was immaterial to every aspect of their case. In the original motion to remand and the opposition to Defendants' motion to

dismiss filed by Fremont, they[7] argued that the underlying ***insurance policies "are irrelevant"*** to their lawsuit, which "asserted . . . claims to enforce . . . independent rights, under Nevada law" that are ***"not derivative or dependent upon the terms of any particular patient's [insurance policy] in any way."*** **Exhibit 1** at 11 (emphasis added); *see also* **Exhibit 2** at 6-7. TeamHealth Plaintiffs also asserted that ***"there is no need to consider the existence of any [insurance policy], at all."*** **Exhibit 1** at 11 (emphasis added); *see also* **Exhibit 2** at 6-7 (arguing that the right to payment was not disputed because all at-issue benefit claims were already paid and that their "dispute with [Defendants] does not involve an employee benefit plan" because no TeamHealth Plaintiff is "a participant or beneficiary of those plans.").

Additionally, TeamHealth Plaintiffs disavowed any legal right or benefit that could flow to them through an assignment of benefits from an insured. In opposing remand, Defendants argued that TeamHealth Plaintiffs received assignments of benefits from Defendants' insureds, so ERISA issues inevitably loomed. *See* **Exhibit 4** at 6. TeamHealth Plaintiffs responded with an amended complaint in federal court. That amended complaint disavowed any assignment of benefits, stating that TeamHealth Plaintiffs "do not assert claims that are dependent on the existence of an assignment of benefits . . . from any of Defendants' Members."[8] **Exhibit 5**, 1/7/2020 Federal Court Amended Complaint ¶ 1 n.1; *see also* **Exhibit 2** at 2 (arguing that the

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[7] Team Physicians and Ruby Crest joined the lawsuit while the motion to dismiss Fremont's complaint was pending in federal court but after the original motion to remand was denied without prejudice. *See* **Exhibit 5**, 1/7/2020 Federal Court Amended Complaint; **Exhibit 6**, 2/20/2020 Order Granting Remand; **Exhibit 7**, 1/15/2020 Amended Mot. to Remand at 5 ("Motion to Remand was denied without prejudice on January 6, 2020, in light of the anticipated filing of the First Amended Complaint."). That opposition was not amended and it made arguments identical to the motion to remand. *Compare* **Exhibit** 1 at 11, *with* **Exhibit** 2 at 6-7. In a renewed and amended motion to remand, TeamHealth Plaintiffs adopted Fremont's prosecution of the case and they made substantively similar arguments to the original motion to remand. *See* **Exhibit 7** at 2, 4-5, 11-14 (asserting that "[t]he Health Care Providers initiated this action in Nevada state court" even though Fremont was the lone plaintiff at the time and that the amended complaint did not change the substance of their case).

[8] TeamHealth Plaintiffs continued to disclaim any assignments of benefits from Defendants' insureds after remand to this Court. 5/15/2020 First Amended Complaint ¶ 1 n.1 ("[TeamHealth Plaintiffs] do not assert claims that are dependent on the existence of an assignment of benefits . . . from any of Defendants' Members."). TeamHealth Plaintiffs then reaffirmed their position with the Second Amended Complaint—*i.e.*, the trial's operative complaint. 10/7/2021 Second Amended Complaint ¶ 1 n.1 (same footnote 1 found in the 5/15/2020 First Amended Complaint).

lawsuit is "not predicated upon" an assignment of benefits from insureds). In sum, TeamHealth Plaintiffs unequivocally took the position that they were not seeking any benefit or advancing any legal position based on any insurance policy that might relate to the at-issue benefit claims. Over Defendants' objections, their strategy succeeded. The federal court did not dismiss the amended complaint and it remanded the action to this Court. *See* **Exhibit 6**, 2/20/2020 Order Granting Remand.

After convincing the federal court to remand the case to this Court, TeamHealth Plaintiffs doubled down on their strategy to evade ERISA by disavowing the insurance policies implicated in this case. For example, TeamHealth Plaintiffs told this Court that they "are not seeking to recover against [Defendants] for any claims arising under their [insurance policies] with their insured[s]. Rather, the claims asserted . . . ***have no connection to the [insurance policies]***," which "could say that emergency services will not be covered or they could say that [the] services will be covered 100%. Under either case, such terms would not form the basis for" TeamHealth Plaintiffs' lawsuit. 3/26/2020 Plfs' Opp. to Defs' Mot. to Dismiss at 12 n.7 (emphasis added). Simply put, TeamHealth Plaintiffs sought to prosecute their lawsuit divorced from any alleged "obligations" that the Defendants might have had "to provide insurance coverage" to their insureds. NRS 42.005(2)(b). As such, TeamHealth Plaintiffs cannot reverse course now and contend that their lawsuit is based on Defendants' obligations to provide insurance coverage in an effort to apply an exception to Nevada's statutory cap on punitive damages.

2. <u>TeamHealth Plaintiffs Are Not Insureds and They Are Not Parties To Any of the Insurance Policies Between Defendants and Their Insureds</u>

Throughout this lawsuit, TeamHealth Plaintiffs confirmed that they are not insureds under any policy of insurance issued by Defendants or parties to such policies. **Exhibit 2** at 2 ("The face of the Complaint makes it clear that Fremont sues as an independent entity claiming damages arising from . . . statutory and common law duties to pay claims at a usual and customary rate and in a reasonable amount[.]"); *id.* at 19-20 (referring to Fremont as a third party

rather than an insured). But, under Nevada law, an allegation of bad faith against an insurer can only be maintained if the plaintiff has an insurance policy with an insurer. *See Torres v. Nev. Direct Ins. Co.*, 131 Nev. 531, 541, 353 P.3d 1203, 1211 (2015) ("Third-party claimants do not have a contractual relationship with insurers and thus have no standing to claim bad faith." (quoting *Gunny v. Allstate Ins. Co.*, 108 Nev. 344, 345, 830 P.2d 1335, 1335-36 (1992))); *Accera Group Corp. v. Sentinel Ins. Co.*, 2010 WL 3118194, at *1 (Nev. June 8, 2020) ("***An insured*** may institute a bad faith action against his or her insurer ***once the insured establishes 'legal entitlement'*** and unreasonable conduct by the insurer concerning its obligations to ***the insureds***." (emphasis added)).

In *Gunny*, the Nevada Supreme Court rejected a third-party's claim for bad faith against an insurer because there was no contractual relationship between Gunny and Allstate. 108 Nev. at 345, 830 P.2d at 1335-36. Likewise, in *Torres*, the Nevada Supreme Court relied on *Gunny* to reject Torres' third-party claim for bad faith against an insurer. *Torres*, 131 Nev. at 541, 353 P.3d at 1211. In *McClelland*, the wife's claim for coverage under an insurance policy as a dependent did not confer standing upon her to bring a claim for bad faith on her husband's behalf because he was the insured. 105 Nev. at 511, 720 P.2d at 198.

While the jury in this case found an implied contract between Defendants and TeamHealth Plaintiffs, that contract was for reimbursement of services rendered for the benefit of the Defendants. 11/23/2021 Tr. 258:15-259:6.[9] However, the implied contract is self-

[9] Throughout trial, TeamHealth Plaintiffs' counsel and witnesses took the position that they (1) were not bound by any health insurance policy and (2) were pursuing reimbursement based on a separate, implied contract with Defendants.

11/15/2021 Tr. 34:20-36:19:

> MR. AHMAD: you understand the providers are not bound by the [insurance policy]? . . .
> MS. PARADISE: . . . the [insurance policy] is providing the provisions for the [insurance policy].
> MR. AHMAD: But we, the provider, is not bound by that?
> MS. PARADISE: A provider does not get involved in drafting [the insurance policy] language that outlines what a plan is covering no.

11/22/2021 Tr. 35:6-11:

Continued on next page…

evidently not an insurance policy, so the implied contract cannot vindicate any right to insurance coverage on behalf of any insured. Indeed, because TeamHealth Plaintiffs disclaimed any reliance on insurance policies and asserted that they are not insureds or even third-party beneficiaries to an insured's right to coverage, the jury could not lawfully find that TeamHealth Plaintiffs had an insurance policy or were privy to any insurance policy with Defendants.

This Court permitted the Unfair Claims Practices Act cause of action to reach the jury without an applicable insurance policy based on the unique language of that statute, which refers to the "fail[ure] to effectuate prompt, fair and equitable settlement of claims," finding that the statute creates a private right of action for claimants, not just insureds, and that any contract could satisfy the requirement of privity under that Act. 6/24/2020 Order Denying Defs' Mot. to Dismiss ¶¶ 63-69. But the Court has yet to consider the very different statutory language of NRS 42.005(2)(b), which is predicated on a finding of "bad faith regarding [an insurer's] obligations to provide insurance coverage." The right to insurance coverage, however, derives necessarily and exclusively from the insured's insurance policy with the insurer. *Zurich Am. Ins. Co.*, 137 Nev. Adv. Op. 66, 497 P.3d at 630 ("Nevada law requires that the insured establish coverage under an insurance policy," *i.e.*, "'a loss . . . within the terms of the policy.'" (quoting *Nat'l Auto & Cas. Ins. Co. v. Havas*, 75 Nev. 301, 303, 339 P.3d 767, 768 (1959)); *United Servs. Auto Ass'n v. Schlang*, 111 Nev. 486, 496, 94 P.2d 967, 973 (1995) (ruling courts "do[] not [have] license to

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> MR. AHMAD: there's nothing in the [insurance policy], necessarily, that requires that TPA pay reasonable value for their services. In fact, that's why the jury is here today. That's what they have to determine, correct?
> MS. KING: I'd have to see the [insurance policy.]

11/22/2021 Tr. 74:18-22:

> MR. BLALACK: Did Plaintiffs have an implied agreement with all commercial health insurers and health plans whose members receive emergency services form the plans on an out-of-network basis?
> MR. BRISTOW: . . . yes.

11/22/2021 Tr. 158:15-159:3:

> MR. BRISTOW: the underlying [insurance policy] . . . dictate[s] . . . how they will pay for out-of-network services. . . . We have no control over [the insurance policy]. That's between the [insured] and [Defendants]. But it doesn't change our position . . . [that] we are due the usual and customary charge.

rewrite the contract of insurance to provide coverage where it does not exist"). Without an insurance policy, then, there are no insurance coverage obligations for an insurer to discharge. Put another way, an insurer cannot act in bad faith with respect to its coverage obligations without an insurance policy that creates those coverage obligations to the insured.

No one would reasonably argue that NRS 42.005(2)(b) applies to an insurance company's bad faith conduct relating to the performance of a contract between the insurer and its information technology vendor since the insurer's bad faith would not pertain to its coverage obligations to an insured but rather its contractual duties to a third-party commercial vendor. The contract between the vendor and the insurer, in this example, is not an insurance policy and the bad faith of the insurer does not involve the denial of insurance coverage. Indeed, the fact that the defendant is an insurer is entirely incidental to the bad faith claim. Because bad faith by the insurer ***acting as an insurer*** is the predicate for the statutory exception in NRS 42.005(2)(b), there must be an applicable insurance policy that extends insurance coverage to the plaintiff. Thus, the exception to the punitive damages cap in NRS 42.005(2)(b) can only be triggered if the plaintiff is privy to an insurance policy, as opposed to a contract between the insurer and a third-party claimant.

Defendants, however, do not owe any insurance obligations to TeamHealth Plaintiffs. TeamHealth Plaintiffs were not a party to any applicable policy of insurance. They have disclaimed all assignments of benefits from any insured. And, they have repeatedly told this Court that their lawsuit is not seeking to enforce rights under insurance policies or an insured's right to coverage. *See, e.g.*, 3/26/2020 Plfs' Opp. to Defs' Mot. to Dismiss at 12 n.7.

* * *

Because they deliberately and tactically elected to characterize their lawsuit as not seeking to recover insurance benefits under any applicable policy of insurance, and because this Court previously held that they were not seeking to enforce rights to coverage under any applicable health plan, TeamHealth Plaintiffs cannot seek unlimited punitive damages pursuant to NRS 42.005(2)(b).

B. DEFENDANTS ACTING AS THIRD-PARTY ADMINISTRATORS DO NOT PROVIDE INSURANCE COVERAGE AND HAD NO OBLIGATION TO PROVIDE INSURANCE COVERAGE

The exception in NRS 42.005(2)(b) must be based on a jury's finding that "[a]n ***insurer*** . . . act[ed] in bad faith regarding its obligations to provide insurance coverage." NRS 42.005(2)(b) (emphasis added); *see also Pioneer Chlor Alkali Co.*, 863 F. Supp. at 1243 ("[B]ad faith involves something more than an unreasonable action . . . ***by the insurer***. . . . Bad faith exists where ***an insurer*** denies a claim." (emphasis added)). Moreover, the conduct of third-party administrators are not within the purview of NRS 42.005(2)(b) because only insurers are included within Nevada's definition of bad faith. *Pioneer Chlor Alkali Co.*, 863 F. Supp. at 1247 ("Nevada's definition of bad faith is (1) ***an insurer's*** denial of (or refusal to pay) an insured's claim . . . ." (emphasis added)). Also, "bad faith is not as broad in scope as NRS 686A.310," *id.* at 1243, and the Nevada Supreme Court has held that a third-party administrator is not an insurer in the context of claims asserted under NRS 686A.310. *Albert H. Wohlers & Co. v. Bartgis*, 114 Nev. 1249, 1265, 969 P.2d 949, 960 (1998) (holding that third-party administrator is not an "insurer" within the meaning of NRS 686A.310); NRS 679A.100 (defining "insurer" as "every person engaged as principal and as indemnitor, surety or contractor in the business of entering into contracts of insurance").

UHS and UMR are not health insurers and they do not provide health insurance coverage. They are third-party administrators. 11/8/2021 Tr. 152:23-153:1 (UMR is a third-party administrator); 11/9/2021 Tr. 130:19-131:10 ("UnitedHealthcare itself is a third-party administrator . . . [f]or self-employed groups"). That is, UHS and UMR act as claim administrators for health insurance coverage that is sponsored by others—*i.e.*, employer and union self-funded plans. *See* 11/9/2021 Tr. 130:19-131:10. As such, UHS and UMR cannot deny coverage to insureds, in bad faith or otherwise, because they are bound to administer the coverage offered by the actual insurer—*i.e.*, the self-funded employer or union. *See* 11/3/2021 Tr. 86:19-87:2. Because UHS and UMR are not insurers, they have no obligation to provide insurance coverage, which remains with the self-funded sponsor of the plan. *See* 11/2/2021 Tr.

44:6-11 (conceding in opening statement that self-insured employers provide the coverage by "insuring the claims themselves"). UHIC acts as both an insurer and a third-party administrator. 11/10/2021 Tr. 24:10-17 (UHIC is a third-party administrator and an insurer). UHIC does not have an obligation to provide insurance coverage when it acts only as a third-party administrator and not an insurer. Therefore, under the plain language of the statute, NRS 42.005(2)(b) cannot apply to non-insurer defendants UHS, UMR, and UHIC as a third-party administrator.[10] For that additional reason, the exception to the statutory limits on punitive damages set forth in NRS 42.005(2)(b) ***cannot*** apply to these entities.

III.

IN THE ALTERNATIVE, IF NRS 42.005(2)(B) COULD BE APPLIED IN THIS CASE, TEAMHEALTH PLAINTIFFS FAILED TO MEET THEIR BURDEN TO OBTAIN A JURY FINDING THAT WOULD SUPPORT UNLIMITED PUNITIVE DAMAGES

Even if this were a case with plaintiffs and causes of action that implicated the right of insureds to insurance coverage—and it is not—the statutory exception to NRS 42.005(2)(b) does not apply because it was never tried to the jury. First, the jury was not presented with any evidence that any insured was denied ***coverage*** under any applicable policy of insurance. Indeed, TeamHealth Plaintiffs could not present that evidence because they disclaimed any assignment of benefits from any insured and alleged that their lawsuit was not seeking to obtain insurance coverage. And, they told the jury in opening statement that insurance coverage was not an issue that needed to be decided. 11/2/2021 Tr. 34:5-7 ("Now one thing that is unique about this case is that [Defendants] do[] not contest that the folks we provided medical services have coverage with them."). Second, the jury did not receive any instruction regarding bad faith by an insurer. As a result, the jury never found that the Defendants acted in bad faith regarding their insurance coverage obligations. Third, an untimely claim of bad faith would introduce further error into the verdict, especially because TeamHealth Plaintiffs conceded at the final charge conference that they were "not pursuing bad faith as a basis for punitive damages."

[10] TeamHealth Plaintiffs did not ask the jury to determine how much, if any, of the awards against UHIC were based on claims that UHIC administered as an insurer rather than a third-party administrator. Thus, there is no factual basis to find that any of the compensatory damages awarded by the jury pertains to UHIC's role as an insurer.

11/22/21 Tr. 310:20-22.

A. TEAMHEALTH PLAINTIFFS DID NOT TRY ANY CLAIM FOR BAD FAITH WITH RESPECT TO INSURANCE COVERAGE—OR ANYTHING ELSE

At trial, TeamHealth Plaintiffs pursued just four causes of action: (1) breach of implied-in-fact contract; (2) unjust enrichment; (3) unfair settlement practices under the Unfair Claims Practices Act, NRS 686A.310; and (4) violations of Nevada's prompt pay statutes. *See* Special Verdict Form Questions 1, 5, 10, 14. In advancing those four causes of action to the jury, TeamHealth Plaintiffs' opening statement informed the jury that insurance coverage was not contested, so it was not an issue for them to decide. 11/2/2021 Tr. 34:5-7. That statement alone is sufficient to prevent application of NRS 42.005(2)(b) because Nevada law defines bad faith as "the denial of an insured's claim without any reasonable basis." *Pioneer Chlor Alkali Co.*, 863 F. Supp. at 1244 ; *see also Powers v. United Servs. Auto Ass'n*, 114 Nev. 690, 703, 962 P.2d 596, 604 (1998) (requiring plaintiff to prove "insurer had no reasonable basis for disputing coverage, and that the insurer knew or recklessly disregarded the fact that there was no reasonable basis for disputing coverage").

Beyond this concession, they also alleged no cause of action in this case that meets the standard for bad faith by an insurer. In order to establish bad faith by an insurer, there must be "[a] violation of the obligation of good faith and fair dealing." *See* 2018 Nev. J.I. 11.4. That obligation originates from the insurance policy between the insurance company and the insured. *Id*. Moreover, a plaintiff must "establish a breach of the implied covenant of good faith and fair dealing" by proving that the insurer: (1) "had no reasonable basis for its conduct in the handling of plaintiff's claim"; (2) "knew, or recklessly disregarded, the fact that there was no reasonable basis for its conduct; and" (3) "was the legal cause of harm." 2018 Nev. J.I. 11.5. TeamHealth Plaintiffs, however, are not insureds. They disavowed the insurance policies that contain the applicable covenants of good faith and fair dealing necessary to maintain a cause of action against an insurer for bad faith. *See McClelland*, 105 Nev. at 511, 780 P.2d at 197 ("Liability for bad faith is strictly tied to the implied-in-law covenant of good faith and fair dealing arising out of an underlying contractual relationship."); *Trans Pacific Ventures, Inc. v. JRJ Investments, Inc.*,

2010 WL 10043042, at *1, 4-5 (Nev. April 29, 2010) (applying the NRS 42.005 punitive damages cap because the bad faith of the defendant did not involve an insurance policy). And, they abandoned their cause of action for breach of the covenant good faith and fair dealing just before trial. Therefore, no cause of action alleging bad faith, let alone a cause of action alleging bad faith by an insurer, was decided in this case, rendering NRS 42.005(2)(b) inapplicable.

1. TeamHealth Plaintiffs' Litigation Decisions Confirm that Bad Faith was Not Presented to the Jury and NRS 42.005(2)(b) is Inapplicable

In the original and First Amended Complaints, which respectively contained seven and eight claims for relief, TeamHealth Plaintiffs asserted an action based on tortious breach of the implied covenant of good faith and fair dealing. 4/15/2019 Complaint ¶¶ 32-99; 5/15/2020 First Amended Complaint ¶¶ 189-273. In order to evade ERISA preemption, TeamHealth Plaintiffs expressly denied that they sought to enforce a "right to payment" under any insurance policy. *See* **Exhibit 2** at 6 (evading ERISA preemption by arguing that TeamHealth Plaintiffs only challenged the rate of payment, not the right to payment, because all at-issue benefit claims were already paid). Instead, they characterized their lawsuit as "enforce[ing] [their] independent rights, under Nevada law" that were "not derivative of or dependent upon the terms of any particular patient's benefit plan in any way." *Id.* 6-7 (arguing their "dispute with [Defendants] d[id] not involve an employee benefit plan" because no TeamHealth Plaintiff is "a participant or beneficiary of those plans"). And they announced that none of their "right[s] ar[ose] under a health benefit plan which is implicated in this case." *Id.* Moreover, TeamHealth Plaintiffs disavowed any assignment of benefits that they received from any insured. 5/15/2020 First Amended Complaint ¶ 1 n.1; 10/7/2021 Second Amended Complaint ¶ 1 n.1. As a result, the alleged "bad faith" described in the First Amended Complaint was limited to the implied contract between Defendants and TeamHealth Plaintiffs for reimbursement of out-of-network emergency services, not coverage under a policy of insurance. *See* **Exhibit 2** at 15-16; **Exhibit 4** ¶¶ 38, 45, 207-215, 233; 5/15/2020 First Amended Complaint ¶¶ 207-215, 233; 10/7/2021 Second Amended Complaint ¶¶ 14-15.

However, just weeks before trial and after Defendants filed a motion for summary judgment, TeamHealth Plaintiffs abandoned this cause of action. *See* 10/7/2021 Second Amended Complaint ¶¶ 11-16. The parties' joint pretrial memorandum then removed all doubt that TeamHealth Plaintiffs had dropped their claim for tortious breach of the implied covenant of good faith and fair dealing. 10/27/2021 Joint Pretrial Memorandum 5-6. And, the trial further reinforced that the exception in NRS 42.005(2)(b) does not apply. No insured took the stand. Nor was there any evidence that insurance coverage was denied. Instead, TeamHealth Plaintiffs' case hinged on convincing the jury that they were not bound by the insurance coverage provided to insureds. *See, e.g.*, 11/23/2021 Tr. 258:15-259:6 (arguing that the doctors "would like to hear what do you all [the jury] think the reasonable value of their service is" and that Defendants "came to court wanting to argue that the[] plan documents somehow controlled everything" even though "[n]o one comes to us [the doctors] and asks us to be part of that negotiation"; so, insurance policies have "nothing to do with reasonable value"). Thus, it is unsurprising that the jury never found that Defendants acted in bad faith with respect to any insurance coverage decisions. *See* Special Verdict Form Questions 1, 5, 10, 14.

Therefore, NRS 42.005(2)(b) cannot lawfully apply in this case.

B. THE JURY WAS NEVER INSTRUCTED ON BAD FAITH

In Nevada, the alleged bad faith of an insurer is a jury issue. *See* 2018 Nev. J.I. 11.5; 2011 Nev. J.I. 11FD.4; *see also* 2018 Nev. J.I. 11.4-11.12. But because TeamHealth Plaintiffs never presented a bad faith case to the jury, the Court never instructed the jury on that legal concept. *See* 11/29/2021 Jury Verdict; 11/30/2021 Tr. 27:25-29:16. In fact, neither TeamHealth Plaintiffs nor Defendants proposed any instruction on "Insurance Bad Faith." *See, e.g.*, 2018 Nev. J.I. 11.5; 2011 Nev. J.I. 11FD.4. Now, having not sought the required finding from the jury, TeamHealth Plaintiffs cannot be permitted to manufacture a *post hoc* reason to justify unlimited punitive damages in the absence of the requisite finding of bad faith under Nevada law. For example, the punitive damages verdict cannot be used as a proxy for a jury finding of bad faith by an insurer because the statutory definitions of fraud, oppression, and malice in NRS

42.001, on which the Court instructed the jury, are not interchangeable with the common-law definition of bad faith in the obligation to provide insurance coverage. *Sandoval v. Hartford Underwriters Ins. Co.*, 2:10-CV-1799-JCM-PAL, 2011 WL 586414, at *3 (D. Nev. Feb. 9, 2011) ("Bad faith is not a prerequisite for punitive damages."); *Pioneer Chlor Alkali Co.*, 863 F. Supp. at 1244, 1250.

Moreover, TeamHealth Plaintiffs' proposed jury instructions and verdict forms demonstrate that they knew they needed to obtain a bad faith finding from the jury but opted not to pursue that finding. Initially, TeamHealth Plaintiffs errantly proposed a punitive damages jury instruction that included a definition of bad faith along with fraud, oppression, and malice. *See* 11/15/2021 TeamHealth Plaintiffs' Proposed Jury Instruction at 16 ("'Bad faith' means that the defendant had no reasonable basis for disputing the claim; and the defendant knew or recklessly disregarded the fact that there was no reasonable basis for disputing the claim"). But then, in their second supplemental jury instructions, TeamHealth Plaintiffs eliminated any reference to bad faith. *Compare* 11/20/2021 TeamHealth Plaintiffs' Second Supplemental Jury Instructions at 6, *with* 11/15/2021 TeamHealth Plaintiffs' Proposed Jury Instructions at 16; *see also* 11/21/2021 Tr. 115:24-116:10 (confirming that the 11/20/2021 supplemental instruction at 6 replaced the 11/15/2021 instruction at 16). Likewise, their initial proposed verdict form also contemplated that the jury would render a finding on bad faith, but they similarly proposed an updated verdict form eliminating any interrogatory regarding bad faith. *Compare* 11/16/2021 TeamHealth Plaintiffs' Proposed Verdict Form Question No. 7 *with* 11/19/2021 TeamHealth Plaintiffs' Proposed Special Verdict Form Question No. 7. Indeed, TeamHealth Plaintiffs explicitly told this Court at the final charge conference that they were "not pursuing bad faith as a basis for punitive damages." 11/22/21 Tr. 310:20-22. Setting aside the other limitations of NRS 42.005(2)(b), TeamHealth Plaintiffs consciously chose not to pursue an instruction or finding of "bad faith" of any kind by the jury.

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C. AN UNTIMELY CLAIM OF BAD FAITH WOULD INTRODUCE FURTHER ERROR INTO THE VERDICT

1. The Statutory Definitions of Fraud, Oppression, and Malice Do Not Apply in a Bad-Faith Insurance Coverage Case

In a case involving allegations of bad faith regarding insurance coverage, the statutory provisions for punitive damages that define malice, oppression, and fraud do not apply: "For the purposes of an action brought against an insurer who acts in bad faith regarding its obligations to provide insurance coverage, the definitions set forth in NRS 42.001 are not applicable and the corresponding provisions of the common law apply." NRS 42.005(5). Likewise, the Use Note for Jury Instruction 12.1 in the 2018 State Bar publication, which is the instruction that the Court read to the jury, cites this provision, confirming that the instruction has no applicability in a case involving allegations of bad faith regarding insurance coverage. *See also Desert Palace, Inc. v. Ace Am. Ins. Co.*, 2:10-CV-01638-RLH, 2011 WL 810235, at *5 (D. Nev. Mar. 2, 2011).

2. Because this is Not a Bad-Faith Insurance Coverage Case, the Jury Was Instructed on the Statutory Definitions Governing an Award of Punitive Damages

Here, TeamHealth Plaintiffs successfully argued for the punitive damages instruction based on the statutory definitions because they had expressly abandoned their claim of bad faith in the Second Amended Complaint. *See* 10/7/2021 Second Amended Complaint ¶¶ 11-16. Indeed, during the final charge conference, no party submitted a proposed jury instruction for the ***common law*** definitions that would have been necessary to sustain a claim for relief subject to NRS 42.005(2)(b). The Court instead instructed the jury on the ***statutory*** definitions for punitive damages, relying on the absence of any instruction or verdict interrogatory regarding bad faith and TeamHealth Plaintiffs' representation that they were not pursuing a claim of bad faith to support their request for punitive damages. *See* 11/21/21 Tr. 115:17-124:1.

To change course after the verdict has been delivered would introduce new and clear legal error.

CONCLUSION

The record is undisputed: the jury's punitive damages verdict is not based on a finding that Defendants acted in bad faith with respect to their coverage obligations under policies of insurance. Therefore, any judgment entered on the verdict must apply the statutory limitations in NRS 42.005(1).

Dated this 30th day of December, 2021.

/s/ Brittany M. Llewellyn

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CERTIFICATE OF SERVICE

I hereby certify that on the December 30, 2021, service of the above and foregoing **DEFENDANTS' MOTION TO APPLY THE STATUTORY CAP ON PUNITIVE DAMAGES** was made upon each of the parties via electronic service through the Eighth Judicial District Court's Odyssey E-file and Serve system.

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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.

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

APPENDIX OF EXHIBITS TO DEFENDANTS' MOTION TO APPLY THE STATUTORY CAP ON PUNITIVE DAMAGES

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; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

Defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services, Inc. ("UHS"), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Co., Inc. ("SHL"), and Health Plan of Nevada, Inc. ("HPN") (collectively, "Defendants"), by and through their attorneys of record, WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC and O'MELVENY & MYERS LLP, hereby submit this Appendix of Exhibit to Defendants' Motion to Apply the Statutory Cap on Punitive Damages.

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1.	Plaintiffs' Motion to Remand
2.	Plaintiffs' Federal Court Opposition to Defendants' Motion to Dismiss
3.	Defendants' Notice of Removal
4.	Defendants' Opposition to Plaintiffs' Motion to Remand
5.	Plaintiffs' Federal Court Amended Complaint
6.	2/20/2020 Order Granting Remand
7.	Plaintiffs' Amended Motion to Remand

Dated this 30th day of December, 2021.

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CERTIFICATE OF SERVICE

I hereby certify that on the 30th day of December, 2021, a true and correct copy of the foregoing **APPENDIX OF EXHIBITS TO DEFENDANTS' MOTION TO APPLY THE STATUTORY CAP ON PUNITIVE DAMAGES** was electronically filed/served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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EXHIBIT 1

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EXHIBIT 1

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

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

Plaintiff Fremont Emergency Services (Mandavia), Ltd. ("Fremont"), by and through its counsel of record, McDonald Carano LLP, hereby moves this Court to remand this action to the Eighth Judicial District Court for Clark County, Nevada. In addition, pursuant to 28 U.S.C. § 1447(c), Fremont also asks that the Court award it its reasonable attorneys' fees and costs incurred in filing this Motion.

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This Motion is based upon the record in this matter, the points and authorities that follow, the Declaration of Kristen T. Gallagher (the "Gallagher Decl."), the exhibits attached thereto, and any argument of counsel entertained by the Court.

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Plaintiff Fremont Emergency Services (Mandavia), Ltd. ("Fremont") has asserted claims against defendants United HealthCare Insurance Company ("UHCIC"), United HealthCare Services, Inc. dba UnitedHealthcare ("UHC Services"), UMR, Inc. dba United Medical Resources ("UMR"), Oxford Health Plans, Inc. ("Oxford" and with UHCIC, UHC Services and UMR, the "UH Parties"), Sierra Health and Life Insurance Company, Inc. ("Sierra"), Sierra Health-Care Options, Inc. ("Sierra Options") and Health Plan of Nevada, Inc. ("HPN" and, collectively with the UH Parties, "United HealthCare") based entirely on United HealthCare's statutory and common law duties. Nothing in Fremont's complaint concerns United HealthCare's obligations under any employee benefit plan that it provides to its members. Pertinent to this Motion, United HealthCare has paid all of the claims at issue in the litigation, making the question of coverage under the respective plans a nonissue. The ***only*** issue here is the amount of payment that was tendered to Fremont and whether that rate of payment is adequate under Nevada statutes and common law. As is detailed below, 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. United HealthCare is well-aware of the governing authority on this issue, especially given that it has filed similar notices of removal in Florida and Oklahoma and motions to remand citing this authority have also been filed in those actions. Further, not only is United HealthCare aware of this authority, United HealthCare has suffered the brunt of this authority in Florida where a case it removed there was remanded to state court based on these very same arguments. Thus, as is detailed below, Fremont's Motion to Remand should be granted and, given the frivolous nature of United HealthCare's arguments

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regarding removal in light of binding precedent and its failure to prevail on these arguments in other jurisdictions, attorneys' fees and costs should be awarded in Fremont's favor.

II. STATEMENT OF FACTS

Fremont is a professional practice group of emergency medicine physicians and healthcare providers that provides emergency medicine services to patients presenting to the emergency departments at eight hospitals and other facilities in Clark County, Nevada staffed by Fremont. *See* Notice of Removal, Ex. 1 (ECF No. 1) (hereinafter "Compl.") at ¶ 14. Fremont and the hospitals whose emergency departments it staffs are obligated by both federal and Nevada law to examine any individual visiting the emergency department and to provide stabilizing treatment to any such individual with an emergency medical condition, regardless of the individual's insurance coverage or ability to pay. *Id.* at ¶ 15; *see also* Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd; NRS 439B.410. Fremont fulfills this obligation for the hospitals which its staffs. Compl. at ¶ 15. In this role, Fremont's physicians provide emergency medicine services to all patients, regardless of insurance coverage or ability to pay, including to patients with insurance coverage issued, administered and/or underwritten by United HealthCare. *Id.*

United HealthCare is responsible for administering and/or paying for certain emergency medical services provided by Fremont which are at issue in the litigation. *Id.* at ¶¶ 3-9. United HealthCare provides, either directly or through arrangements with providers such as hospitals and Fremont, healthcare benefits to its members. *Id.* at ¶ 16. There is no written agreement between United HealthCare and Fremont for the healthcare claims at issue in this litigation; Fremont is therefore designated as "non-participating" or "out-of-network" for all of the claims at issue in this litigation. *Id.* at ¶ 17. Notwithstanding the lack of a written agreement, an implied-in-fact agreement exists between the parties. *Id.*

Despite not participating in United HealthCare's "provider network" for the period in dispute, Fremont has continued to provide emergency medicine treatment, as required by law, to patients covered by United HealthCare's plans (the "Members") who seek care at the emergency departments where they provide coverage. *Id.* at ¶ 22. In emergency situations, patients are likely

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to go to the nearest hospital for care, particularly if they are transported by ambulance. *Id*. at ¶ 23. Patients facing an emergency situation are unlikely to have the luxury of determining which hospitals and physicians are in-network under their health plan. *Id*. United HealthCare is obligated to reimburse Fremont at the usual and customary rate for emergency services Fremont provided to its Patients, or alternatively for the reasonable value of the services provided. *Id*.

From July 1, 2017 through the present, Fremont has provided emergency medicine services to United HealthCare's members; however, commencing July 1, 2017, the UH Parties arbitrarily began drastically reducing the rates at which they paid Fremont for emergency services for some claims, but not others. *Id*. at ¶¶ 19-20. The UH Parties paid some of the claims for emergency services rendered by Fremont at far below the usual and customary rates, yet paid other substantially identical claims submitted by Fremont at higher rates. *Id*. at ¶ 20.

Relevant to this Motion, for each of the healthcare claims at issue in this litigation, **United HealthCare has already determined that each claim is payable**; however, it paid the claim at an artificially reduced rate. *Id*. at ¶ 27. Thus, the claims at issue involve no questions of whether the claim should be covered under a health plan or whether it is payable; rather, the questions at issue in this case involve only a determination of whether United HealthCare paid the claim at the required usual and customary rate or, alternatively, for the reasonable value of services rendered.

On April 15, 2019, Fremont filed its complaint against United HealthCare for breach of implied in fact contract, tortious breach of the implied covenant of good faith and fair dealing, alternative claim for unjust enrichment, violation of NRS 686A.020 and 686A.310, violations of Nevada Prompt Pay statutes and regulations, Consumer Fraud & Deceptive Trade Practices Acts and for declaratory judgment. *See* Complaint, Notice of Removal (ECF No. 1) at Exhibit 1. On May 14, 2019, United HealthCare filed its Notice of Removal with this Court, contending that the state law claims asserted are completely preempted by ERISA because the subject claims relate to an employee benefit plan. (ECF No. 1). As detailed herein, the claims arise not from an employee benefit plan, but United HealthCare's statutory and common law duty to pay for its Members' emergency services at usual and customary rates or, alternatively, for the reasonable value of services rendered. Binding precedent in the Ninth Circuit makes clear that cases, such as

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this, which concern the rate of payment only, do not relate to employee benefit plans, are not preempted by ERISA and, therefore, do no give rise to federal question jurisdiction. Although United HealthCare has made and lost these same arguments before another federal court, it again pursues this frivolous[1] removal for, what appears to be, no other purpose than to delay and unnecessarily expand these proceedings. Because ERISA does not preempt the claims at issue, there is no basis for federal question jurisdiction and the case should be remanded back to state court.

II. ARGUMENT

A. Legal Standard

A motion to remand for lack of subject matter jurisdiction may be filed at any time. 28 U.S.C. § 1447(c) (requiring remand for lack of subject matter jurisdiction "at any time before judgment"). There is a "strong presumption against removal and federal jurisdiction must be rejected if there is any doubt as to the right of removal in the first instance." *Kern v. State Farm Mut. Auto. Ins. Co.*, 2014 WL 6983241 at *2 (D. Nev. 2014). The defendant "always has the

[1] The frivolous nature of United HealthCare's removal of this action is underscored by correspondence between the parties wherein counsel for Fremont made it clear that Fremont only alleged claims concerning the rate of payment, which, as is detailed below, are clearly not subject to ERISA's preemption. Specifically, on May 7, 2019, counsel for United HealthCare contacted Fremont's counsel requesting a list of all of the patient names of which there were disputed claims, clearly indicating that United HealthCare intended to remove the action and was seeking to identify claims which they believed would give rise to preemption. Gallagher Decl. at ¶ 3. In response, counsel for Fremont made clear that ERISA does not apply by highlighting, "the claims at issue concern a dispute over the amount paid, not whether the claim was payable because defendants already determined the subject claims were payable. As a result, there is no basis to remove the action to federal court under federal question jurisdiction." *Id*.

In addition, UHCIC and its affiliates have already tried and failed to obtain federal question jurisdiction based upon the same arguments forwarded in its Notice of Removal here, i.e. that ERISA completely preempts state law claims. *See e.g. Gulf-To-Bay Anesthesiology Associates, LLC v. UnitedHealthcare of Florida, Inc.*, No. 8:18-cv-00233-EAK-AAS (M.D. Fla.); *Low-T Physicians Service, P.L.L.C. v. United HealthCare of Texas, Inc., et al.*, No. 4:18-cv-00938-A (N.D. Tex.). In Florida, the federal court granted a motion to remand, finding that ERISA does not apply to claims involving rate of payment. *Gulf-to-Bay Anesthesiology Associates, LLC*, 2018 WL 3640405, at *3 (M.D. Fla. July 20, 2018) ("The Court finds unavailing UHIC's attempt to recast through an ERISA lens GTB's entitlement to full payment."). Similarly, a Texas federal court remanded for the same reason. *Low-T Physicians Serv., P.L.L.C.*, 2019 WL 935800, at *2 (N.D. Tex. Feb. 26, 2019) ("the question here is not as to the right to ERISA benefits under a particular plan but on the amount of payment due under certain provider agreements. Such claims are not preempted by ERISA."). Accordingly, United HealthCare's actions, here, are clearly frivolous given its knowledge of the inapplicability of ERISA to rate of payment claims.

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burden of establishing that removal is proper," and it cannot do so with "[c]onclusory allegations." *Id.* Generally, when there is no diversity jurisdiction, "a case will not be removable if the complaint does not affirmatively allege a federal claim."[2] *Beneficial Nat'l Bank v. Anderson*, 539 U.S. 1, 6 (2003). Furthermore, a defendant cannot, "merely by injecting a federal question into an action that asserts what is plainly a state-law claim, transform the action into one arising under federal law, thereby selecting the forum in which the claim shall be litigated." *Caterpillar, Inc. v. Williams*, 482 U.S. 386, 399 (1987).

Finally, upon a proper motion to remand for lack of subject matter jurisdiction, the Court may enter an order remanding the case and "may require payment of just costs and any actual expenses, including attorney fees, incurred as a result of removal." 28 U.S.C. § 1447(c). This Court has recognized it should grant fees and costs where there is not an objectively reasonable basis for removal, "with reasonableness analogized to whether 'the relevant case law clearly foreclosed the defendant's basis of removal.'" *J.M. Woodworth Risk Retention Grp., Inc. v. Uni-Ter Underwriting Mgmt. Corp.*, No. 13-cv-0911-JAD-PAL, 2014 WL 6065820, at *1 (D. Nev. Nov. 12, 2014) *quoting Lussier v. Dollar Tree Stores, Inc.,* 518 F.3d 1062, 1066 (9th Cir.2006).

B. Claims Involving *Rates* of Payment Are Not Preempted By ERISA

"[R]emoval on ERISA grounds is only appropriate if ERISA completely preempts a state law claim."[3] *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)). In determining whether a claim for payment falls within the purview of ERISA's civil enforcement provision, the Ninth Circuit distinguishes between claims that implicate the *right* of payment, which are preempted by ERISA, and claims

[2] Under the well-pleaded complaint rule, federal question jurisdiction exists only when a plaintiff pleads a cause of action that arises under federal law. *Edwards v. BQ Resorts, LLC*, No. 2:16-cv-01649-JAD-VCF, 2016 WL 6905378, at *1 (D. Nev. Nov. 23, 2016).

[3] Ordinarily, federal preemption is merely a defense to the merits of a claim and does not provide federal question jurisdiction or a basis to remove an action to federal court. *Caterpillar Inc. v. Williams*, 482 U.S. 386, 392 (1987). Complete preemption, if it exists, is a "narrow exception" to the well-pleaded complaint rule that "converts" state-law claims into federal law ones, and thereby allows removal to federal court. *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 209 (2004).

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that implicate the *rate* of payment, which are not preempted. *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-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."). Federal courts in other states likewise have determined that ERISA does not completely preempt claims based on statutory or other common law rate-payment obligations. *E.g., 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.*, 579 F.3d at 530 ("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.").

As the Complaint makes clear,[4] Fremont's claims in this action concern the *rate* of payment rather than the right to payment; thus, ERISA preemption does not apply. In its

[4] In its Notice of Removal, United HealthCare contends that approximately 90% of Fremont's medical claims were made against employee welfare benefit plans governed by ERISA. This is a red herring. Regardless of whether this is true, it does not impact the analysis of whether Fremont's claims are preempted by ERISA. Even if 100% of the claims were claims that were covered under ERISA plans, it does not change the issue in this litigation – which is not whether the claims are covered by the ERISA plans, but, rather, whether the rate of payment was appropriate. As is detailed in case after case, in various jurisdictions, including the Ninth Circuit,

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Complaint, Fremont specifically asserted that it is only pursuing claims which have already been paid by United HealthCare to make clear that ERISA has no application to the case at hand. Compl. at ¶ 27 ("For each of the healthcare claims at issue in this litigation, United HealthCare determined the claim was payable; however, it paid the claim at an artificially reduced rate. Thus, the claims at issue involve no questions of whether the claim is payable; rather, they involve only a determination of whether United HealthCare paid the claim at the required usual and customary rate, which it did not."). As such, there can be no question that the claims at issue – which center around the rate of payment tendered to Fremont – are not preempted by ERISA and, consequently, this Court lacks subject matter jurisdiction over this case.

The cases cited by United HealthCare in its Notice of Removal (ECF No. 1) are inapposite. Indeed, in *Tingey v. Pixley-Richards W., Inc*., the plaintiff was an *employee* bringing suit for claims concerning the employer's and insurer's termination of health insurance coverage, squarely within the scope of ERISA because the claims related to an employee welfare benefit plan. *Tingey v. Pixley-Richards W., Inc*., 953 F.2d 1124, 1133 (9th Cir. 1992). Similarly, in *Misic v. Bldg. Serb. Employees Health & Welfare Tr*., the insurer was being sued for failure to cover a claim based on the amount that was expressly required to be paid under the health plan when the beneficiary's rights were assigned to the medical provider. *Misic v. Bldg. Serv. Employees Health & Welfare Tr*., 789 F.2d 1374, 1376 (9th Cir. 1986). Here, the health plan at issue has nothing to do with the claims that are being asserted. The health plans do not govern the amount of payment to be made to the provider and the claims that are being asserted do not relate to the plan.

In *Gables*, while the Court did note that substance of a complaint prevails over form, the Eleventh Circuit noted that the state law claims that were asserted by the provider concerned an alleged wrongful denial of *coverage* under the health care plan. *Gables Ins. Recovery, Inc. v. Blue Cross & Blue Shield of Fla., Inc*., 813 F.3d 1333, 1338 (11th Cir. 2015). Here, on the other hand, there is no dispute concerning coverage. United HealthCare approved the claims at issue for

claims involving the rate of payment tendered to a provider are not preempted by ERISA when coverage under a health plan has already been determined.

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payment. The only dispute is whether United HealthCare paid a sufficient rate for such claims which is governed by statute and common law.

Finally, in *Cleghorn*, an employee bringing claims against the insurer asserted claims which arose directly from the health plan. *Cleghorn v. Blue Shield of California*, 408 F.3d 1222, 1223–24 (9th Cir. 2005). Cleghorn brought state law claims based on his health plan's denial of coverage for medical services he received. *Id*. Specifically, the plan provided that emergency services would only be covered if the condition of the patient met certain criteria or treatment was approved by the primary care physician or health plan. *Id*. at 1224. Coverage was denied when Cleghorn did not meet either of those conditions, as set forth in the health plan. *Id*. Here, again, there is no dispute that all of the claims at issue in this litigation were deemed payable by the various health plans and such claims were, indeed, paid. The only dispute is the amount of payment that was received. Accordingly, *Cleghorn* is also inapplicable to the facts at issue here.

Based on applicable statutes and common law, the amount Fremont received from United HealthCare for the services provided to its Members is inadequate and, therefore, such underpayment gives rise to the claims for relief asserted by Fremont. The cases identified by United HealthCare in its Notice of Removal have no effect on the analysis here because they do not relate to disputes concerning rate of payment between a provider and an insurer. Because the Ninth Circuit and numerous other jurisdictions have determined that disputes involving rates of payment are not subject to ERISA, this Court should reject United HealthCare's argument and grant Fremont's Motion to allow this matter to be adjudicated in state court.

C. Under *Davila*, United HealthCare Cannot Remove this Action on the Basis of ERISA Preemption

ERISA, the federal law governing employee benefits, completely preempts state law only to the extent that the state law "duplicates, supplements, or supplants the ERISA civil enforcement remedy." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004). Importantly, complete preemption under ERISA does not extend to state laws and state-law causes of action that "attempt to remedy any violation of a legal duty independent of ERISA"—that is, state law causes of action that are distinct and independent from the terms of an employee health benefit plan. *Id*. at 214;

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see also Lone Star OB/GYN Assocs. v. Aetna Health Inc., 579 F.3d 525, 529-530 (5th Cir. 2009). In other words, when a claim implicates an independent legal duty, unrelated to ERISA or the terms of an ERISA plan, it does not overlap with the ERISA enforcement scheme and is therefore not preempted. *Lone Star OB/GYN Assocs.*, 579 F.3d at 529-30. As the party removing the case, United HealthCare bears the burden of establishing complete preemption under ERISA. To satisfy this burden, United HealthCare must establish that (1) Fremont could have brought its claims directly under ERISA, and (2) Fremont's state law causes of action are not predicated on a legal duty that is independent of ERISA. *See Davila*, 542 U.S. at 210. As neither prong is satisfied, remand of this case is appropriate for this additional reason.[5]

1. Fremont could not have asserted its claims under ERISA

Applying the two-part *Davila* test, the Eleventh Circuit has held that when in-network providers challenge only the rate of payment, not the right to payment, neither *Davila* requirement is satisfied. *Connecticut State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1347–50 (11th Cir. 2009). The first *Davila* requirement cannot be satisfied because the duty under the agreement is not one owed to a plan beneficiary or participant; it is owed only to the provider. *See id.* at 1348 ("patients are not parties to the provider agreements"). The claim cannot be asserted under ERISA's civil enforcement provision because that provision is available only to vindicate rights owed to participants and beneficiaries. *See id.* at 1348 (reimbursement-rate claims are "not claims for benefits that could be asserted by the patients-assignors").

Here, Fremont could not have asserted its claims against United HealthCare under ERISA because its dispute with United HealthCare does not involve an employee benefit plan, just as was the case in *Connecticut State Dental*. Fremont does not bring suit under ERISA or the ERISA plans at issue, nor is it a participant or beneficiary of those plans authorized to independently bring suit under ERISA. *See* 29 U.S.C. § 1132(a)(1)(B) (authorizing a "participant or beneficiary" to

[5] In rate of payment cases, courts considering motions to remand often do not consider *Davila* in detail because, as a threshold matter, rate of payment cases are not preempted by ERISA. However, because *Davila* is the guiding case on ERISA preemption, Fremont will endeavor to perform an analysis under *Davila*; although the mere fact that this case involves rate of payment should be dispositive in determining that the case is not preempted by ERISA.

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bring a civil action to recover benefits due under a plan). Further, Fremont does not sue derivatively to enforce an ERISA plan beneficiary's claim for benefits.[6] Instead, Fremont asserted its claims to enforce its independent rights, under Nevada law, for timely payment at the usual and customary rate or reasonable value of services for emergency care provided to United HealthCare's insureds. This right is not derivative of or dependent upon the terms of any particular patient's benefit plan in any way -- the terms of the patients' benefit plans are irrelevant to Fremont's claims. In fact, for each of the claims asserted by Fremont, there is no need to consider the existence of the health plan, at all. Rather, the question of liability turns on whether the rate of payment tendered to Fremont was usual and customary and/or a reasonable value for the services rendered. Thus, Fremont could not have asserted its claims against United HealthCare under ERISA because there is no right arising under a health benefit plan which is implicated in this case.

2. Fremont's claims arise from an independent legal duty from ERISA

The Ninth Circuit, along with federal courts in numerous other jurisdictions have found that claims like those asserted by Fremont concern independent legal duties that do not implicate ERISA's civil enforcement scheme. *See, e.g., Marin Gen. Hosp. v. Modesto & Empire Traction Co.,* 581 F.3d 941 (9th Cir. 2009); *California Spine & Neurosurgery Inst.*, 2019 WL 1974901, at

[6] Whether or not an assignment of benefits exists does not change this analysis because Fremont is not asserting any claims as assignee of benefits under an ERISA plan. Indeed, in the Ninth Circuit in *Marin Gen. Hosp. v. Modesto & Empire Traction Co*. the Court dealt with this exact issue and determined it was of no consequence:

> the patient assigned to the Hospital any claim he had under his ERISA plan. Pursuant to that assignment, the Hospital was paid the money owed to the patient under the ERISA plan. The Hospital now seeks more money based upon a different obligation. The obligation to pay this additional money does not stem from the ERISA plan, and the Hospital is therefore not suing as the assignee of an ERISA plan participant or beneficiary under § 502(a)(1)(B). Rather, the asserted obligation to make the additional payment stems from the alleged oral contract between the Hospital and MBAMD. As in *Blue Cross*, the Hospital is not suing defendants based on any assignment from the patient of his rights under his ERISA plan pursuant to § 502(a)(1)(B); rather, it is suing in its own right pursuant to an independent obligation.

581 F.3d 941, 948 (9th Cir. 2009).

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*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.") (citing *Catholic Healthcare West-Bay Area v. Seafarers Health & Benefits Plan*, 321 Fed. App'x 563, 564 (9th Cir. 2008)); *Emergency Servs. of Zephyrhills, P.A. v. Coventry Health Care of Fla., Inc.*, 281 F. Supp. 3d 1338, 1345–46 (S.D. Fla. Apr. 5, 2017) (remanding out-of-network provider's claim under particular Florida statute); *Lone Star*, 579 F.3d at 532 ("[I]n seeking remedies under the Texas Pay Prompt Act, Lone Star is not seeking relief that 'duplicates, supplements or supplants' that provided by ERISA.").

In *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, Marin General Hospital filed suit against Modesto (a patient's insurer) based on allegations that Modesto promised to pay 90% of medical expenses incurred by the patient, but instead paid only 26% of such medical expenses. 581 F.3d 941, 943 (9th Cir. 2009). Marin asserted claims of breach of an implied contract, breach of an oral contract, negligent misrepresentation, quantum meruit, and estoppel. *Id.* at 944. In analyzing the *Davila* case and deciding that the hospital's claims were not preempted by ERISA, the Ninth Circuit explained:

> The question under the second prong of *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 independent legal dut[ies]" within the meaning of *Davila*.

Id. at 950 (emphasis added). The Eleventh Circuit, in *Connecticut State Dental*, also highlighted that in rate of payment cases, the second *Davila* factor is not satisfied, because the provider-plan agreement[7] creates a "separate duty independent of ERISA." *Id.* at 1349 (citation omitted). That

[7] Although contracts between the plan and provider furnished the duty to the providers in *Connecticut State Dental*, "[n]o 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." *Hialeah Anesthesia Specialists, LLC v. Coventry Health Care of Fla., Inc.*, 258 F. Supp. 3d 1323, 1329 (S.D. Fla. 2017) (remanding a provider's similar out-of-network rate-based Florida statutory and common claims for underpayment); *see also Emergency Servs. of Zephyrhills, P.A. v. Coventry Health Care of Fla., Inc.*, 281 F. Supp. 3d 1339, 1342-46 (S.D. Fla. 2017) (remanding claims for implied-in-fact contract and unjust enrichment); *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) (remanding claims for unjust enrichment and quantum meruit).

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is true even if the court must "refer to the plan in order to determine the correct payment rate." *Id*. at 1349-50 (citation omitted). Thus, so long as the complaint's allegations challenge only the rate of payment for claims the plan paid, rather than contending that the plan should have paid something when it paid nothing, ERISA complete preemption does not apply. *Id*. at 1350-51.

Fremont's claims arise from duties that are completely independent of ERISA—namely, United HealthCare's duty under Nevada statutes and common law to reimburse out-of-network providers for emergency care at the usual and customary rate or the reasonable value of services provided. Just as was the case in *Marin*, the statutory and common law based claims[8] which are asserted in the complaint are entirely independent of ERISA because such claims would exist whether or not an ERISA plan existed. In fact, many of the underpaid claims at issue arise out of non-ERISA plans. The fact that the claims asserted in the complaint make no distinction between ERISA and non-ERISA plans further underscores that these claims are completely unaffected by the existence of an ERISA plan. Because Fremont brings claims that are independent of any duty under ERISA, ERISA preemption does not apply, and this Court lacks federal question subject matter jurisdiction over this action. Accordingly, the Court should grant Fremont's Motion to Remand.

D. Fremont is Entitled to Recover Its Attorney's Fees and Costs Incurred in Filing this Motion Because of United's Improper Removal

Should the Court grant this Motion, Fremont may recover its attorneys' fees and costs from United HealthCare's improper removal. 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*, 2014 WL 6065820 at *1.

Here, United HealthCare did not have an objectively reasonable basis for removal. Clear case law, of which United HealthCare was apprised (given its affiliates' pending actions in Florida and Oklahoma which were filed before United HealthCare filed its Notice of Removal)

[8] The claims asserted are breach of implied in fact contract, tortious breach of the implied covenant of good faith and fair dealing, alternative claim for unjust enrichment, violation of NRS 686A.020 and 686A.310, violations of Nevada Prompt Pay statutes and regulations, Consumer Fraud & Deceptive Trade Practices Acts and for declaratory judgment.

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demonstrated that removal was improper because ERISA does not preempt disputes concerning rates of payment. Thus, despite the well-established legal standards prohibiting removal for rate payment cases, United HealthCare chose to disregard Ninth Circuit precedent and remove this action. This is exactly the type of misconduct envisioned by 28 U.S.C. § 1447(c) when it was enacted to allow for the recovery of fees and costs upon the improper removal of a case. Accordingly, Fremont is entitled to recover its attorneys' fees and costs incurred in filing the Motion. Based on clear case law, United HealthCare did not have an objectively reasonable basis for removal yet chose to proceed in this manner ignoring binding precedent on this issue.

III. CONCLUSION

Fremont respectfully requests that the Court remand the matter back to the Eighth Judicial District Court, Clark County, Nevada. United HealthCare's Notice of Removal does not satisfy its burden upon removal to plead federal question jurisdiction. Additionally, Fremont further requests that the Court, pursuant to 28 U.S.C. § 1447(c), award it its attorneys' fees and costs incurred in filing this Motion.

DATED this 24th day of May, 2019.

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 May, 2019, I caused a true and correct copy of the foregoing **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.
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Attorneys for Defendants UnitedHealthcare Insurance Company, United HealthCare Services, Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health and Life Insurance Co., Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc.

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

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INDEX OF EXHIBITS

Description	Exhibit No.
Declaration of Kristen T. Gallagher, Esq.	
Email chain dated May 9, 2019	1

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Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

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

I, KRISTEN T. GALLAGHER, declare as follows:

1. I am an attorney licensed to practice law in the State of Nevada and am a partner in the law firm of McDonald Carano LLP, counsel for Fremont.

2. This declaration is submitted in support of Fremont Emergency Services (Mandavia), Ltd.'s Motion to Remand and is made of my own personal knowledge, unless otherwise indicated. I am over 18 years of age, and I am competent to testify as to same.

3. On May 7, 2019, counsel for United HealthCare[1] contacted Pat Lundvall, Amanda Perach and me and requested "the Patients' names, dates of birth and/or a social security numbers so we can determine whether these are United's insureds/participants and which benefit plans are involved?" In response, I stated, among other things, that "the claims at issue concern a dispute over the amount paid, not whether the claim was payable because defendants already determined the subject claims were payable. As a result, there is no basis to remove the action to federal court under federal question jurisdiction." *See* **Exhibit 1**.

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

Executed: May 24, 2019. /s/ *Kristen T. Gallagher*

Kristen T. Gallagher

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[1] Terms not otherwise defined herein shall have the meanings ascribed to them in the Motion to Remand.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 24th day of May 2019, I caused a true and correct copy of the foregoing **DECLARATION OF KRISTEN T. GALLAGHER IN SUPPORT OF 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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Attorneys for Defendants UnitedHealthcare Insurance Company, United HealthCare Services, Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health and Life Insurance Co., Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc.

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

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EXHIBIT 1

Email chain dated May 9, 2019

Kristen T. Gallagher

From: Kristen T. Gallagher
Sent: Thursday, May 9, 2019 5:39 PM
To: 'Balkenbush, Colby'; Pat Lundvall; Amanda Perach
Cc: Roberts, Lee; Bowman, Cindy S.
Subject: RE: Fremont Emergency Services v. United Healthcare Insurance, et. al.

Thank you for your message.

As you likely noted from review of the Complaint, Fremont Emergency Services does not assert any causes of action with respect to defendants' insureds/participants whose health insurance was issued under Medicare Part C (Medicare Advantage) or is provided under the Federal Employee Health Benefits Act (FEHBA), nor does it assert any claims relating to defendants' managed Medicaid business. Additionally, the claims at issue concern a dispute over the amount paid, not whether the claim was payable because defendants already determined the subject claims were payable. As a result, there is no basis to remove the action to federal court under federal question jurisdiction. Once defendants have filed a response to the Complaint, we can discuss next steps.

Regards,

Kristen T. Gallagher | Partner

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From: Balkenbush, Colby <CBalkenbush@wwhgd.com>
Sent: Tuesday, May 7, 2019 12:02 PM
To: Pat Lundvall <plundvall@mcdonaldcarano.com>; Kristen T. Gallagher <kgallagher@mcdonaldcarano.com>; Amanda Perach <aperach@mcdonaldcarano.com>
Cc: Roberts, Lee <LRoberts@wwhgd.com>; Bowman, Cindy S. <CBowman@wwhgd.com>
Subject: Fremont Emergency Services v. United Healthcare Insurance, et. al.

Pat, Kristen, Amanda,

Lee and I represent the defendants in the attached complaint and are preparing a response. The Complaint alleges that Fremont provided treatment to more than 10,800 Patients who were members of United HealthCare's Health Plans. *See* Complaint at ¶ 25. Would you be willing to provide the Patients' names, dates of birth and/or a social security numbers so we can determine whether these are United's insureds/participants and which benefit plans are involved? We understand that Fremont has no obligation to provide this information at this stage but it certainly would be among one of the first things we would seek when discovery begins.

Best,

Colby

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EXHIBIT 2

EXHIBIT 2

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Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

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

Plaintiff Fremont Emergency Services (Mandavia), Ltd. ("Fremont") responds to the Motion to Dismiss (ECF No. 4) (the "Motion") filed by defendants United Healthcare Insurance Company ("UHCIC") and its affiliates United Health Care Services Inc. dba UnitedHealthcare ("UHC Services"); UMR, Inc. dba United Medical Resources ("UMR"); Oxford Benefit Management, Inc. ("Oxford" together with UHC Services and UMR, the "UHC Affiliates" and with UHCIC, the "UH Parties"); Sierra Health and Life Insurance Company, Inc. ("Sierra

Health"); Sierra Health-Care Options, Inc. ("Sierra Options" and together with Sierra Health, the "Sierra Affiliates"); Health Plan of Nevada, Inc. ("HPN") (collectively "United HealthCare")

This Opposition is based upon the record in this matter, the points and authorities that follow, the pleadings and papers on file in this action, and any argument of counsel entertained by the Court.

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION.

United HealthCare removed this action on the flawed premise that the claims asserted by Fremont are subject to complete preemption under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). 29 U.S.C. § 1132(a)(1)(B). Now, United HealthCare presses forward on these same meritless arguments in its Motion to Dismiss. As Fremont set forth in its Motion to Remand, binding Ninth Circuit precedent makes clear that disputes concerning **rates of payment** -- which is the exact dispute at issue here -- do not fall within ERISA's scope and are not subject to complete preemption. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.,* 581 F.3d 941 (9th Cir. 2009); *see also California Spine & Neurosurgery Inst.*, 2019 WL 1974901, at *3 ("Under Ninth Circuit law, ERISA does not preempt claims by a third party [medical provider] who sues an ERISA plan not as an assignee of a purported ERISA beneficiary, but as an independent entity claiming damages."). Against this clear legal authority, United HealthCare tries to redraft Fremont's Complaint to suggest Fremont's claims are somehow subject to ERISA. United HealthCare goes so far as to argue that Fremont asserts claims as an assignee of benefits from insureds. That is a false statement. The face of the Complaint makes it clear that Fremont sues as an independent entity claiming damages arising from United HealthCare's statutory and common law duties to pay claims at a usual and customary rate and in a reasonable amount, which it has not done. *See* Motion to Remand (ECF No. 5) at n. 6. Since Fremont's claims are not predicated upon an assertion as an assignee of benefits, there is no basis for complete preemption or conflict preemption.

As is detailed below, the facts drawn from the Complaint giving rise to each of the claims for relief alleged do not implicate ERISA – even if *all* of the claims were initially paid under

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ERISA plans. This is because such claims were indeed paid; thus, there is no remaining question as to whether the claims were covered under an ERISA plan. Rather, the question raised in Fremont's Complaint concerns the *rate* of each payment. This does not require any consultation with any ERISA plan, making the doctrines of complete and conflict preemption inapplicable here.

Finally, Fremont has adequately alleged each of its claims for relief and, accordingly, there is no basis for dismissal of any of the claims asserted by Fremont. Fremont therefore respectfully requests that the Motion to Dismiss be denied in its entirety.

II. STATEMENT OF RELEVANT FACTS.

Fremont is a professional practice group of emergency medicine physicians and healthcare providers that provides emergency medicine services to patients presenting to the emergency departments at hospitals and other facilities in Nevada staffed by Fremont. *See* Notice of Removal, Ex. 1 (ECF No. 1-1) (hereinafter "Compl.") at ¶ 14. Fremont is obligated by both federal and Nevada law to examine any individual visiting the emergency department and to provide stabilizing treatment to any such individual with an emergency medical condition, regardless of the individual's insurance coverage or ability to pay. *Id.* at ¶ 15; NRS 439B.410. Thus, Fremont's physicians provide emergency medicine services to all patients, regardless of insurance coverage, including to patients with insurance coverage issued, administered and/or underwritten by United HealthCare. Compl. at ¶ 15

United HealthCare is responsible for administering and/or paying for certain emergency medical services provided by Fremont which are at issue in the litigation. *Id.* at ¶¶ 3-9. United HealthCare provides, either directly or through arrangements with providers such as hospitals and Fremont, healthcare benefits to its members. *Id.* at ¶ 16. There is no written agreement between United HealthCare and Fremont for the healthcare claims at issue in this litigation; Fremont is therefore designated as "non-participating" or "out-of-network" for all of the claims at issue. *Id.* at ¶ 17.

Despite not participating in United HealthCare's "provider network" for the period in dispute, Fremont has continued to provide emergency medicine treatment, as required by law, to

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patients covered by United HealthCare's plans (the "Members") who seek care at the emergency departments where they provide coverage. *Id*. at ¶ 22. United HealthCare is obligated to reimburse Fremont at the usual and customary rate for emergency services Fremont provided to United HealthCare's Members, or alternatively for the reasonable value of the services provided. *Id*. Commencing July 1, 2017, the UH Parties arbitrarily began drastically reducing the rates at which they paid Fremont for emergency services for some claims, but not others. *Id*. at ¶¶ 19-20. The UH Parties paid some of the claims for emergency services rendered by Fremont at far below the usual and customary rates, yet paid other substantially identical claims submitted by Fremont at higher rates. *Id*. at ¶ 20.

For each of the healthcare claims at issue in this litigation, United HealthCare has already determined that each claim is payable; however, it paid the claim at an artificially reduced rate. *Id*. at ¶ 27. **Thus, the claims at issue involve no questions of whether the claim should be covered under a health plan or whether it is payable; rather, the questions at issue in this case involve only a determination of whether United HealthCare paid the claim at the required usual and customary rate or, alternatively, for the reasonable value of services rendered**.

On April 15, 2019, Fremont filed its complaint (the "Complaint") against United HealthCare. *See generally* Compl.. On May 14, 2019, United HealthCare filed its Notice of Removal with this Court, contending that the state law claims asserted are completely preempted by ERISA. (ECF No. 1). On May 21, 2019, United HealthCare filed its 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[1], they fail as a matter of law. On May 24, 2019, Fremont filed a Motion to Remand (ECF No. 5) because this case is a rate of payment case, rather than a right to payment case and, therefore, complete ERISA preemption does not apply.

[1] If the claims are not preempted under the doctrine of complete preemption, this Court lacks jurisdiction to decide the Motion for lack of subject matter jurisdiction and, consequently the remaining arguments may be disregarded.

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II. ARGUMENT

A. Standard of Review.

Federal Rule of Civil Procedure 8(a)(2) requires that each claim in a pleading be supported by "a short and plain statement of the claim showing that the pleader is entitled to relief." *See* FRCP 8(a)(2); *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (internal quotation marks omitted); *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 555 (2007). "Although this standard requires that a claim be 'plausible on its face,' it does not require that a complaint contain 'detailed factual allegations.'" *Iqbal*, 556 U.S. at 678 (internal quotation marks omitted). "As the text of Rule 8(a)(2) itself makes clear, even a 'short and plain' statement can state a claim for relief." *See Sheppard v. Evans and Assoc.*, 694 F.3d 1045, 1049 (9th Cir. 2012) (citing FRCP 8(a)(2)) (holding a brief two-and-one-half page amended complaint met Rule 8's requirements). Importantly, Rule 8 ***does not*** require a plaintiff to make detailed factual allegations. *Id*. Fremont's Complaint meets and exceeds the required pleading standards.

B. This Action Is Not Completely Preempted Under ERISA.

ERISA, the federal law governing employee benefits, completely preempts state law only to the extent that the state law "duplicates, supplements, or supplants the ERISA civil enforcement remedy." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004). Complete preemption under ERISA does not extend to state laws and state law causes of action that "attempt to remedy any violation of a legal duty independent of ERISA." *Id*. at 214. That is, state law causes of action that are distinct and independent from the terms of an employee health benefit plan. *Id*.; *see also Lone Star OB/GYN Assocs. v. Aetna Health Inc.,* 579 F.3d 525, 529-530 (5th Cir. 2009). When a claim implicates an independent legal duty, unrelated to ERISA or the terms of an ERISA plan, it does not overlap with the ERISA enforcement scheme and is therefore not preempted. *Lone Star OB/GYN Assocs.,* 579 F.3d at 529-30.

In order to obtain dismissal of Fremont's claims based on complete preemption, United HealthCare must establish that (1) Fremont could have brought its claims directly under ERISA, and (2) Fremont's state law causes of action are not predicated on a legal duty that is independent

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of ERISA. *See Davila*, 542 U.S. at 210. As neither prong is satisfied, dismissal is inappropriate under the complete preemption doctrine.[2]

1. Fremont could not and did not assert its claims under ERISA.

Applying the two-part *Davila* test, the Eleventh Circuit has held that when in-network providers challenge only the rate of payment, not the right to payment, neither *Davila* requirement is satisfied. *Connecticut State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1347–50 (11th Cir. 2009). The first *Davila* requirement cannot be satisfied because the duty under the agreement is not one owed to a plan beneficiary or participant; it is owed only to the provider. *See id.* at 1348 ("patients are not parties to the provider agreements"). The claim cannot be asserted under ERISA's civil enforcement provision because that provision is available only to vindicate rights owed to participants and beneficiaries. *See id.* at 1348 (reimbursement-rate claims are "not claims for benefits that could be asserted by the patients-assignors").

Here, Fremont could not have asserted its claims against United HealthCare under ERISA because its dispute with United HealthCare does not involve an employee benefit plan, just as was the case in *Connecticut State Dental*. Fremont does not bring suit under ERISA or the ERISA plans at issue, nor is it a participant or beneficiary of those plans authorized to independently bring suit under ERISA. *See* 29 U.S.C. § 1132(a)(1)(B) (authorizing a "participant or beneficiary" to bring a civil action to recover benefits due under a plan).

Fremont also does not sue derivatively to enforce an ERISA plan beneficiary's claim for benefits.[3] Instead, Fremont asserted its claims to enforce its independent rights, under Nevada

[2] In rate of payment cases, courts considering motions to dismiss based on complete preemption or motions to remand often do not consider *Davila* in detail because, as a threshold matter, rate of payment cases are not preempted by ERISA. However, because *Davila* is the guiding case on ERISA preemption, Fremont will endeavor to perform an analysis under *Davila*; although the mere fact that this case involves rate of payment should be dispositive in determining that the case is not preempted by ERISA.

[3] Although United HealthCare argues that Fremont brings its claims as an assignee of benefits, nothing in the Complaint asserts this. Fremont now takes this opportunity to expressly reject such a contention. Fremont does not intend to assert claims as the assignee of benefits of United HealthCare Members. In *Marin Gen. Hosp. v. Modesto & Empire Traction Co*. the Ninth Circuit dealt with this exact issue and determined it was of no consequence:
(footnote cont'd.)

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law, for timely payment at the usual and customary rate or reasonable value of services for emergency care provided to United HealthCare's Members. This right is not derivative of or dependent upon the terms of any particular patient's benefit plan in any way -- the terms of the patients' benefit plans are irrelevant to Fremont's claims. The question of liability turns on whether the rate of payment tendered to Fremont was usual and customary and/or a reasonable value for the services rendered. Thus, Fremont could not have asserted its claims against United HealthCare under ERISA because there is no right arising under a health benefit plan which is implicated in this case, and Fremont did not assert such claims.

2. Fremont's claims arise from an independent legal duty apart from ERISA.

The Ninth Circuit, along with federal courts in numerous other jurisdictions have found that claims like those asserted by Fremont concern independent legal duties which do not implicate ERISA's civil enforcement scheme. *See, e.g., Marin Gen. Hosp. v. Modesto & Empire Traction Co.,* 581 F.3d 941 (9th Cir. 2009); *California Spine & Neurosurgery Inst.*, 2019 WL 1974901, at *3 ("Under Ninth Circuit law, ERISA does not preempt claims by a third party [medical provider] who sues an ERISA plan not as an assignee of a purported ERISA beneficiary, but as an independent entity claiming damages.") (citing *Catholic Healthcare West-Bay Area v. Seafarers Health & Benefits Plan*, 321 Fed. App'x 563, 564 (9th Cir. 2008)); *Emergency Servs. of Zephyrhills, P.A. v. Coventry Health Care of Fla., Inc*., 281 F. Supp. 3d 1338, 1345–46 (S.D. Fla. Apr. 5, 2017) (remanding out-of-network provider's claim under particular Florida statute); *Lone*

> the patient assigned to the Hospital any claim he had under his ERISA plan…the Hospital was paid the money owed to the patient under the ERISA plan. The Hospital now seeks more money based upon a different obligation [which]… does not stem from the ERISA plan, and the Hospital is therefore not suing as the assignee of an ERISA plan… the asserted obligation to make the additional payment stems from the alleged oral contract between the Hospital and MBAMD. As in *Blue Cross*, the Hospital is not suing defendants based on any assignment from the patient of his rights under his ERISA plan pursuant to § 502(a)(1)(B); rather, it is suing in its own right pursuant to an independent obligation.

581 F.3d 941, 948 (9th Cir. 2009).

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Star, 579 F.3d at 532 ("[I]n seeking remedies under the Texas Pay Prompt Act, Lone Star is not seeking relief that 'duplicates, supplements or supplants' that provided by ERISA.").

In *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, plaintiff (a hospital) filed suit against defendant (a patient's insurer) based on allegations that defendant promised to pay 90% of medical expenses incurred by the patient, but instead paid only 26% of such medical expenses. 581 F.3d at 943. The plaintiff asserted claims of breach of an implied contract, breach of an oral contract, negligent misrepresentation, quantum meruit, and estoppel. *Id*. at 944. In analyzing the *Davila* case and deciding that the hospital's claims were not preempted by ERISA, the Ninth Circuit[4] explained:

> The question under the second prong of *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 independent legal dut[ies]" within the meaning of *Davila*.

Id. at 950 (emphasis added).

Fremont's claims arise from duties that are completely independent of ERISA—namely, United HealthCare's duty under Nevada statutes and common law to reimburse out-of-network providers for emergency care at the usual and customary rate or the reasonable value of services provided. Just as was the case in *Marin,* the statutory and common law based claims which are asserted in the complaint are entirely independent of ERISA because such claims would exist whether or not an ERISA plan existed. In fact, many of the underpaid claims at issue arise out of non-ERISA plans which United HealthCare expressly admits when it contends that approximately 10% of the claims involve non-ERISA plains. Motion at 3:14-15. The fact that the claims asserted in the complaint make no distinction between ERISA and non-ERISA plans further underscores that these claims are completely unaffected by the existence of an ERISA plan. Because Fremont

[4] The Eleventh Circuit, in *Connecticut State Dental,* also highlighted that in rate of payment cases, the second *Davila* factor is not satisfied, because the provider-plan agreement creates a "separate duty independent of ERISA." *Id*. at 1349 (citation omitted). That is true even if the court must "refer to the plan in order to determine the correct payment rate." *Id*. at 1349-50 (citation omitted). Thus, so long as the complaint's allegations challenge only the rate of payment for claims the plan paid, rather than contending that the plan should have paid something when it paid nothing, ERISA complete preemption does not apply. *Id*. at 1350-51.

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brings claims that are independent of any duty under ERISA, ERISA preemption does not apply. Accordingly, the Court should deny United HealthCare's Motion to Dismiss because Fremont's claims are not subject to complete preemption.

3. Claims Involving *Rates* of Payment Are Not Preempted By ERISA.

In determining whether a claim for payment falls within the purview of ERISA's civil enforcement provision, the Ninth Circuit distinguishes between claims that implicate the *right* of payment, which are preempted by ERISA, and claims that implicate the *rate* of payment, which are not preempted. *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-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.").

Federal courts in other states likewise have determined that ERISA does not completely preempt claims based on statutory or other common law rate-payment obligations. *E.g., 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.*, 579 F.3d at 530 ("A claim that implicates the rate of payment …rather than the right to payment under the terms of the benefit plan … is not preempted by ERISA.").

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As the Complaint makes clear, Fremont's claims in this action concern the *rate* of payment rather than the right to payment; thus, ERISA preemption does not apply. In its Complaint, Fremont specifically asserted that it is only pursuing claims which have already been paid by United HealthCare to make clear that ERISA has no application to the case at hand. Compl. at ¶ 27 ("For each of the healthcare claims at issue in this litigation, United HealthCare determined the claim was payable; however, it paid the claim at an artificially reduced rate. Thus, the claims at issue involve … only a determination of whether United HealthCare paid the claim at the required usual and customary rate, which it did not."). As such, there can be no question that the claims at issue – which center around the *rate* of payment tendered to Fremont – are not preempted by ERISA and, consequently, such claims should not be dismissed based on complete preemption.

The cases cited by United HealthCare in its Motion to Dismiss are inapposite. Indeed, in *Misic v. Bldg. Serb. Employees Health & Welfare Tr.*, the insurer was being sued for failure to cover a claim based on the amount that was expressly required to be paid under the health plan when the beneficiary's rights were assigned to the medical provider. 789 F.2d 1374, 1376 (9th Cir. 1986). Here, Fremont is not bringing any claims as the assignee of benefits under a health plan; indeed, the health plan at issue has nothing to do with the claims that are being asserted and does not govern the amount of payment to be made to Fremont.

In *Gables*, while the court did note that substance of a complaint prevails over form, the Eleventh Circuit noted that the state law claims that were asserted by the provider concerned an alleged wrongful denial of *coverage* under the health plan. *Gables Ins. Recovery, Inc. v. Blue Cross & Blue Shield of Fla., Inc.*, 813 F.3d 1333, 1338 (11th Cir. 2015). Here, on the other hand, there is no dispute concerning coverage. United HealthCare approved the subject claims for payment. The only dispute is whether United HealthCare paid a sufficient rate for such claims which is governed by statute and common law.

Finally, in *Cleghorn*, an employee bringing claims against the insurer asserted claims which arose directly from the health plan. *Cleghorn v. Blue Shield of California*, 408 F.3d 1222, 1223–24 (9th Cir. 2005). Cleghorn brought state law claims based on his health plan's denial of coverage for medical services he received. *Id.* Here, again, there is no dispute that all of the

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claims at issue in this litigation were deemed payable by the various health plans and such claims were, indeed, paid. The only dispute is the amount of payment that was received. Accordingly, *Cleghorn* is also inapplicable to the facts at issue here.

Based on applicable statutes and common law, the amount Fremont received from United HealthCare for the services provided to its Members is inadequate and, therefore, such underpayment gives rise to the claims for relief asserted by Fremont. The cases identified by United HealthCare in its Motion to Dismiss have no effect on the analysis here because they do not relate to disputes concerning rate of payment between a provider and an insurer. United HealthCare was well aware of the authority supporting Fremont's position (given that it has already lost on this issue in Florida and Texas[5]), but chose to completely ignore these directly on point cases in preparing its Motion to Dismiss. Because the Ninth Circuit and numerous other jurisdictions have determined that disputes involving rates of payment are not subject to ERISA, this Court should reject United HealthCare's argument and deny United HealthCare's Motion to Dismiss in its entirety.

C. This Action Is Not Subject to Conflict Preemption.

Conflict preemption may serve as an affirmative defense to a plaintiff's state law cause of action where state law conflicts with, and is overridden by, a federal law. *Morris B. Silver M.D., Inc. v. Int'l Longshore & Warehouse etc.*, 2 Cal. App. 5th 793, 799, 206 Cal. Rptr. 3d 461, 466 (Ct. App. 2016). "Conflict preemption… applies where state-law causes of action 'relate to' to an ERISA benefit plan, in which case the state-law claims are preempted under § 514(a).[6] *Nationwide DME, LLC v. Cigna Health & Life Ins. Co.*, 136 F. Supp. 3d 1079, 1084 (D. Ariz.

[5] In Florida, a federal court considering whether to remand a rate of payment case, in which United HealthCare is a defendant, found that ERISA does not apply to claims involving rate of payment. *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) ("The Court finds unavailing UHIC's attempt to recast through an ERISA lens GTB's entitlement to full payment."). A Texas federal court also reached this conclusion in another United HealthCare case. *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) ("the question here is not as to the right to ERISA benefits under a particular plan but on the amount of payment... Such claims are not preempted by ERISA.").

[6] Conflict preemption is often referred to as "section 514"; however, the relevant provision giving rise to this affirmative defense is 29 U.S.C. § 1144.

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2015); *see also Marin Gen. Hosp.*, 581 F.3d at 946. Because the Ninth Circuit rate of payment cases decided conclude that claims arising from disputes involving rate of payment are not completely preempted, Fremont has been unable to locate any binding authority which considers whether disputes involving rate of payment could "relate to" an employee benefit plan for purposes of conflict preemption. This is because, in those cases, the courts lack jurisdiction to decide such cases and, consequently, conflict preemption never comes into play.

Notwithstanding, several courts have considered whether conflict preemption applies to third party provider claims which do not concern "claims [asserted] by a participant, an assignee of the participant (for example, a medical provider that has stepped into the shoes of the participant) or a beneficiary …[and] held they are not preempted." *Morris B. Silver M.D., Inc. v. Int'l Longshore & Warehouse etc.*, 2 Cal. App. 5th 793, 802, 206 Cal. Rptr. 3d 461, 468 (Ct. App. 2016). In *Morris B. Silver M.D., Inc.*, the California Court cited to a two-part test articulated by the Fifth Circuit and noted that when considering each factor, state law claims raised by a third party provider based on a quasi-contract are not preempted. *Id*. The two-part test cited by *Morris* and recognized by the Ninth Circuit[7] in *Meadows*, considers: "(1) the state law claims address areas of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan; and (2) the claims directly affect the relationship among the traditional ERISA entities—the employer, the plan and its fiduciaries, and the participants and beneficiaries." *Id.,* 2 Cal. App. 5th at 804, 206 Cal. Rptr. 3d at 470; *see also The Meadows v. Employers Health Ins.*, 47 F.3d 1006, 1009 (9th Cir. 1995).

United HealthCare's entire argument concerning conflict preemption relies on the contention that "Fremont's ultimate aim is to obtain a benefits pay-out via the assignments it received from Defendants' members". *See e.g*. Motion at 11:17-18. This argument is based on

[7] Because the *Meadows* decision does not expressly address conflict preemption, it is unclear whether it intended this test to apply to this doctrine; however, in *Morris,* the California court noted these issues and concluded that this test was adopted by the Ninth Circuit for purposes of considering whether conflict preemption applies. *Morris B. Silver M.D., Inc.,* 2 Cal. App. 5th at 804, 206 Cal. Rptr. 3d at 470; *see also Marin Gen. Hosp.*, 581 F.3d at 945 (noting that the Ninth Circuit "may have been partially responsible for the parties' confusion between complete preemption under § 502(a), which provides a basis for federal question removal jurisdiction, and conflict preemption under § 514(a), which does not.")

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an assumption which is inaccurate. In Fremont's Complaint, Fremont does not assert any right to recover benefits owed to United HealthCare's beneficiaries. Fremont makes clear that the language of any benefit plan does not impact whether or not the rate paid by United HealthCare for Fremont's services is adequate under statutory or common law. Furthermore, the benefit plans at issue certainly do not identify a specific rate at which United HealthCare is required to pay out of network emergency service medical providers. Nothing about the benefit plans needs to be considered in order to fully adjudicate each of the claims at issue. The claims all rely on statutory and common law to address whether a certain rate of payment is appropriate – not any one benefit plan. Thus, the claims asserted do not "relate to" any ERISA benefit plans.

Glaringly absent from United HealthCare's Motion to Dismiss is any analysis concerning the rules of conflict preemption. Indeed, there is no mention of the test articulated by the Fifth Circuit, likely because, when applying this test, there can be no question that conflict preemption does not apply. In applying the test expressed by the Fifth Circuit, it is clear that conflict preemption does not apply here. First, the claims asserted by Fremont do not address areas of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan -- they address purely state law issues, *i.e.* whether the rate at which claims were paid to Fremont was adequate under statutory and common law. Nothing about these claims even concern or relate to an ERISA plan nor does an ERISA plan need to be consulted to adjudicate these claims. Second, the claims asserted do not affect the relationship among the employer, the plan and its fiduciaries, and the participants and beneficiaries. This is a dispute between an insurer and a medical provider. Plan participants and beneficiaries have nothing to do with the claims asserted. As such, conflict preemption is clearly inapplicable here because the claims asserted by Fremont do not relate, in any way, to United HealthCare benefit plans.

D. The Complaint Properly States Viable Claims for Relief.

1. Fremont Stated A Cognizable Claim for Breach of Implied In Fact Contract Claim.

Fremont has pled detailed factual allegations about the parties' conduct, understanding, and course of dealing from which a jury could conclude an implied contract arose. A plaintiff

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states a claim for breach of contract, whether express or implied, by alleging: (1) the existence of a valid contract, (2) a breach by the defendant, and (3) damage as a result of the breach. *Saini v. Int'l Game Tech.*, 434 F. Supp. 2d 913, 919-20 (D. Nev. 2006) (*citing Richardson v. Jones*, 1 Nev. 405, 405 (1865)); *Smith v. Recrion Corp.*, 541 P.2d 663, 664 (Nev. 1975) (recognizing the elements of breach of express and implied contract claims are the same). In an implied contract, such intent is inferred from the conduct of the parties and other relevant facts and circumstances. *Warrington v. Empey*, 95 Nev. 136, 138–139 (1979). The terms of an implied contract can also be manifested by conduct or by other customs. *Smith*, 541 P.2d at 668; *Nevada Ass'n Servs., Inc. v. First Am. Title Ins. Co.*, No. 2:11-cv-02015-KD-VCF, 2012 WL 3096706, at *3 (D. Nev. July 30, 2012) (denying motion to dismiss on breach of contract claim because the plaintiff stated "a plausible claim that, through a course of dealing involving hundreds of transactions over several years, Defendants and Plaintiff manifested an intent to be bound and agreed to material terms of an implied contract."). In *Nevada Ass'n Servs., Inc.*, the district court also noted that a motion to dismiss is not the proper place for such a factual evaluation of whether parties entered into an implied contract because "it necessarily requires examination of the facts and circumstance." *Id.*

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

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

Compl. at ¶ 38 (emphasis added). This course of conduct clearly supports the existence of an implied contract, based on an exchange of consideration, and a breach by United HealthCare that has caused damage to Fremont. Moreover, Fremont's allegations that both parties, throughout the course of conduct, understood United HealthCare's legal obligation to pay, only further supports

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the assertion that an implied contract was formed.

United HealthCare also argues that payments for past services cannot constitute a promise by United HealthCare to pay for future services and cites to *Recrion Corp*. to support this proposition. United HealthCare misunderstands the allegations presented by Fremont. Under Nevada law, Fremont is required to provide emergency medical services and, in exchange, United Healthcare is required to pay for such services. *See Williams v. EDCare Mgmt., Inc.*, No. CIV. A. 1:08-CV-278, 2008 WL 4755744, at *5 (E.D. Tex. Oct. 28, 2008) (remanding state law claims that alleged violation of federal regulations as an element of those claims); *see also* Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd; NRS 439B.410. *Recrion Corp*. is distinguishable for this reason. As United HealthCare highlighted, the services provided in *Recrion Corp*. were *unsolicited*. Here, Nevada law mandates that Fremont provide these services to United HealthCare's insureds, a key distinction from *Recrion Corp*. Of course, if Fremont provided these services to United HealthCare's Members without any obligation to do so, this may not form the basis for an implied in fact agreement. However, United HealthCare has always understood that if its Members encounter an emergency situation, Fremont will provide the necessary medical services and, in exchange United HealthCare will be required to pay for such services. An implied in fact contract exists here, and United HealthCare has breached this contract, as expressly alleged in the Complaint. Because Fremont has stated a cognizable claim for breach of implied contract, United HealthCare's Motion to Dismiss must be denied.

2. Fremont Stated A Cognizable Claim for Tortious Breach of Implied Covenant of Good Faith and Fair Dealing.

In Nevada, a plaintiff need only allege three elements to assert a claim for tortious breach of the implied covenant of good faith and fair dealing: (1) an enforceable contract (2) "a special relationship between the tortfeasor and the tort victim…a relationship of trust and special reliance" and (3) the conduct of the tortfeasor must go beyond the bounds of ordinary liability for breach of contract. *Martin v. Sears, Roebuck and Co.*, 111 Nev. 923, 929, 899 P.2d 551, 555 (1995). The special relationship required in *Martin* is characterized by elements of public interest, adhesion, and fiduciary responsibility." *Ins. Co. of the W. v. Gibson Tile Co.,* 122 Nev. 455, 461, 134 P.3d

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698, 702 (2006). Moreover, a tortious breach of the covenant requires that "the party in the superior or entrusted position has engaged in grievous and perfidious misconduct." *Great Am. Ins. Co. v. Gen. Builders, Inc.,* 113 Nev. 346, 355, 934 P.2d 257, 263 (1997) (internal quotes and citations omitted).

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

Moreover, *Aluevich v. Harrah's* does not stand for the proposition that "the Nevada Supreme Court has refused to expand this tort to contracts between sophisticated parties in the commercial realm" as argued by United HealthCare. Motion at 14:10-11. Rather, in *Aluevich v. Harrah's*, the Nevada Supreme Court held that "[t]he relationship between appellant and respondent was that of lessee and lessor. We do not find, in the present case, the special element of reliance which prompted this court in *Peterson* to recognize a cause of action in tort for the breach of an implied covenant of good faith and fair dealing." 99 Nev. 215, 218, 660 P.2d 986, 987 (1983). The *Aluevich* did not make a blanket statement, as United HealthCare implies, that this claim for relief could not apply to sophisticated parties in the commercial realm. In fact, the *Aluevich* court cited to *U.S. Fidelity v. Peterson*, 91 Nev. 617, 540 P.2d 1070 (1975), a case involving insurance agreements, and noted that "an implied covenant of good faith and fair dealing has mainly been implied in contractual relations which involve a special element of reliance such as that found in partnership, **insurance** and franchise **agreements**." *Id.* at 217. While *Peterson* involved a dispute between an insurer and an insured, neither *Peterson* nor *Aluevich* forecloses the possibility that a special element of reliance can exist between Fremont and United HealthCare. The type of relationship at issue here is one that undoubtedly gives rise to a relationship in which Fremont relies on United HealthCare. Fremont performed millions of dollars in services to United HealthCare's Members with the expectation that United HealthCare

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would pay for these services. Because Fremont is obligated to provide these services under Nevada law, United HealthCare sits in a superior position over Fremont, wielding a a disparate level of power over whether Fremont gets paid for its services and therefore, the facts alleged in the Complaint fall squarely within the scope of a claim of tortious breach of implied covenant of good faith and fair dealing.

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

3. Fremont Stated A Cognizable Alternative Claim for Unjust Enrichment.

Nevada law permits recovery for unjust enrichment where a plaintiff provides an indirect benefit to the defendant that defendant accepts without adequate compensation, as United HealthCare 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). Fremont's provision of services to United HealthCare's Members allows United HealthCare to discharge its duties under its contracts with its Members to cover medically necessary emergency healthcare services, thereby creating an indirect benefit to United HealthCare, giving rise to an actionable claim for unjust enrichment under Nevada law. *See Emergency Physicians LLC v. Arkansas Health & Wellness Health Plan, Inc.*, No. 4:17-CV-00492-KGB, 2018 WL 3039517, at *5 (E.D. Ark. Jan. 31, 2018) (finding that because Texas law allows for an indirect benefit to sustain a claim for unjust enrichment, a claim for unjust enrichment based on indirect benefits received by insurer for services provided to insureds was actionable); *Bell v. Blue Cross of California*, 131 Cal. App. 4th 211, 221, 31 Cal. Rptr. 3d 688, 695–96 (2005) (emergency provider had standing to assert quantum meruit claim against payor because "he who has 'performed the duty of another by supplying a third person with necessaries . . . is entitled to restitution . . . "); *El Paso Healthcare*

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System, Ltd. v. Molina Healthcare of New Mexico, 683 F.Supp.2d 454, 461–462 (W.D. Tex. 2010) (insurer "receive[d] the benefit of having its obligations to its plan members, and to the state in the interests of plan members, discharged."); *Appalachian Reg'l Healthcare vs. Coventry Health & Life Ins*. Co., 2013 WL 1314154 at *4 (E.D. Ky. Mar. 28, 2013) (granting summary judgment to provider on unjust enrichment claim where plaintiff's services allowed managed care organization to discharge its duty to provide coverage to Medicaid patients); *Fisher v. Blue Cross Blue Shield of Texas, Inc*., 2011 WL 11703781, at *8 (N.D. Tex. June 27, 2011) (defendant insurer received the benefit of having its obligations to its plan members discharged.); *Forest Ambulatory Surgical Associates, L.P. v. United Healthcare Ins. Co*., 2013 WL 11323600, at *10 (C.D. Cal. March 12, 2013) ("Plaintiff sufficiently stated a claim upon which relief can be granted because the allegations ... establish that Defendants received the benefit of having their obligations to the [policyholders] discharged."); *River Park Hosp., Inc. v. BlueCross BlueShield of Tennessee, Inc*., 173 S.W.3d 43, 58-59 (Tenn. Ct. App. 2002) (MCO was unjustly enriched by hospital's emergency services provided to the insurer's enrollees); *New York City Health & Hosps. Corp. v. Wellcare of New York*, Inc., 35 Misc. 3d 250, 251, 937 N.Y.S.2d 540, 541, 546 (2011) (non-contracted hospital's unjust enrichment claim for systematic underpayment for emergency services by MCO should not be dismissed under New York law);

To support its position, United HealthCare cites to a handful of cases from Florida, Texas, New York, Georgia and California which are readily distinguishable. *See e.g. Adventist Health Sys./Sunbelt Inc. v. Med. Sav. Ins. Co*., No. 6:03-CV-1121-ORL-19, 2004 WL 6225293, at *6 (M.D. Fla. Mar. 8, 2004) (noting that Florida law requires that the benefit conferred be "direct, not indirect or attenuated" thus any indirect benefit would not be actionable under Florida law); *Peacock Med. Lab, LLC v. UnitedHealth Grp., Inc*., No. 14-81271-CV, 2015 WL 2198470, at *5 (S.D. Fla. May 11, 2015) (same); *Encompass Office Sols., Inc. v. Ingenix, Inc*., 775 F. Supp. 2d 938, 966 (E.D. Tex. 2011) (addressing payment for equipment and nursing staff not in the context of emergency medical services); *Electrostim Med. Servs., Inc. v. Health Care Serv. Corp*., 962 F. Supp. 2d 887, 898 (S.D. Tex. 2013), *aff'd in part, rev'd in part*, 614 F. App'x 731 (5th Cir. 2015) (concerning payments relating to the sale of a medical device, not in the context of emergency

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medical services); *Travelers Indem. Co. of Connecticut v. Losco Grp., Inc*., 150 F. Supp. 2d 556, 562–63 (S.D.N.Y. 2001) (under New York law, claim of quantum meruit requires more than a benefit received, plaintiff must show services were performed at the behest of the defendant); *Joseph M. Still Burn Centers, Inc. v. AmFed Nat. Ins. Co*., 702 F. Supp. 2d 1371, 1377 (S.D. Ga. 2010) (plaintiff was already paid reimbursement rates set forth in Mississippi's and Georgia's workers' compensation fee schedules); *Cedars Sinai Med. Ctr. v. Mid-W. Nat. Life Ins. Co*., 118 F. Supp. 2d 1002, 1013 (C.D. Cal. 2000) (since this decision, the same court has concluded in *Forest Ambulatory Surgical Associates v. United Healthcare Ins. Co.,* that a claim for quantum meruit can survive dismissal upon "establish[ing] that Defendants received the benefit of having their obligations to the [policyholders] discharged.").

Thus, the overwhelming majority of cases considering this issue conclude that where a state allows for an indirect benefit to provide the basis for an unjust enrichment claim, a claim of unjust enrichment against an insurer is actionable. United HealthCare's grounds for dismissal therefore fail because Nevada law permits an unjust enrichment claim to lie on assertions of United HealthCare's receipt of a material, indirect benefit from Fremont's services.

4. Fremont Stated A Cognizable Claim for Violation of NRS 686A.020 and 686A.310.

United HealthCare cites to *Gunny v. Allstate Ins. Co*. for the proposition that Nevada's Unfair Insurance Practices Act "does not create a private right of action against insurers in favor of third party claimants like Fremont." Motion at 17:28-18:2. *Gunny* does not reach this blanket conclusion, rather the *Gunny* court emphasized that Gunny did not have a contractual relationship with the insurer. *Gunny v. Allstate Ins. Co.*, 108 Nev. 344, 346, 830 P.2d 1335, 1336 (1992). Thus, while the *Gunny* court did find that Gunny could not assert a private action against the insurer under NRS 686A.310, the absence of a contract between Gunny and the insurer makes this case distinguishable. Here, Fremont does have an implied in fact contract with United HealthCare and, consequently, a claim asserted by a medical services provider under NRS 686A.020 and 686A.310 should be deemed actionable. Notably, the plain language of NRS 686A.310 does not *prohibit* a third party, such as Fremont, from raising claims under NRS 686A.310, but, instead,

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provides that claims may be asserted by the Commissioner and an insured. NRS 686A.310(2) ("In addition to any rights or remedies available to the Commissioner, an insurer is liable to its insured for any damages sustained by the insured as a result of the commission of any act set forth in subsection 1 as an unfair practice."). Under NRS 686A.020, "[a] person shall not engage in this state in any practice which is defined in NRS 686A.010 to 686A.310, inclusive, as, or determined pursuant to NRS 686A.170 to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance." Thus, based on the plain language of NRS 686A.310 and 686A.020 and the specific holding in *Gunny*, there is no express prohibition barring Fremont from asserting this claim. Accordingly, dismissal on this basis would be improper.

5. Fremont Stated A Cognizable Claim for Violation of Nevada's Prompt Pay Statutes.

United HealthCare did not challenge Fremont's claim for violation of Nevada's prompt pay statutes. Consequently, this claim is not subject to dismissal under FRCP 12(b)(6).

6. Fremont Stated A Cognizable Claim for Violation of Nevada's Deceptive Trade Practices Act.

a. Fremont Has Pled This Claim with Particularity Even Though Such Is Not Required Under Nevada Law.

In its Motion to Dismiss, United HealthCare relies entirely on an unpublished and federal district court decision in asserting that a claim for violation of Nevada's Deceptive Trade Practices Act ("DTPA") must be pled with particularity. *See* Motion at 21:26-27. However, the Nevada Supreme Court has held, in a published decision, that violations of DTPA do not need to be proven with the same level of particularity as fraud claims. *Betsinger v. D.R. Horton, Inc*., 232 P.3d 433, 436 (2010) (holding that a violation of the DTPA need not be proven under the clear and convincing standard as is required for a fraud claim). Thus, by analogy, such claims should not need to be pled with the particularity required for fraud claims and, based on the statements made in *Betsinger,* when faced with this question, the Nevada Supreme Court would not likely require a heightened pleading standard for a violation of the DTPA.

Even if this Court were to require that this claim be subject to heightened pleading standards, Fremont pled its claim for violation of DTPA with particularity. To support its claim,

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Fremont alleges:

> …from July 1, 2017 through the present, Fremont has provided emergency medicine services to United HealthCare's members as follows: ER at Aliante (approximately July 2017-present); ER at The Lakes (approximately July 2017-present); Mountainview Hospital (approximately July 2017-present); Dignity Health – St. Rose Dominican Hospitals, Rose de Lima Campus (approximately July 2017-October 2018); Dignity Health – St. Rose Dominican Hospitals, San Martin Campus approximately (July 2017-October 2018); Dignity Health – St. Rose Dominican Hospitals, Siena Campus (approximately July 2017-October 2018); Southern Hills Hospital and Medical Center (approximately July 2017-present); and Sunrise Hospital and Medical Center (approximately July 2017-present.
>
> Beginning on July 1, 2017, the UH[] Parties arbitrarily began drastically reducing the rates at which they paid Fremont for emergency services for some claims, but not others. The UH[] Parties paid some of the claims for emergency services rendered by Fremont at far below the usual and customary rates, yet paid other substantially identical claims submitted by Fremont at higher rates.
> …
> From July 2017 to the present, Fremont provided treatment for emergency services to more than 10,800 Patients who were members in United HealthCare's Health Plans…
>
> During … July 2017 to the present, United HealthCare paid some claims at an appropriate rate and others at a significantly reduced rate which is demonstrative of an arbitrary and selective program and motive or intent to unjustifiably reduce the overall amount United Healthcare pays to Fremont. Upon information and belief, United Healthcare has implemented this program to coerce, influence and leverage business discussions regarding the potential for Fremont to become a participating provider.
>
> The UH Parties have violated the DTPA and the Consumer Fraud Statute through their acts, practices, and omissions described above, including but not limited to (a) wrongfully refusing to pay Fremont for the medically necessary, covered emergency services Fremont provided to Members in order to gain unfair leverage against Fremont now that they are out-of-network and in contract negotiations to potentially become a participating provider under a new contract in an effort to force Fremont to accept lower amounts than it is entitled for its services; and (b) engaging in systematic efforts to delay adjudication and payment of Fremont's claims for its services provided to UH Parties' members in violation of their legal obligations

Compl. at ¶¶ 19-20, 25-26 & 87. Fremont adequately alleges that the UH Parties knowingly made a false representation by paying Fremont for emergency medical services at artificially reduced rates, thereby representing that, through their actions, these payments represent usual and customary rates and a reasonable value for services rendered when such rates are not usual and customary or reasonable. These representations commenced in July 2017 and have continued to present date. Accordingly, Fremont has adequately alleged this part of the DTPA claim.

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Next, Fremont alleges that the UH Parties violated "a state or federal statute or regulation relating to the sale or lease of goods or services." Fremont sufficiently alleges this claim as the UH Parties have violated NRS 679B.152, NRS 686A.020, 686A.310, NRS 683A.0879 (third party administrator), NRS 689A.410 (Individual Health Insurance), NRS 689B.255 (Group and Blanket Health Insurance), NRS 689C.485 (Health Insurance for Small Employers), NRS 695C.185 (HMO) and NAC 686A.675 by failing to timely pay claims submitted at a usual and customary rate within 30 days of receipt of the claim. Compl. at ¶¶ 69-71,77-80. Fremont expressly states that the UH Parties began to violate these provisions in July 2017 and continue to violate such provisions through the present date. Nothing further is required to establish that this claim is actionable. As such, Fremont has sufficiently alleged this portion of the DTPA claim.

Fremont also properly alleges that the DPTA has been violated by the UH Parties' use of "coercion, duress or intimidation in a transaction". Specifically, Fremont alleges that the UH Parties are "wrongfully refusing to pay Fremont for the medically necessary, covered emergency services Fremont provided to Members **in order to gain unfair leverage against Fremont now that they are out-of-network and in contract negotiations to potentially become a participating provider** under a new contract in an effort **to force Fremont to accept lower amounts than it is entitled for its services.**" Compl. at ¶ 87 (emphasis added). Further, as is detailed above, Fremont alleges that "[d]uring this same period, July 2017 to the present, United HealthCare paid some claims at an appropriate rate and others at a significantly reduced rate which is demonstrative of an arbitrary and selective program and motive or intent to unjustifiably reduce the overall amount United Healthcare pays to Fremont. Upon information and belief, United Healthcare has implemented this program to coerce, influence and leverage business discussions regarding the potential for Fremont to become a participating provider." Compl. at ¶ 26. Based on the foregoing, Fremont has alleged who engaged in these bad acts (the UH Parties) when such parties engaged in these acts (July 2017 to present) and the scope of the bad acts alleged (improperly lowering amounts paid to leverage negotiations).

Finally, Fremont properly alleges that the UH Parties have knowingly misrepresented the "legal rights, obligations or remedies of a party to a transaction." Specifically, Fremont asserts

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that by paying claims at artificially reduced rates, the UH Parties are representing that these claims are being paid at usual and customary and reasonable rates when such a representation is clearly inaccurate. This conduct commenced in July 2017 and continues to present date and each of the UH Parties have engaged in these bad acts. Accordingly, Fremont has sufficiently alleged this aspect of its claim for violation of DTPA.

While United HealthCare argues that it is improper to lump all the parties together in Fremont's allegations, this is not a situation in which only one party engaged in the improper acts. Rather, each of the UH Parties has improperly engaged in artificially reducing the rates paid to Fremont for an ulterior purpose. Thus, it is certainly permissible for Fremont to make an allegation which encompasses all of these parties. To force Fremont to reallege this same claim using each of the Defendants' names would be inefficient and unnecessary under these circumstances. As is detailed herein, Fremont has satisfied the heightened pleading standard required for claims based on violation of DTPA.

b. Fremont Is a "Victim" Under NRS 41.600 and Has Standing.

NRS 41.600(1) provides that "[a]n action may be brought by any person who is a victim of consumer fraud." The statute does not define the scope of "victim," but upon review of the deceptive trade practice statutes as a whole, it is clear that the legislature did not intend to limit the scope of this term. However, even under *Igbinovia's* definition of "victim" limiting it to passive victims who suffered a loss that was "unexpected and occurs without voluntary participation of the person suffering the harm or loss," Fremont qualifies as a victim. *See Igbinovia v. State*, 111 Nev. 699, 706, 895 P.2d 1304, 1308 (1995). As is detailed in the Complaint, Fremont does not voluntarily provide services to out of network patients. Rather, state law mandates that Fremont provide emergency medical services to any person presenting to an emergency room in need of emergency medical services. NRS 439B.410(1) ("each hospital … has an obligation to provide emergency services and care, including care provided by physicians … regardless of the financial status of the patient."). The provision of services to United HealthCare's Members was not voluntary and the loss Fremont has suffered was unexpected given that United HealthCare is refusing to pay usual and customary rates and the reasonable value of

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the services provided despite previously doing so. Thus, Fremont is not an active participant in United HealthCare's fraudulent conduct and should be deemed a "victim" under NRS 41.600(1) even if the definition of "victim" is limited in the way United HealthCare proposes.

Furthermore, contrary to United HealthCare's arguments, while one court has found that business competitors cannot be victims under Nevada law, the Ninth Circuit has reached a contrary conclusion, finding that the term "victim of consumer fraud" is broad and includes "any person" who is a victim of consumer fraud, including business competitors, consumers and even businesses which do not have competing interests. *Del Webb Community, Inc. v. Partington*, 652 F.3d 1145, 1153 (9th Cir. 2011). Thus, United HealthCare's passing reference to *Rebel Oil Co.* for the proposition that business competitors are not "victims" should be disregarded.

Based on the foregoing, Fremont would undoubtedly be treated as a victim of consumer fraud, even if this Court accepts the narrow definition of "victim" forwarded by United HealthCare because Fremont has never been an active participant in United HealthCare's fraud.

7. Fremont Has Stated A Cognizable Claim for Declaratory Relief.

United HealthCare did not challenge Fremont's declaratory relief claim. Consequently, this claim is not subject to dismissal under FRCP 12(b)(6).

III. CONCLUSION.

Based on the foregoing, Fremont respectfully requests that the Motion to Dismiss be denied in its entirety.

DATED this 18th day of June, 2019.

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By: */s/ Amanda M. Perach*

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 18th day of June, 2019, I caused a true and correct copy of the foregoing **OPPOSITION TO DEFENDANTS' MOTION TO DISMISS** to be served via the U.S. District Court's Notice of Electronic Filing system ("NEF") in the above-captioned case, upon the following:

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EXHIBIT 3

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EXHIBIT 3

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UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC. dba UNITED HEALTHCARE, 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.: **DEFENDANTS' UNITEDHEALTHCARE INSURANCE COMPANY, UNITED HEALTHCARE SERVICES INC., UMR, INC., OXFORD HEALTH PLANS, INC., SIERRA HEALTH AND LIFE INSURANCE CO., INC., SIERRA HEALTH-CARE OPTIONS, INC. AND HEALTH PLAN OF NEVADA, INC.'S NOTICE OF REMOVAL**

PLEASE TAKE NOTICE that Defendants UnitedHealthcare Insurance Company, United HealthCare Services, Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health and Life Insurance Co., Inc., Sierra Health-Care Options, Inc., and Health Plan of Nevada, Inc. (collectively "Defendants"), by and through their attorneys of the law firm of Weinberg Wheeler Hudgins Gunn & Dial, LLC, hereby remove this action from the Eighth Judicial District Court for Clark County, Nevada, Case No. A-19-792978-B, to the United States District Court for the District of Nevada.

I. INTRODUCTION

1. On or about April 23, 2019, Plaintiff Fremont Emergency Services (Mandavia), LTD. ("Fremont") served a seven count Complaint on Defendants. The Complaint was filed in the Eighth Judicial District Court for Clark County, Nevada. The suit was assigned to Department 27 and assigned Case No. A-19-792978-B ("State Court Action").

2. Defendants remove this action as an action which raises federal questions under 28 U.S.C. § 1331. The State Court Action advances claims which are completely preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et. seq.* ("ERISA").

II. NATURE OF THE CASE

3. In its Complaint, Fremont alleges that its physicians provided medical treatment to various patients who presented to the emergency departments of various hospitals around Clark County, Nevada. Complaint at ¶ 14. Fremont alleges that some of the patients it provided emergency medical services to were members of health plans issued and/or administered by the Defendants. *Id.* at ¶¶ 18, 25. Fremont further alleges that, beginning on July 1, 2017, the Defendants began to drastically reduce the amount of money paid to Fremont for the services Fremont was providing to the members of Defendants' health plans. *Id.* at ¶ 20.

4. Based on the Defendants' alleged failure to pay the appropriate amounts for the medical services that Fremont provided to Defendants' members, Fremont alleges various state law claims, including (1) Breach of Implied-in-Fact Contract, (2) Tortious Breach of the Implied Covenant of Good Faith and Fair Dealing, (3) Unjust Enrichment, (4) Violation of NRS 686A.020 and 686A.310, (5) Violation of Nevada Prompt Pay Statutes & Regulations, (6)

Consumer Fraud & Deceptive Trade Practices Acts, and (7) Declaratory Judgment.

5. Fremont alleges that no written agreement exists between Defendants and Fremont since Fremont is an out-of-network provider and thus has not alleged a standard breach of contract claim. *Id.* at ¶ 17.

6. All of Fremont's claims seek an identical form of relief, i.e. recovery of the amount that Fremont contends is due and owing for the medical services that Fremont rendered to Defendants' members who allegedly had health plan coverage in full force and effect when the services were rendered. All of Fremont's claims take direct aim at the manner in which Defendants' processed and adjudicated claims for health plan benefits. *See generally* Complaint.

7. Fremont alleges that, from July 2017 to present, it provided medical services to over 10,800 patients who were members of Defendants' health plans. Complaint at ¶ 25. However, Fremont's Complaint provides only limited identifying information related to the patients or specific health plans at issue. As explained further below, this was almost certainly done in an attempt to conceal the fact that numerous employee welfare benefit plans are implicated by Fremont's claims and thus removal under ERISA's complete preemption doctrine is appropriate.

III. COMPLETE PREEMPTION UNDER ERISA

8. ERISA is a "comprehensive legislative scheme" enacted to protect the interests of participants and beneficiaries in employee benefit plans. 29 U.S.C. § 1001(b); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004). As part of this comprehensive scheme, Congress created a special civil enforcement mechanism to deal with all claims related to employee benefit plans. That scheme is set forth in 29 U.S.C. § 1132(a) and permits a participant or beneficiary to bring a special statutory ERISA claim over which federal courts have original jurisdiction.

9. ERISA defines an "employee welfare benefit plan" or "welfare plan" as follows:

> [A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness,

accident, disability, death or unemployment . . .

29 U.S.C. § 1002(1).

10. Under the "well-pleaded complaint" rule a plaintiff ordinarily is entitled to remain in state court if its complaint does not, on its face, affirmatively allege a federal claim. However, complete preemption under ERISA is an exception to this rule. *Beneficial Nat. Bank v. Anderson*, 539 U.S. 1, 6, 123 S. Ct. 2058, 2062 (2003). The U.S. Supreme Court has held that "the ERISA civil enforcement mechanism [i.e. 29 U.S.C. § 1132(a)] is one of those provisions with such extraordinary pre-emptive power that it converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule." *Davila*, 542 U.S. at 209, 124 S. Ct. at 2496.

11. Thus, state law claims that relate to an employee welfare benefit plan are properly removed to federal court even where the complaint does not facially state an ERISA cause of action. *Tingey v. Pixley-Richards W., Inc.*, 953 F.2d 1124, 1130 (9th Cir. 1992) ("It follows that although the Tingeys' original four-count state cause of action purported to plead only state law claims, the action was properly removed because the claims fell within the purview of the exclusive remedy provisions in ERISA. This means only a federal court can hear the claims when stripped of their state law disguises. The basis of jurisdiction, even though none of the claims facially stated an ERISA cause of action, was federal question jurisdiction."),

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

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IV. FEDERAL QUESTIONS

13. The Complaint makes reference to Fremont making claims/requests for payment to the Defendants and the Defendants failing/refusing to pay the full amount requested. After being served with the Complaint, the Defendants began conducting a preliminary investigation into Fremont's medical claims to determine, among other things, whether any of those claims relate to employee welfare benefit plans governed by ERISA. Although their investigation is ongoing, Defendants have a reasonably certain belief that approximately 90% of Fremont's medical claims were made against employee welfare benefit plans governed by ERISA. Moreover, Defendants have also determined that, for all or nearly all of the medical claims that Fremont made against the employee welfare benefit plans, Fremont received an assignment of benefits from plan members such that Fremont has derivative standing to bring a statutory ERISA claim under 29 U.S.C. § 1132(a). Thus, just as in *Misic*, all or at least some of Fremont's state law claims are completely preempted by ERISA and removal to federal court is appropriate.

14. The state law claims in this action are "in reality based on federal law." *Davila*, 542 U.S. at 208, 124 S. Ct. at 2495. They "duplicate, supplement, or supplant" the ERISA civil enforcement remedy that Congress intended to be exclusive. *Id.* Instead of proceeding under ERISA's federal enforcement mechanism which allows for the recovery of benefits allegedly due under a plan, Fremont casts its claim under state law principles of implied-in-fact contract, unjust enrichment, state statutory violations, and declaratory relief. Fremont's labels, however, do not control the complete preemption question. Federal courts are "not bound by the labels used in the complaint . . . merely referring to labels affixed to claims to distinguish between preempted and non-preempted claims is not helpful because doing so would elevate form over substance and allow parties to evade the pre-emptive scope of ERISA.'" *Gables Ins. Recovery, Inc. v. Blue Cross & Blue Shield of Florida*, Inc., 813 F.3d 1333, 1337 n.2 (11th Cir. Dec. 1, 2015) (internal quotation omitted); *see also Cleghorn v. Blue Shield of California*, 408 F.3d 1222, 1226 (9th Cir. 2005) ("Artful pleading does not alter the potential for this suit to frustrate the objectives of ERISA. The only factual basis for relief pleaded in Cleghorn's complaint is the refusal of Blue Shield to reimburse him for the emergency medical care he received. Any duty or liability that

Blue Shield had to reimburse him would exist here only because of [Blue Shield's] administration of ERISA-regulated benefit plans.") (internal citation omitted).

15. As further evidence that removal is appropriate and that Fremont is engaged in artful pleading to avoid federal question jurisdiction, footnote 1 of the Complaint alleges that Fremont does not assert any claims with respect to patients whose health insurance was issued under Medicare Part C or provided under the Federal Employee Benefits Act (FEHBA). Thus, Fremont asserts that "there is no basis to remove this lawsuit to federal court under federal question jurisdiction." Conspicuously absent from this footnote is any allegation that the lawsuit is not removable under ERISA.

16. Removal of this action which squarely implicates numerous ERISA plans is consistent with ERISA's purpose "to provide a uniform regulatory regime over employee benefit plans." *Davila*, 542 U.S. at 208, 124 S. Ct. at 2495. In order to adjudicate Fremont's claims, it will be necessary for the Court to consult the Defendants' members' employer sponsored health plans which are subject to ERISA.

17. Removal of the claims asserted by Fremont is proper on the grounds that Fremont has alleged claims in substance seeking to recover benefits from employee welfare benefit plans. This Court has federal question jurisdiction over such claims pursuant to 28 U.S.C § 1331 and original jurisdiction over such claims pursuant to ERISA. *See* 29 U.S.C. § 1132(e)(1). Therefore, removal is appropriate pursuant to 28 U.S.C. § 1441(a).

V. SUPPLEMENTAL JURISDICTION

18. To the extent that any claims asserted by Fremont relate to a benefits plan other than one governed by ERISA or are conflict preempted as opposed to completely preempted, those claims come within this Court's supplemental jurisdiction because they are so related to those other claims that they form part of the same case or controversy under Article III of the United States Constitution. 28 U.S.C. §1367(a); *Beneficial Nat. Bank v. Anderson*, 539 U.S. 1, 8, 123 S. Ct. 2058, 2063, n. 3 (2003) ("Of course, a state claim can also be removed through the use of the supplemental jurisdiction statute, 28 U.S.C. § 1367(a), provided that another claim in the complaint is removable."); *see also Gaming Corp. of Am. v. Dorsey & Whitney*, 88 F.3d 536, 543

(8th Cir. 1996) ("Only those claims that fall within the preemptive scope of the particular statute, or treaty, are considered to make out federal questions, but the presence of even one federal claim gives the defendant the right to remove the entire case to federal court.") (internal citations omitted); *Milwaukee Carpenter's District Council Health Fund v. Philip Morris*, 70 F.Supp.2d 888 (E.D. Wisc. 1999) (denying remand while noting that "[s]o long as any one claim concerned a federal question, the entire case could be removed" under the ERISA complete preemption doctrine).

VI. CONCLUSION

19. This Notice of Removal is timely because Defendants have filed it within thirty days of being served with Fremont's Complaint. 28 U.S.C. § 1446.

20. Defendants will file a copy of this Notice of Removal with the Clerk of the Eighth Judicial District Court and will serve a copy on Fremont's counsel as required by 28 U.S.C. § 1446(d).

21. With this Notice of Removal, Defendants have filed a copy of the process, pleadings and all other papers served upon the Defendants in the State Court Action as required by 28 U.S.C. § 1446(a). *See* **Exhibit 1**.

Dated this 14 day of May, 2019.

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CERTIFICATE OF SERVICE

I hereby certify that on the 14 day of May, 2019, a true and correct copy of the foregoing **DEFENDANTS' UNITEDHEALTHCARE INSURANCE COMPANY, UNITED HEALTHCARE SERVICES INC., UMR, INC., OXFORD HEALTH PLANS, INC., SIERRA HEALTH AND LIFE INSURANCE CO., INC., SIERRA HEALTH-CARE OPTIONS, INC. AND HEALTH PLAN OF NEVADA, INC.'S NOTICE OF REMOVAL** was filed through CM/ECF and served by mailing a copy of the foregoing document in the United States Mail, postage fully prepaid, to the following:

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EXHIBIT 1

Documents filed in
District Court, Clark County, Nevada
Case No. A-19-792978-B

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EXHIBIT 1

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CASE NO: A-19-792978-C
Department 9

DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiff,

vs.

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

Defendants.

Case No.:
Dept. No.:

COMPLAINT

Business Court Requested
(EDCR 1.61(a)(2)(ii))

Exempt From Arbitration: In Excess of $50,000, Declaratory and Injunctive Relief Requested

Jury Trial Demanded

Plaintiff Fremont Emergency Services (Mandavia), Ltd. ("Fremont" or "Plaintiff") as and for its Complaint against defendants United Healthcare Insurance Company ("UHCIC") and its affiliates United Health Care Services Inc. dba UnitedHealthcare ("UHC Services"); UMR, Inc. dba United Medical Resources ("UMR"); Oxford Benefit Management, Inc. ("Oxford"

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together with UHC Services and UMR, the "UHC Affiliates" and with UHCIC, the "UH Parties"); Sierra Health and Life Insurance Company, Inc. ("Sierra Health"); Sierra Health-Care Options, Inc. ("Sierra Options" and together with Sierra Health, the "Sierra Affiliates"); Health Plan of Nevada, Inc. ("HPN") (collectively "United HealthCare") hereby complains and alleges as follows:

NATURE OF THIS ACTION

1. This action arises out of a dispute concerning the rate at which United HealthCare reimburses Fremont for the emergency medicine services it has already provided, and continues to provide, to patients covered under the health plans underwritten, operated, and/or administered by United HealthCare (the "Health Plans") (Health Plan beneficiaries for whom Fremont performed covered services that were not reimbursed correctly shall be referred to as "Patients").[1]

PARTIES

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

3. Defendant United HealthCare Insurance Company ("UHCIC") is a Connecticut corporation with its principal place of business in Connecticut. UHCIC is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On

[1] Fremont does not assert any causes of action with respect to any Patient whose health insurance was issued under Medicare Part C (Medicare Advantage) or is provided under the Federal Employee Health Benefits Act (FEHBA). Thus, there is no basis to remove this lawsuit to federal court under federal question jurisdiction. Fremont also does not assert any claims relating to United HealthCare's managed Medicaid business.

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information and belief, United HealthCare Insurance Company is a licensed Nevada health and life insurance company.

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

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

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

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

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

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

10. There may be other persons or entities, whether individuals, corporations, associations, or otherwise, who are or may be legally responsible for the acts, omissions,

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circumstances, happenings, and/or the damages or other relief requested by this Complaint. The true names and capacities of Does 1-10 and Roes Entities 11-20 are unknown to Fremont, who sues those defendants by such fictitious names. Fremont will seek leave of this Court to amend this Complaint to insert the proper names of the defendant Doe and Roe Entities when such names and capacities become known to Fremont.

JURISDICTION AND VENUE

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

12. Venue is proper in Clark County, Nevada pursuant to NRS 13.010(1), NRS 13.020 and NRS 13.040.

FACTS COMMON TO ALL CAUSES OF ACTION

Fremont Provides Necessary Emergency Care

13. This is an action for damages stemming from United HealthCare's failure to properly reimburse Fremont for emergency services provided to members of their Health Plans.

14. Fremont is a professional practice group of emergency medicine physicians and healthcare providers that provides emergency medicine services 24 hours per day, 7 days per week to patients presenting to the emergency departments at hospitals and other facilities in Nevada staffed by Fremont. Fremont provides emergency department services at eight hospitals located in Clark County, Nevada.

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

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

17. There is no written agreement between United HealthCare and Fremont for the healthcare claims at issue in this litigation; Fremont is therefore designated as "non-participating" or "out-of-network" for all of the claims at issue in this litigation. Notwithstanding the lack of a written agreement, an implied-in-fact agreement exists between the parties.

18. Fremont regularly provides emergency services to United HealthCare's health plan members.

19. Relevant to this action, from July 1, 2017 through the present, Fremont has provided emergency medicine services to United HealthCare's members as follows: ER at Aliante (approximately July 2017-present); ER at The Lakes (approximately July 2017-present); Mountainview Hospital (approximately July 2017-present); Dignity Health – St. Rose Dominican Hospitals, Rose de Lima Campus (approximately July 2017-October 2018); Dignity Health – St. Rose Dominican Hospitals, San Martin Campus approximately (July 2017-October 2018); Dignity Health – St. Rose Dominican Hospitals, Siena Campus (approximately July 2017-October 2018); Southern Hills Hospital and Medical Center (approximately July 2017-present); and Sunrise Hospital and Medical Center (approximately July 2017-present.

20. Beginning on July 1, 2017, the UHC Parties arbitrarily began drastically reducing the rates at which they paid Fremont for emergency services for some claims, but not others. The UHC Parties paid some of the claims for emergency services rendered by Fremont at far below the usual and customary rates, yet paid other substantially identical claims submitted by Fremont at higher rates.

21. Upon information and belief, among other things, the UH Parties generally pay lower reimbursement rates for services provided to members of their fully insured plans and

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authorize payment at higher reimbursement rates for services provided to members of self-insured plans or those plans under which they provide administrator services only.

United HealthCare Has Underpaid Fremont for Emergency Services

22. Despite not participating in United HealthCare's "provider network" for the times identified herein, Fremont has continued to provide emergency medicine treatment, as required by law, to patients covered by United HealthCare's plans who seek care at the emergency departments where they provide coverage.

23. In emergency situations, patients are likely to go to the nearest hospital for care, particularly if they are transported by ambulance. Patients facing an emergency situation are unlikely to have the luxury of determining which hospitals and physicians are in-network under their health plan. United HealthCare is obligated to reimburse Fremont at the usual and customary rate for emergency services Fremont provided to its Patients, or alternatively for the reasonable value of the services provided.

24. United HealthCare's members have received a wide variety of emergency services (in some instances, life-saving services) from Fremont's physicians: treatment of conditions ranging from cardiac arrest, to broken limbs, to burns, to diabetic ketoacidosis and shock, to gastric and/or obstetrical distress.

25. From July 2017 to the present, Fremont provided treatment for emergency services to more than 10,800 Patients who were members in United HealthCare's Health Plans. The total underpayment amount for these related claims is in excess of the jurisdictional threshold of $15,000.00 and continues to grow. United HealthCare has likewise failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of these claims.

26. During this same period, July 2017 to the present, United HealthCare paid some claims at an appropriate rate and others at a significantly reduced rate which is demonstrative of an arbitrary and selective program and motive or intent to unjustifiably reduce the overall amount United Healthcare pays to Fremont. Upon information and belief, United Healthcare has implemented this program to coerce, influence and leverage business discussions regarding the potential for Fremont to become a participating provider.

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27. For each of the healthcare claims at issue in this litigation, United HealthCare determined the claim was payable; however, it paid the claim at an artificially reduced rate. Thus, the claims at issue involve no questions of whether the claim is payable; rather, they involve only a determination of whether United HealthCare paid the claim at the required usual and customary rate, which it did not.

28. United HealthCare has failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of the subject claims.

29. Fremont brings this action to compel United HealthCare to pay it the usual and customary rate or alternatively for the reasonable value of the professional emergency medical services for the for the emergency services that it provided and will continue to provide Members.

30. Fremont has adequately contested the unsatisfactory rate of payment received from the UH Parties in connection with the claims that are the subject of this action.

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

FIRST CLAIM FOR RELIEF

(Breach of Implied-in-Fact Contract – UH Parties)

32. Fremont incorporates herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

33. At all material times, Fremont was obligated under federal and Nevada law to provide emergency medicine services to all patients presenting at the emergency departments they staff, including United HealthCare Patients.

34. At all material times, the UH Parties knew that Fremont was non-participating emergency medicine groups that provided emergency medicine services to Patients.

35. From July 1, 2017 to the present, Fremont has undertaken to provide emergency medicine services to UH Parties' Patients, and the UH Parties have undertaken to pay for such services provided to UH Parties' Patients.

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36. At all material times, the UH Parties were aware that Fremont was entitled to and expected to be paid at rates in accordance with the standards established under Nevada law.

37. At all material times, the UH Parties have received Fremont's bills for the emergency medicine services Fremont has provided and continue to provide to UH Parties' Patients, and the UH Parties have consistently adjudicated and paid, and continue to adjudicate and pay, Fremont directly for the non-participating claims, albeit at amounts less than usual and customary.

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

39. Under Nevada common law, including the doctrine of quantum meruit, the UH Parties, by undertaking responsibility for payment to Fremont for the services rendered to United HealthCare Patients, impliedly agreed to reimburse Plaintiffs at rates, at a minimum, equivalent to the reasonable value of the professional emergency medical services provided by Fremont.

40. The UH Parties, by undertaking responsibility for payment to Fremont for the services rendered to the UH Parties' Patients, impliedly agreed to reimburse Fremont at rates, at a minimum, equivalent to the usual and customary rate or alternatively for the reasonable value of the professional emergency medical services provided by Fremont.

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

42. Fremont has performed all obligations under its implied contract with the UH Parties concerning emergency medical services to be performed for Patients.

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

44. Fremont did not agree that the lower reimbursement rates paid by UH Parties were reasonable or sufficient to compensate Fremont for the emergency medical services provided to Patients.

45. Fremont has suffered damages in an amount equal to the difference between the amounts paid by the UH Parties and the usual and customary fees professional emergency medicine services in the same locality, that remain unpaid by the UH Parties through the date of trial, plus Fremont's loss of use of that money; or in an amount equal to the difference between the amounts paid by the UH Parties and the reasonable value of its professional emergency medicine services, that remain unpaid by the UH Parties through the date of trial, plus Fremont's loss of use of that money.

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

47. Fremont has been forced to retain counsel to prosecute this action and is entitled to receive their costs and attorneys' fees incurred herein.

SECOND CLAIM FOR RELIEF

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

48. Fremont incorporates herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

49. Fremont and the UH Parties had a valid implied-in-fact contract as alleged herein.

50. A special element of reliance or trust between Fremont and the UH Parties, such that, the UH Parties were in a superior or entrusted position of knowledge.

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51. That Fremont did all or substantially all of its obligations pursuant to the implied-in-fact contract.

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

53. That the UH Parties' conduct was a substantial factor in causing damage to Fremont.

54. As a result of the UH Parties' tortious breach of the implied covenant of good faith and fair dealing, Fremont has suffered injury and is entitled to monetary damages from the UH Parties to compensate it for that injury in an amount in excess of $15,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

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

56. Fremont has been forced to retain counsel to prosecute this action and is entitled to receive their costs and attorneys' fees incurred herein.

THIRD CLAIM FOR RELIEF

(Alternative Claim for Unjust Enrichment – UH Parties)

57. Fremont incorporates herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

58. Fremont rendered valuable emergency services to the Patients.

59. The UH Parties received the benefit of having their healthcare obligations to their plan members discharged and their members received the benefit of the emergency care provided to them by Fremont.

60. As insurers or plan administrators, the UH Parties were reasonably notified that emergency medicine service providers such as Fremont would expect to be paid by the UH Parties for the emergency services provided to Patients.

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

62. The UH Parties have received a benefit from Fremont's provision of services to its Patients and the resulting discharge of their healthcare obligations owed to their Patients.

63. Under the circumstances set forth above, it is unjust and inequitable for the UH Parties to retain the benefit they received without paying the value of that benefit; i.e., by paying Fremont at usual and customary rates, or alternatively for the reasonable value of services provided, for the claims that are the subject of this action and for all emergency medicine services that Fremont will continue to provide to United HealthCare's members.

64. Fremont seeks compensatory damages in an amount which will continue to accrue through the date of trial as a result of United Healthcare's continuing unjust enrichment.

65. As a result of the UH Parties' actions, Fremont has been damaged in an amount in excess of $15,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

66. Fremont sues for the damages caused by the UH Parties' conduct and is entitled to recover the difference between the amount the UH Parties paid for emergency care Fremont rendered to its members and the reasonable value of the service that Fremont rendered to the UH Parties by discharging their obligations to their plan members.

67. As a direct result of the UH Parties' acts and omissions complained of herein, it has been necessary for Fremont to retain legal counsel and others to prosecute its claims. Fremont is thus entitled to an award of attorneys' fees and costs of suit incurred herein.

FOURTH CLAIM FOR RELIEF

(Violation of NRS 686A.020 and 686A.310 – UH Parties)

68. Fremont incorporates herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

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

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

71. As detailed above, the UH Parties have failed to comply with NRS 686A.310(1)(e) by failing to pay Fremont's medical professionals the usual and customary rate for emergency care provided to UH Parties' members. By failing to pay Fremont's medical professionals the usual and customary rate the UH Parties have violated NRS 686A.310(1)(e) and committed an unfair settlement practice.

72. Fremont is therefore entitled to recover the difference between the amount the UH Parties paid for emergency care Fremont rendered to their members and the usual and customary rate, plus court costs and attorneys' fees.

73. Fremont is entitled to damages in an amount in excess of $15,000.00, exclusive of interest, costs and attorneys' fees, the exact amount of which will be proven at the time of trial.

74. The UH Parties have acted in bad faith regarding their obligation to pay the usual and customary fee; therefore, Fremont is entitled to recover punitive damages against the UH Parties.

75. As a direct result of the UH Parties' acts and omissions complained of herein, it has been necessary for Fremont to retain legal counsel and others to prosecute its claims. Fremont is thus entitled to an award of attorneys' fees and costs of suit incurred herein.

FIFTH CLAIM FOR RELIEF

(Violations of Nevada Prompt Pay Statutes & Regulations - UH Parties)

76. Fremont incorporates herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

77. The Nevada Insurance Code requires an HMO, MCO or other health insurer to pay a healthcare provider's claim within 30 days of receipt of a claim. NRS 683A.0879 (third

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party administrator), NRS 689A.410 (Individual Health Insurance), NRS 689B.255 (Group and Blanket Health Insurance), NRS 689C.485 (Health Insurance for Small Employers), NRS 695C.185 (HMO), NAC 686A.675 (all insurers) (collectively, the "NV Prompt Pay Laws"). Thus, for all submitted claims, the UH Parties were obligated to pay Fremont the usual and customary rate within 30 days of receipt of the claim.

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

79. For all claims payable by plans that the UH Parties insure wherein it failed to pay at the usual and customary fee within 30 days, UH Parties is liable to Fremont for penalties as provided for in the Nevada Insurance Code.

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

81. Fremont seeks penalties payable to it for late-paid and partially paid claims under the NV Prompt Pay Laws.

82. Fremont is entitled to damages in an amount in excess of $15,000.00 to be determined at trial, including for its loss of the use of the money and its attorneys' fees.

83. Under the Nevada Insurance Code and NV Prompt Pay Laws, Fremont is also entitled to recover its reasonable attorneys' fees and costs.

SIXTH CLAIM FOR RELIEF

(Consumer Fraud & Deceptive Trade Practices Acts – UH Parties)

84. Fremont incorporates herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

85. The Nevada Deceptive Trade Practices Act (DTPA) prohibits the UH Parties from engaging in "deceptive trade practices," including but not limited to (1) knowingly making

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a false representation in a transaction; (2) violating "a state or federal statute or regulation relating to the sale or lease of goods or services"; (3) using "coercion, duress or intimidation in a transaction"; and (4) knowingly misrepresent the "legal rights, obligations or remedies of a party to a transaction." NRS 598.0915(15), 598.0923(3), 598.0923(4), NRS 598.092(8), respectively.

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

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

88. As a result of the UH Parties' violations of the DTPA and the Consumer Fraud Statute, Fremont is entitled to damages in an amount in excess of $15,000.00 to be determined at trial.

89. Due to the willful and knowing engagement in deceptive trade practices, Fremont is entitled to recover treble damages and all profits derived from the knowing and willful violation.

90. As a direct result of UH Parties' acts and omissions complained of herein, it has been necessary for Fremont to retain legal counsel and others to prosecute its claims. Fremont is thus entitled to an award of attorneys' fees and costs of suit incurred herein.

SEVENTH CLAIM FOR RELIEF

(Declaratory Judgment – All Defendants)

91. Fremont incorporates herein by reference the allegations set forth in the preceding paragraphs as if fully set forth herein.

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

93. As explained above, pursuant to federal and Nevada law, United HealthCare is required to cover and pay Fremont for the medically necessary, covered emergency medicine services Fremont has provided and continues to provide to United HealthCare members.

94. Under Nevada law, United HealthCare is required to pay Fremont the usual and customary rate for that emergency care. Instead of reimbursing Fremont at the usual and customary rate or for the reasonable value of the professional medical services, United HealthCare has reimbursed Fremont at reduced rates with no relation to the usual and customary rate.

95. Beginning in or about July 2017, Fremont became out-of-network with the UH Parties. Since then, the UH Parties have demonstrated their refusal to timely settle insurance claims submitted by Fremont and have failed to pay the usual and customary rate based on this locality in violation of UH Parties' obligations under the Nevada Insurance Code, the parties' implied-in-fact contract and pursuant to Nevada law of unjust enrichment and quantum merit.

96. Beginning in or about March 2019, Fremont became out-of-network with the Sierra Affiliates and HPN. Since then, upon information and belief, the Sierra Affiliates and HPN are failing to timely settle insurance claims submitted by Fremont and to pay the usual and customary rate based on this locality in violation of the Sierra Affiliates' and HPN's obligations under the Nevada Insurance Code, the parties' implied-in-fact contract and pursuant to Nevada law of unjust enrichment and quantum merit.

97. An actual, justiciable controversy therefore exists between the parties regarding the rate of payment for Fremont's emergency care that is the usual and customary rate that United HealthCare is obligated to pay.

98. Pursuant to NRS 30.040 and 30.050, Fremont therefore requests a declaration establishing the usual and customary rates that Fremont is entitled to receive for claims between July 1, 2017 and trial, as well as a declaration that the UH Parties are required to pay to Fremont at a usual and customary rate for claims submitted thereafter.

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

100. As a direct result of United HealthCare's acts and omissions complained of herein, it has been necessary for Fremont to retain legal counsel and others to prosecute its claims. Fremont is thus entitled to an award of attorneys' fees and costs of suit incurred herein.

REQUEST FOR RELIEF

WHEREFORE, Fremont requests the following relief:

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

B. For an award of punitive damages, the exact amount of which will be proven at trial;

C. A Declaratory Judgment that United HealthCare's failure to pay Fremont a usual and customary fee or rate for this locality or alternatively, for the reasonable value of its services violates the Nevada Insurance Code, breaches the parties' implied-in-fact contract, is a tortious breach of the implied covenant of good faith and fair dealing, and violates Nevada common law;

D. An Order permanently enjoining United HealthCare from paying rates that do not represent usual and customary fees or rates for this locality or alternatively, that do not compensate Fremont for the reasonable value of its services; and enjoining United HealthCare from timely paying claims that are not in conformity with Nevada's Prompt Pay statutes and regulations;

E. Reasonable attorneys' fees and court costs;

F. Pre-judgment and post-judgment interest; and

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

...

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...

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JURY DEMAND

Fremont hereby demands trial by jury on all issues so triable.

DATED this 15th day of April, 2019.

McDONALD CARANO LLP

By: /s/ *Pat Lundvall*

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Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
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4820-6308-4435, v. 4

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Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

CASE NO: A-19-792978-C
Department 9

DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiff,

vs.

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

Defendants.

Case No.:
Dept. No.:

INITIAL APPEARANCE FEE DISCLOSURE

(Business Court)

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Pursuant to NRS Chapter 19, as amended by Senate Bill 106, filing fees are submitted for parties appearing in the above entitled action as indicated below:

Fremont Emergency Services (Mandavia), Ltd., Plaintiff	$1,530.00
TOTAL	$1,530.00

DATED this 15th day of April, 2019.

McDONALD CARANO LLP

By: /s/ *Pat Lundvall*

Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
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Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

4812-1265-8324, v. 1

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A-19-792978-B

DISTRICT COURT
CLARK COUNTY, NEVADA

NRS Chapters 78-89 | **COURT MINUTES** | **April 16, 2019**

A-19-792978-B Fremont Emergency Services Mandavia Ltd, Plaintiff(s)
vs.
United Healthcare Insurance Company, Defendant(s)

April 16, 2019 **03:00 AM** **Minute Order**

HEARD BY: Cherry, Michael A. **COURTROOM:**

COURT CLERK: Trujillo, Athena

RECORDER:

REPORTER:

PARTIES PRESENT:

JOURNAL ENTRIES

No parties present.

This matter came before the Court on April 16, 2019. Having reviewed the pleadings, authorities, and exhibits
therein, this Court finds this case would be properly litigated in Specialty Court due to its claims and controversies regarding business matters as defined by E.D.C.R 1.61(a)(1), matters in which the primary claims or issues are based on, or will require decision under N.R.S. Chapters 78-92A. Therefore, pursuant to E.D.C.R. 2.49, the Court ORDERS case A-19-792978-C be sent to Master Calendar for random assignment to an appropriate Business/Specialty Court for determination as to whether the matter should be handled on the specialty docket.

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Electronically Filed
4/16/2019 2:42 PM
Steven D. Grierson
CLERK OF THE COURT

DISTRICT COURT
CLARK COUNTY, NEVADA
****

Fremont Emergency Services Mandavia Ltd, Plaintiff(s) vs. United Healthcare Insurance Company, Defendant(s)	Case No.: A-19-792978-B Department 11

NOTICE OF DEPARTMENT REASSIGNMENT

NOTICE IS HEREBY GIVEN that the above-entitled action has been randomly reassigned to Judge Elizabeth Gonzalez.

☒ This reassignment is due to: Minute Order Re: Business Court Designation Dated 04-16-19.

ANY TRIAL DATE AND ASSOCIATED TRIAL HEARINGS STAND BUT MAY BE RESET BY THE NEW DEPARTMENT.

PLEASE INCLUDE THE NEW DEPARTMENT NUMBER ON ALL FUTURE FILINGS.

STEVEN D. GRIERSON, CEO/Clerk of the Court

By: /s/ Salevao Asifoa
S.L. Asifoa, Deputy Clerk of the Court

CERTIFICATE OF SERVICE

I hereby certify that this 16th day of April, 2019

☒ The foregoing Notice of Department Reassignment was electronically served to all registered parties for case number A-19-792978-B.

/s/ Salevao Asifoa
S.L. Asifoa, Deputy Clerk of the Court

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aperach@mcdonaldcarano.com

Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: A-19-792978-B Dept. No.: 11 **PEREMPTORY CHALLENGE OF JUDGE**

Pursuant to Supreme Court Rule 48.1 and EDCR 1.61(d), plaintiff Fremont Emergency Services (Mandavia), Ltd. files a Notice of Peremptory Challenge of Judge in the above-captioned matter. This case has been assigned to Business Court. *See* Minute Order Re: Business Court

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Designation dated April 16, 2019.

The judge to be challenged is the Honorable Elizabeth Gonzalez.

DATED this 17th day of April, 2019.

McDONALD CARANO LLP

By: /s/ Kristen T. Gallagher

Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
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Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

4814-5128-7444, v. 1

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DISTRICT COURT
CLARK COUNTY, NEVADA
* * * *

FREMONT EMERGENCY SERVICES MANDAVIA LTD, PLAINTIFF(S) VS. UNITED HEALTHCARE INSURANCE COMPANY, DEFENDANT(S)	Case No.: A-19-792978-B DEPARTMENT 27

NOTICE OF DEPARTMENT REASSIGNMENT

NOTICE IS HEREBY GIVEN that the above-entitled action has been randomly reassigned to Judge Nancy Allf.

☒ This reassignment follows the filing of a Peremptory Challenge of Judge Elizabeth Gonzalez.

ANY TRIAL DATE AND ASSOCIATED TRIAL HEARINGS STAND BUT MAY BE RESET BY THE NEW DEPARTMENT. PLEASE INCLUDE THE NEW DEPARTMENT NUMBER ON ALL FUTURE FILINGS.

STEVEN D. GRIERSON, CEO/Clerk of the Court

By:/S/ Ivonne Hernandez
Ivonne Hernandez,
Deputy Clerk of the Court

CERTIFICATE OF SERVICE

I hereby certify that this 17th day of April, 2019

☒ The foregoing Notice of Department Reassignment was electronically served to all registered parties for case number A-19-792978-B.

/S/ Ivonne Hernandez
Ivonne Hernandez
Deputy Clerk of the Court

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Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTHCARE 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 **SUMMONS –** **UMR, INC. dba UNITED MEDICAL RESOURCES**

SUMMONS

NOTICE! YOU HAVE BEEN SUED, THE COURT MAY DECIDE AGAINST YOU WITHOUT YOUR BEING HEARD UNLESS YOU RESPOND WITHIN 31 DAYS. READ THE INFORMATION BELOW.

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TO THE DEFENDANT(S):

UMR, INC. dba UNITED MEDICAL RESOURCES
c/o Nevada Division of Insurance
3300 W. Sahara Avenue, Suite 275
Las Vegas, NV 89102

A civil Complaint has been filed by the Plaintiff against you for the relief set forth in the Complaint.

1. If you intend to defend this lawsuit, within **31 days** after this Summons is served, exclusive of the day of service, you must do the following:

   (a) File with the Clerk of this Court, whose address is shown below, a formal written response to the Complaint in accordance with the rules of the Court, with the appropriate filing fee.
   (b) Serve a copy of your response upon the attorney whose name and address is shown below.

2. Unless you respond, your default will be entered upon application of the Plaintiff(s) and failure to so respond will result in a judgment of default against you for the relief demanded in the Complaint, which could result in the taking of money or property or other relief requested in the Complaint.

3. If you intend to seek the advice of an attorney in this matter, you should do so promptly so that your response may be filed on time.

4. The State of Nevada, its political subdivisions, agencies, officers, employees, board members, commission members and legislators each have 45 days after service of this Summons within which to file an Answer or other responsive pleading to the Complaint.

Submitted by:

McDONALD CARANO LLP

By: /s/ Kristen T. Gallagher
PAT LUNDVALL (NSBN 3761)
KRISTEN T. GALLAGHER (NSBN 9561)
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aperach@mcdonaldcarano.com

Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

STEVEN D. GRIERSON
CLERK OF THE COURT

By: Chaunte Pleasant 4/18/2019
Deputy Clerk Chaunte Pleasant Date
Regional Justice Center
200 Lewis Avenue
Las Vegas, NV 89101

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

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PROOF OF SERVICE

I hereby declare that on this day I served a copy of the Summons and Complaint upon the following defendant in the within matter, by shipping a copy thereof, via Certified mail, return receipt requested, to the following:

UMR, Inc.
Attn: Kristin Erickson
9700 Health Care Ln., MN017-E300
Minnetonka, MN 55343
CERTIFIED MAIL NO. 7018 0680 0002 0258 3262

I declare, under penalty of perjury, that the foregoing is true and correct.

DATED this 22nd day of April, 2019.

RHONDA KELLY
Employee of the State of Nevada
Department of Business and Industry
Division of Insurance

RE: Fremont Emergency Services (Mandavia), Ltd. vs. United Healthcare Insurance Company, et al.
District Court, Clark County, Nevada
Case No. A-19-792978-B

Date: 4/22/19 By:

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aperach@mcdonaldcarano.com

Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTHCARE 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 **SUMMONS –** **UNITED HEALTH CARE SERVICES INC. dba UNITEDHEALTHCARE**

SUMMONS

NOTICE! YOU HAVE BEEN SUED, THE COURT MAY DECIDE AGAINST YOU WITHOUT YOUR BEING HEARD UNLESS YOU RESPOND WITHIN 31 DAYS. READ THE INFORMATION BELOW.

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TO THE DEFENDANT(S):

UNITED HEALTH CARE SERVICES INC. dba UNITEDHEALTHCARE
c/o Nevada Division of Insurance
3300 W. Sahara Avenue, Suite 275
Las Vegas, NV 89102

A civil Complaint has been filed by the Plaintiff against you for the relief set forth in the Complaint.

1. If you intend to defend this lawsuit, within **31 days** after this Summons is served, exclusive of the day of service, you must do the following:

   (a) File with the Clerk of this Court, whose address is shown below, a formal written response to the Complaint in accordance with the rules of the Court, with the appropriate filing fee.
   (b) Serve a copy of your response upon the attorney whose name and address is shown below.

2. Unless you respond, your default will be entered upon application of the Plaintiff(s) and failure to so respond will result in a judgment of default against you for the relief demanded in the Complaint, which could result in the taking of money or property or other relief requested in the Complaint.

3. If you intend to seek the advice of an attorney in this matter, you should do so promptly so that your response may be filed on time.

4. The State of Nevada, its political subdivisions, agencies, officers, employees, board members, commission members and legislators each have 45 days after service of this Summons within which to file an Answer or other responsive pleading to the Complaint.

Submitted by:

McDONALD CARANO LLP

By: /s/ Kristen T. Gallagher
PAT LUNDVALL (NSBN 3761)
KRISTEN T. GALLAGHER (NSBN 9561)
AMANDA M. PERACH (NSBN 12399)
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kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

STEVEN D. GRIERSON
CLERK OF THE COURT

By: Chaunté Pleasant 4/18/2019
Deputy Clerk Chaunte Pleasant Date
Regional Justice Center
200 Lewis Avenue
Las Vegas, NV 89101

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

PROOF OF SERVICE

I hereby declare that on this day I served a copy of the Summons and Complaint upon the following defendant in the within matter, by shipping a copy thereof, via Certified mail, return receipt requested, to the following:

United Healthcare Services, Inc.
Attn: Kristin Erickson
9700 Health Care Ln., MN017-E300
Minnetonka, MN 55343
CERTIFIED MAIL NO. 7018 0680 0002 0258 3279

I declare, under penalty of perjury, that the foregoing is true and correct.

DATED this 22nd day of April, 2019.

RHONDA KELLY
Employee of the State of Nevada
Department of Business and Industry
Division of Insurance

RE: Fremont Emergency Services (Mandavia), Ltd. vs. United Healthcare Insurance Company, et al.
District Court, Clark County, Nevada
Case No. A-19-792978-B

Date: 4/22/19 By:

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kgallagher@mcdonaldcarano.com
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Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTHCARE 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 **SUMMONS –** **UNITED HEALTHCARE INSURANCE COMPANY**

SUMMONS

NOTICE! YOU HAVE BEEN SUED, THE COURT MAY DECIDE AGAINST YOU WITHOUT YOUR BEING HEARD UNLESS YOU RESPOND WITHIN 31 DAYS. READ THE INFORMATION BELOW.

012458
012458

TO THE DEFENDANT(S):

UNITED HEALTHCARE INSURANCE COMPANY
c/o Nevada Division of Insurance
3300 W. Sahara Avenue, Suite 275
Las Vegas, NV 89102

A civil Complaint has been filed by the Plaintiff against you for the relief set forth in the Complaint.

1. If you intend to defend this lawsuit, within **31 days** after this Summons is served, exclusive of the day of service, you must do the following:

   (a) File with the Clerk of this Court, whose address is shown below, a formal written response to the Complaint in accordance with the rules of the Court, with the appropriate filing fee.
   (b) Serve a copy of your response upon the attorney whose name and address is shown below.

2. Unless you respond, your default will be entered upon application of the Plaintiff(s) and failure to so respond will result in a judgment of default against you for the relief demanded in the Complaint, which could result in the taking of money or property or other relief requested in the Complaint.

3. If you intend to seek the advice of an attorney in this matter, you should do so promptly so that your response may be filed on time.

4. The State of Nevada, its political subdivisions, agencies, officers, employees, board members, commission members and legislators each have 45 days after service of this Summons within which to file an Answer or other responsive pleading to the Complaint.

Submitted by:

McDONALD CARANO LLP

By: /s/ Kristen T. Gallagher
PAT LUNDVALL (NSBN 3761)
KRISTEN T. GALLAGHER (NSBN 9561)
AMANDA M. PERACH (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
Facsimile: (702) 873-9966
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

STEVEN D. GRIERSON
CLERK OF THE COURT

By: Chaunte Pleasant 4/18/2019
Deputy Clerk Chaunte Pleasant Date
Regional Justice Center
200 Lewis Avenue
Las Vegas, NV 89101

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

012459 012459 012459

PROOF OF SERVICE

I hereby declare that on this day I served a copy of the Summons and Complaint upon the following defendant in the within matter, by shipping a copy thereof, via Certified mail, return receipt requested, to the following:

United Healthcare Insurance Company
Attn: Kristin Erickson
185 Asylum St.
Hartford, CT 06103
CERTIFIED MAIL NO. 7018 0680 0002 0258 3286

I declare, under penalty of perjury, that the foregoing is true and correct.

DATED this 22nd day of April, 2019.

RHONDA KELLY
Employee of the State of Nevada
Department of Business and Industry
Division of Insurance

RE: Fremont Emergency Services (Mandavia), Ltd. vs. United Healthcare Insurance Company, et al.
District Court, Clark County, Nevada
Case No. A-19-792978-B

Date 4/22/19 By

012460

012460

012460

AOS
PAT LUNDVALL (NSBN 3761)
KRISTEN T. GALLAGHER (NSBN 9561) AMANDA M. PERACH (NSBN 12399) McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200 Las Vegas, Nevada 89102
Telephone: (702) 873-4100
Facsimile: (702) 873-9966
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTHCARE 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 **SUMMONS –** **HEALTH PLAN OF NEVADA, INC.**

SUMMONS

NOTICE! YOU HAVE BEEN SUED, THE COURT MAY DECIDE AGAINST YOU WITHOUT YOUR BEING HEARD UNLESS YOU RESPOND WITHIN 21 DAYS. READ THE INFORMATION BELOW.

012461
012461

TO THE DEFENDANT(S):

HEALTH PLAN OF NEVADA, INC.
CT Corporation System-Registered Agent
701 South Carson Street, Suite 200
Carson City, Nevada 89701

A civil Complaint has been filed by the Plaintiff against you for the relief set forth in the Complaint.

1. If you intend to defend this lawsuit, within **21 days** after this Summons is served on you, exclusive of the day of service, you must do the following:

   (a) File with the Clerk of this Court, whose address is shown below, a formal written response to the Complaint in accordance with the rules of the Court, with the appropriate filing fee.
   (b) Serve a copy of your response upon the attorney whose name and address is shown below.

2. Unless you respond, your default will be entered upon application of the Plaintiff(s) and failure to so respond will result in a judgment of default against you for the relief demanded in the Complaint, which could result in the taking of money or property or other relief requested in the Complaint.

3. If you intend to seek the advice of an attorney in this matter, you should do so promptly so that your response may be filed on time.

4. The State of Nevada, its political subdivisions, agencies, officers, employees, board members, commission members and legislators each have 45 days after service of this Summons within which to file an Answer or other responsive pleading to the Complaint.

Submitted by:

McDONALD CARANO LLP

By: /s/ Kristen T. Gallagher
PAT LUNDVALL (NSBN 3761)
KRISTEN T. GALLAGHER (NSBN 9561)
AMANDA M. PERACH (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
Facsimile: (702) 873-9966
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

STEVEN D. GRIERSON
CLERK OF THE COURT

By: Chaunté Pleasant 4/18/2019
Deputy Clerk Chaunte Pleasant Date
Regional Justice Center
200 Lewis Avenue
Las Vegas, NV 89101

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

012462

012462

012462

STATE OF NEVADA)
) ss.
COUNTY OF WASHOE)

DECLARATION OF SERVICE

Robert Deale, declares and says: That at all times herein declarant was and is a citizen of the United States, over 18 years of age, not a party to nor interested in the proceedings in which this declaration is made, and is licensed to serve process in Nevada under License #1088. That declarant received 1 copy(ies) of the **SUMMONS and COMPLAINT** in Case No. **A-19-792978-B** on the 22nd day of April, 2019 and served the same at **12:35 PM** on the 23rd day of April, 2019 by:

(Declarant must complete the appropriate paragraph)

1. delivering and leaving a copy with the defendant _____ at _____

2. serve the defendant _____ by personally delivering and leaving a copy with _____, a person of suitable age and discretion residing at the defendant's usual place of abode located at _____

(Use paragraph 3 for serve upon agent, completing A or B)

3. serving the defendant HEALTH PLAN OF NEVADA, INC. by personally delivering and leaving a copy at The Corporation Trust Company of Nevada, Registered Agent, 701 S. Carson St, Suite 200, Carson City, Nevada 89701

a. With Danielle Naki as Admin., an agent lawfully designated by statute to accept service of process;

b. With _____, pursuant to NRS 14.020 as a person of suitable age and discretion at the above address, which address is the address of the registered agent as shown on the current certificate of designation filed with the Secretary of State.

4. personally depositing a copy in a mail box of the United States Post Office, enclosed in a sealed envelope postage prepaid (check appropriate method):

_____ ordinary mail
_____ certified mail, return receipt requested
_____ registered mail, return receipt requested

addressed to the defendant _____ at the defendant's last known address which is _____

Per NRS 53.045: I declare under penalty of perjury that the foregoing is true and correct.

Executed on: April 23, 2019.

Signature of Process Server, Robert Deale

American Process Service
10580 N. McCarran Blvd., Suite 115-130
Reno, Nevada 89503
775-337-1117
Nevada License 1088A

012463

012463

AOS
PAT LUNDVALL (NSBN 3761)
KRISTEN T. GALLAGHER (NSBN 9561)
AMANDA M. PERACH (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
Facsimile: (702) 873-9966
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTHCARE 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 **SUMMONS –** **SIERRA HEALTH-CARE OPTIONS, INC.**

SUMMONS

NOTICE! YOU HAVE BEEN SUED, THE COURT MAY DECIDE AGAINST YOU WITHOUT YOUR BEING HEARD UNLESS YOU RESPOND WITHIN 21 DAYS. READ THE INFORMATION BELOW.

012464

012464

TO THE DEFENDANT(S):

SIERRA HEALTH-CARE OPTIONS, INC.
CT Corporation System-Registered Agent
701 South Carson Street, Suite 200
Carson City, Nevada 89701

A civil Complaint has been filed by the Plaintiff against you for the relief set forth in the Complaint.

1. If you intend to defend this lawsuit, within **21 days** after this Summons is served on you, exclusive of the day of service, you must do the following:

   (a) File with the Clerk of this Court, whose address is shown below, a formal written response to the Complaint in accordance with the rules of the Court, with the appropriate filing fee.
   (b) Serve a copy of your response upon the attorney whose name and address is shown below.

2. Unless you respond, your default will be entered upon application of the Plaintiff(s) and failure to so respond will result in a judgment of default against you for the relief demanded in the Complaint, which could result in the taking of money or property or other relief requested in the Complaint.

3. If you intend to seek the advice of an attorney in this matter, you should do so promptly so that your response may be filed on time.

4. The State of Nevada, its political subdivisions, agencies, officers, employees, board members, commission members and legislators each have 45 days after service of this Summons within which to file an Answer or other responsive pleading to the Complaint.

Submitted by:

McDONALD CARANO LLP

By: /s/ Kristen T. Gallagher
PAT LUNDVALL (NSBN 3761)
KRISTEN T. GALLAGHER (NSBN 9561)
AMANDA M. PERACH (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
Facsimile: (702) 873-9966
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

STEVEN D. GRIERSON
CLERK OF THE COURT

By: Chaunté Pleasant 4/18/2019
Deputy Clerk Chaunte Pleasant Date
Regional Justice Center
200 Lewis Avenue
Las Vegas, NV 89101

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

012465

012465

012465

STATE OF NEVADA)
) ss.
COUNTY OF WASHOE)

DECLARATION OF SERVICE

Robert Deale, declares and says: That at all times herein declarant was and is a citizen of the United States, over 18 years of age, not a party to nor interested in the proceedings in which this declaration is made, and is licensed to serve process in Nevada under License #1088. That declarant received 1 copy(ies) of the SUMMONS and COMPLAINT in Case No. A-19-792978-B on the 22nd day of April, 2019 and served the same at 12:35 PM on the 23rd day of April, 2019 by:

(Declarant must complete the appropriate paragraph)

1. delivering and leaving a copy with the defendant _____ at _____

2. serve the defendant _____ by personally delivering and leaving a copy with _____, a person of suitable age and discretion residing at the defendant's usual place of abode located at _____

(Use paragraph 3 for serve upon agent, completing A or B)

3. serving the defendant SIERRA HEALTH-CARE OPTIONS, INC. by personally delivering and leaving a copy at The Corporation Trust Company of Nevada, Registered Agent, 701 S. Carson St, Suite 200, Carson City, Nevada 89701

a. With Danielle Naki as Admin., an agent lawfully designated by statute to accept service of process;

b. With _____, pursuant to NRS 14.020 as a person of suitable age and discretion at the above address, which address is the address of the registered agent as shown on the current certificate of designation filed with the Secretary of State.

4. personally depositing a copy in a mail box of the United States Post Office, enclosed in a sealed envelope postage prepaid (check appropriate method):

_____ ordinary mail
_____ certified mail, return receipt requested
_____ registered mail, return receipt requested

addressed to the defendant _____ at the defendant's last known address which is _____

Per NRS 53.045: I declare under penalty of perjury that the foregoing is true and correct.

Executed on: April 23, 2019.

Signature of Process Server, Robert Deale

American Process Service
10580 N. McCarran Blvd., Suite 115-130
Reno, Nevada 89503
775-337-1117
Nevada License 1088A

012466

012466

AOS

PAT LUNDVALL (NSBN 3761)
KRISTEN T. GALLAGHER (NSBN 9561)
AMANDA M. PERACH (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
Facsimile: (702) 873-9966
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTHCARE 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 **SUMMONS –** **SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.**

SUMMONS

NOTICE! YOU HAVE BEEN SUED, THE COURT MAY DECIDE AGAINST YOU WITHOUT YOUR BEING HEARD UNLESS YOU RESPOND WITHIN 21 DAYS. READ THE INFORMATION BELOW.

012467
012467

TO THE DEFENDANT(S):

SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.
CT Corporation System-Registered Agent
701 South Carson Street, Suite 200
Carson City, Nevada 89701

A civil Complaint has been filed by the Plaintiff against you for the relief set forth in the Complaint.

1. If you intend to defend this lawsuit, within **21 days** after this Summons is served on you, exclusive of the day of service, you must do the following:
   (a) File with the Clerk of this Court, whose address is shown below, a formal written response to the Complaint in accordance with the rules of the Court, with the appropriate filing fee.
   (b) Serve a copy of your response upon the attorney whose name and address is shown below.

2. Unless you respond, your default will be entered upon application of the Plaintiff(s) and failure to so respond will result in a judgment of default against you for the relief demanded in the Complaint, which could result in the taking of money or property or other relief requested in the Complaint.

3. If you intend to seek the advice of an attorney in this matter, you should do so promptly so that your response may be filed on time.

4. The State of Nevada, its political subdivisions, agencies, officers, employees, board members, commission members and legislators each have 45 days after service of this Summons within which to file an Answer or other responsive pleading to the Complaint.

Submitted by:

McDONALD CARANO LLP

By: /s/ Kristen T. Gallagher
PAT LUNDVALL (NSBN 3761)
KRISTEN T. GALLAGHER (NSBN 9561)
AMANDA M. PERACH (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
Facsimile: (702) 873-9966
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

STEVEN D. GRIERSON
CLERK OF THE COURT

By: Chaunté Pleasant 4/18/2019
Deputy Clerk Chaunte Pleasant Date
Regional Justice Center
200 Lewis Avenue
Las Vegas, NV 89101

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

012468

012468

012468

STATE OF NEVADA)
) ss.
COUNTY OF WASHOE)

DECLARATION OF SERVICE

Robert Deale, declares and says: That at all times herein declarant was and is a citizen of the United States, over 18 years of age, not a party to nor interested in the proceedings in which this declaration is made, and is licensed to serve process in Nevada under License #1088. That declarant received 1 copy(ies) of the SUMMONS and COMPLAINT in Case No. A-19-792978-B on the 22nd day of April, 2019 and served the same at 12:35 PM on the 23rd day of April, 2019 by:

(Declarant must complete the appropriate paragraph)

1. delivering and leaving a copy with the defendant _____ at _____

2. serve the defendant _____ by personally delivering and leaving a copy with _____, a person of suitable age and discretion residing at the defendant's usual place of abode located at _____

(Use paragraph 3 for serve upon agent, completing A or B)

3. serving the defendant SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC. by personally delivering and leaving a copy at The Corporation Trust Company of Nevada, Registered Agent, 701 S. Carson St, Suite 200, Carson City, Nevada 89701

a. With Danielle Naki as Admin., an agent lawfully designated by statute to accept service of process;

b. With _____, pursuant to NRS 14.020 as a person of suitable age and discretion at the above address, which address is the address of the registered agent as shown on the current certificate of designation filed with the Secretary of State.

4. personally depositing a copy in a mail box of the United States Post Office, enclosed in a sealed envelope postage prepaid (check appropriate method):

_____ ordinary mail
_____ certified mail, return receipt requested
_____ registered mail, return receipt requested

addressed to the defendant _____ at the defendant's last known address which is _____

Per NRS 53.045: I declare under penalty of perjury that the foregoing is true and correct.

Executed on: April 23, 2019.

Signature of Process Server, Robert Deale

American Process Service
10580 N. McCarran Blvd., Suite 115-130
Reno, Nevada 89503
775-337-1117
Nevada License 1088A

012469
012469
012469

AOS
PAT LUNDVALL (NSBN 3761)
KRISTEN T. GALLAGHER (NSBN 9561)
AMANDA M. PERACH (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
Facsimile: (702) 873-9966
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation, Plaintiff, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTHCARE 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 **SUMMONS –** **OXFORD HEALTH PLANS, INC.**

SUMMONS

NOTICE! YOU HAVE BEEN SUED, THE COURT MAY DECIDE AGAINST YOU WITHOUT YOUR BEING HEARD UNLESS YOU RESPOND WITHIN 21 DAYS. READ THE INFORMATION BELOW.

012470
012470

TO THE DEFENDANT(S):

OXFORD HEALTH PLANS, INC.
Corporation Trust Center – Registered Agent
1209 Orange Street
Wilmington, Delaware 19801

A civil Complaint has been filed by the Plaintiff against you for the relief set forth in the Complaint.

1. If you intend to defend this lawsuit, within **21 days** after this Summons is served on you, exclusive of the day of service, you must do the following:

   (a) File with the Clerk of this Court, whose address is shown below, a formal written response to the Complaint in accordance with the rules of the Court, with the appropriate filing fee.

   (b) Serve a copy of your response upon the attorney whose name and address is shown below.

2. Unless you respond, your default will be entered upon application of the Plaintiff(s) and failure to so respond will result in a judgment of default against you for the relief demanded in the Complaint, which could result in the taking of money or property or other relief requested in the Complaint.

3. If you intend to seek the advice of an attorney in this matter, you should do so promptly so that your response may be filed on time.

4. The State of Nevada, its political subdivisions, agencies, officers, employees, board members, commission members and legislators each have 45 days after service of this Summons within which to file an Answer or other responsive pleading to the Complaint.

Submitted by:

McDONALD CARANO LLP

By: /s/ Kristen T. Gallagher
PAT LUNDVALL (NSBN 3761)
KRISTEN T. GALLAGHER (NSBN 9561)
AMANDA M. PERACH (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
Facsimile: (702) 873-9966
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiff Fremont Emergency Services (Mandavia), Ltd.

STEVEN D. GRIERSON
CLERK OF THE COURT

By: Chaunté Pleasant 4/18/2019
Deputy Clerk Chaunte Pleasant Date
Regional Justice Center
200 Lewis Avenue
Las Vegas, NV 89101

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

AFFIDAVIT OF SERVICE

State of Nevada **County of Clark** **District Court**

Case Number: A-19-792978-B

Plaintiff:
FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation
vs.
Defendants:
UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; et al.

Received by Bullet Legal Services on the 19th day of April, 2019 at 10:17 am to be served on **OXFORD HEALTH PLANS, INC., c/o Corporation Trust Center, 1209 Orange Street, Wilmington, DE 19801.** I, DENORRIS BRITT, being duly sworn, depose and say that on the 25 day of APRIL, 2019 at 1230 pm., executed service by delivering a true copy of the **SUMMONS and COMPLAINT** in accordance with state statutes in the manner marked below:

(X) CORPORATION: By serving AMY MCLAREN as MANAGING AGENT, an agent designated by statute to accept service of process.
( ) RECORDS CUSTODIAN: By serving _____ as _____, an agent designated by statute to accept service of process.
( ) PUBLIC AGENCY: By serving _____ as _____ of the within-named agency.
( ) OTHER SERVICE: As described in the Comment below by serving _____ as _____, who stated they were authorized to accept.
( ) NON SERVICE: For the reasons detailed in the Comments below.

COMMENTS: _____

Age 40 Sex X M F Race WHITE Height 5'5 Weight 130 Hair BROWN Glasses X N

AFFIDAVIT OF SERVICE For A-19-792978-B

I certify that I have no interest in the above action, am of legal age and have proper authority in the jurisdiction in which this service was made.

012473

State of DE

County of NEW CASTLE

Subscribed and Sworn to before me on the 25 day of APRIL 2019 by the affiant who is personally known to me.

NOTARY PUBLIC

KEVIN DUNN
NOTARY PUBLIC
STATE OF DELAWARE
My Commission Expires September 14, 2020

DENORRIS BRITT
PROCESS SERVER # 1958
Appointed in accordance with State Statutes

Bullet Legal Services
1930 Village Center Circle, #3-965
Las Vegas, NV 89134
(702) 823-1000

Our Job Serial Number: 2019001243

012473

EXHIBIT 4

012474

012474

EXHIBIT 4

D. Lee Roberts, Jr., Esq.
Nevada Bar No. 8877
lroberts@wwhgd.com
Colby L. Balkenbush, Esq.
Nevada Bar No. 13066
cbalkenbush@wwhgd.com
Josephine E. Groh, Esq.
Nevada Bar No. 14209
jgroh@wwhgd.com
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
Facsimile: (702) 938-3864

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

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

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

Plaintiff,

vs.

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

Defendants.

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

DEFENDANTS' OPPOSITION TO FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.'S MOTION TO REMAND

Defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services, Inc. ("UHS"), UMR, Inc. ("UMR"), Oxford Health Plans, Inc. ("Oxford"), Sierra Health and Life Insurance Co., Inc. ("SHL"), Sierra Health-Care Options, Inc. ("SHO"), and Health Plan of Nevada, Inc. ("HPN") (collectively "Defendants"), hereby oppose Fremont Emergency Services (Mandavia), Ltd.'s ("Fremont") Motion to Remand (ECF No. 5).

I. INTRODUCTION

Fremont argues that so long as its claims involve the "rate of payment" rather than the "right to payment" complete preemption under ERISA does not apply. This is a misreading of the case law. There are only two issues the Court must decide here pursuant to the *Davila* Test. First, does Fremont have standing to bring a statutory ERISA claim? Second, do Fremont's allegations give rise to any legal duties on the part of Defendants that are independent of Defendants' legal duties under the ERISA plans?

The first element of the *Davila* Test is met as Fremont received an assignment of benefits from Defendants' plan members that allows it to stand in their shoes and bring the same ERISA claims those members could have brought. Contrary to Fremont's contentions, the only question is whether Fremont *could* have brought an ERISA claim, not whether it actually pled such a claim in its Complaint.

The second element of the *Davila* Test is also met as Fremont has failed to allege any facts that give rise to a legal duty independent of ERISA. Fremont is an out-of-network provider that lacks a written contract with Defendants, lacks a Nevada statute requiring a specific rate of payment and lacks any oral promise by Defendants to pay a particular rate. Thus, the only legal duties Defendants owe to Fremont (if any) flow from the terms of the ERISA plans and the assignments that Fremont received from Defendants' plan members.

Every single "rate of payment" case that Fremont cites where courts found that complete preemption did not occur involved (1) providers who failed to receive an assignment of benefits from the plan members and thus lacked standing to bring an ERISA claim (i.e. element 1 of *Davila* Test was not met), (2) providers who had an express written agreement with the plan administrator/insurer that created an independent legal duty (element 2 of *Davila* Test was not

met), (3) a special state statute requiring a particular rate of payment to out-of-network providers that created an independent legal duty (element 2 of *Davila* Test was not met) or (4) an oral promise by the plan administrator/insurer to the provider that created an independent legal duty (element 2 of *Davila* Test was not met). Since it is undisputed that none of these facts are present here, the *Davila* Test is met and all of Fremont's state law claims are completely preempted by ERISA.

A close reading of the case law in both this Opposition and Fremont's Motion favors Defendants' position.[1] For example, Fremont argues that Defendants[2] have removed on these same grounds before only to have those cases remanded. However, the UnitedHealthcare cases Fremont refers to only reinforce why complete preemption is appropriate under the facts of this case. In *Gulf-to-Bay*,[3] the second element of the *Davila* Test was not met because a Florida statute created a legal duty independent of ERISA to pay out-of-network providers at a particular rate. Here, Fremont admits that Nevada does not have a rate of payment statute and thus Defendants have no legal duty independent of their duties under the ERISA plans. Similarly, in *Low-T Physicians Service*[4] the second element of the *Davila* Test was also not met because the medical provider had an express written provider agreement with United Healthcare which gave rise to a duty independent of the ERISA plan. Here, Fremont admits it is an out-of-network provider that lacks a written agreement with Defendants that would give rise to an independent duty. For all these reasons and those set forth below, Defendants have satisfied both elements of the *Davila* Test and Fremont's Motion to Remand should be denied.

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[1] While a large portion of this Opposition sets forth the basic legal framework governing complete preemption, the case law in **Sections IV(C) and (D)** is particularly instructive and demonstrates the Fremont's "rate of payment" argument does not fit the facts of this case.

[2] Fremont is incorrect in claiming that the Defendants in this case were the same as those in the *Gulf-to-Bay* and *Low-T Physicians* cases. Most of the defendants in those cases were different United Healthcare affiliates than those who are Defendants in this matter.

[3] *Gulf-to-Bay Anesthesiology Assoc., LLC, v. UnitedHealthcare of Florida, Inc.*, No. 8:18-cv-00233-EAK-AAS, 2018 WL 3640405 (M.D. Fla. July 20, 2018).

[4] *Low-T Physicians Service, P.L.L.C. v. United HealthCare of Texas, Inc. et. al.*, No. 4:18-cv-00938-A, 2019 WL 935800 (N.D. Tex. Feb. 26, 2019).

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II. KEY FACTS OUTSIDE OF FREMONT'S COMPLAINT SUPPORT DENYING THE MOTION TO REMAND BECAUSE THEY DEMONSTRATE THAT ELEMENT 1 OF THE *DAVILA* TEST IS MET

A. Defendants Are Entitled to Introduce Evidence Outside the Four Corners of Fremont's Complaint In Order to Establish that Fremont's Claims Are Completely Preempted by ERISA

Under the "well-pleaded complaint" rule a plaintiff ordinarily is entitled to remain in state court if its complaint does not, on its face, affirmatively allege a federal claim. However, complete preemption under ERISA is an exception to this rule. *Beneficial Nat. Bank v. Anderson*, 539 U.S. 1, 6, 123 S. Ct. 2058, 2062 (2003). Federal courts are "not bound by the labels used in the complaint . . . merely referring to labels affixed to claims to distinguish between preempted and non-preempted claims is not helpful because doing so would elevate form over substance and allow parties to evade the pre-emptive scope of ERISA.'" *Gables Ins. Recovery, Inc. v. Blue Cross & Blue Shield of Florida, Inc.*, 813 F.3d 1333, 1337 n.2 (11th Cir. Dec. 1, 2015) (internal quotation omitted). Thus, when considering whether complete preemption is present, federal courts regularly consider evidence outside of the complaint to determine the true nature of a plaintiff's claims. *See e.g., Connecticut State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1351 (11th Cir. 2009) (considering affidavits and claims forms that were submitted to show that the plaintiffs had received an assignment of benefits from the plan members and thus had standing to sue under ERISA, meaning at least some of the claims asserted were subject to complete preemption).

Fremont argues that the Court's analysis should be limited to the allegations in the Complaint, but the cases it cites are inapposite. *See* Motion at p. 6. Fremont cites to *Beneficial* for the proposition that, when there is no diversity jurisdiction, "a case will not be removable if the complaint does not affirmatively allege a federal claim." *Beneficial Nat. Bank,* 539 U.S. at 6, 123 S. Ct. at 2062. This cherry picked quote misses the entire holding of *Beneficial*. After stating this general rule, the U.S. Supreme Court went on to hold that the doctrine of complete preemption is an exception to this rule and therefore the plaintiff's complaint could be removed to federal court even though it only alleged state law claims. *Id.* at 11, 123 S. Ct. at 2064.

Fremont cites to *Edwards* for the proposition that, "under the well-pleaded complaint rule, federal question jurisdiction exists only when a plaintiff pleads a cause of action that arises under federal law." Motion at p. 6, n. 2. However, Fremont leaves out that *Edwards* also states that complete preemption under ERISA is a firmly established exception to the well-pleaded complaint rule. *Edwards v. BQ Resorts, LLC*, No. 216CV01649JADVCF, 2016 WL 6905378, at *2 (D. Nev. Nov. 23, 2016) (unpublished). Remand was granted in *Edwards* because the defendant argued that the Telephone Consumer Protection Act ("TCPA") completely preempted the plaintiff's state law claims but, in contrast to ERISA, the U.S. Supreme Court has never recognized the TCPA as a completely preemptive federal statute. *Id.*

Fremont cites to *Caterpillar* for the proposition that "a defendant cannot, merely by injecting a federal question into an action that asserts what is plainly a state-law claim, transform the action into one arising under federal law, thereby selecting the forum in which the claim shall be litigated." *Caterpillar Inc. v. Williams*, 482 U.S. 386, 399, 107 S. Ct. 2425, 2433 (1987). However, this is another statement taken out of context as the Court was only discussing the rule that a defense of federal preemption under the Labor Management Relations Act does not create a basis for removal. Defendants have no quarrel with this argument. This is similar to the doctrine under ERISA that a defense of conflict preemption does not create a basis for removal whereas complete preemption does. *See Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 946 (9th Cir. 2009). Again, Defendants removed based on complete preemption, not a defense of conflict preemption.

In sum, this Court is not limited to the four corners of Fremont's Complaint in assessing whether that Complaint raises a federal question and is subject to complete preemption.

B. Over 90 Percent of Fremont's Requests for Reimbursement to Defendants Relate to Employee Benefit Plans Governed by ERISA.

Fremont's Complaint does not identify the plan members it treated or the health plans at issue. Rather, the threadbare Complaint only identifies the time frame during which Fremont provided medical services to Defendants' members and submitted claims/requests for payment to Defendants. Complaint at ¶¶ 19-20, 25. Moreover, in an implicit admission that it is engaging in

artful pleading to avoid preemption and removal to federal court, when Counsel for Defendants requested that Fremont provide additional information so that Defendants could determine whether this suit is governed by ERISA, Fremont's counsel refused.[5]

Despite Fremont's stonewalling, Defendants have determined that nearly all of Fremont's claims for payment relate to employee benefit plans (i.e. employer sponsored health plans) that are governed by ERISA and are thus completely preempted. During the time frames discussed in the Complaint, Fremont made claims/requests for payment to the following Defendants: UHIC, UHS, UMR, Oxford, SHL, HPN, and SHO. For the tens of thousands of claims that Fremont submitted to UHIC, UHS and UMR, all but one of the claims were made against employee benefit plans.[6] For the claims that Fremont made against Oxford and SHO, all of the claims were made against employee benefit plans.[7] For the claims that Fremont made against SHL, approximately 72% of the claims were made against employee benefit plans.[8] For the claims that Fremont made against HPN, approximately 84% of the claims were made against employee benefit plans.[9] Taking into account all of Fremont's claims/requests for payment, over 90% were for services provided to members of employee benefit plans governed by ERISA. Fremont has not contested this key fact in its Motion to Remand.

C. For all of the Claims Fremont is Asserting, it Received an Assignment of Benefits from Defendants' Plan Members.

For all of the claims that Fremont is asserting in this litigation, Fremont received an assignment of benefits from the plan member such that Fremont now stands in the shoes of that plan member and may assert a claim for reimbursement.[10] Critically, Fremont's Motion to

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[5] *See* **Exhibit 1** (May 9, 2019 email from Counsel for Fremont to Defendants' Counsel).
[6] **Exhibit 2** at ¶ 7 (UHIC, UHS and UMR Declaration).
[7] **Exhibit 3** at ¶ 7 (Oxford Declaration); **Exhibit 4** at ¶ 7 (SHO Declaration).
[8] **Exhibit 5** at ¶ 7 (SHL and HPN Declaration).
[9] *Id.* at ¶ 8.

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

Remand does not challenge that it received an assignment of benefits for every single claim it is asserting. As discussed in more detail below, the plan members' assignments of benefits to Fremont is significant because it means Fremont has standing to bring a claim under ERISA § 502(a)(1)(B), ERISA's civil enforcement statute, and thus the first element of the *Davila* Test is met.

III. KEY ADMISSIONS AND OMISSIONS IN FREMONT'S COMPLAINT SUPPORT DENYING THE MOTION TO REMAND BECAUSE THEY DEMONSTRATE THAT ELEMENT 2 OF THE *DAVILA* TEST IS MET.

Fremont admits that it does not have a written provider agreement with any of the Defendants. Complaint at ¶ 17. Fremont further admits that it is a "non-participating" or "out-of-network" provider. *Id.* Fremont also fails to cite a single Nevada statute that either (1) requires plan administrators/insurers to pay out-of-network providers or (2) requires a particular rate of payment to out-of-network providers. *See generally* Complaint. Fremont does cite to the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd and NRS 439B.410. 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 or say anything about the required rate of payment.

Fremont also alleges that "Fremont was entitled to and expected to be paid at rates in accordance with the standards established under Nevada law." Complaint at ¶ 36. However, Fremont's allegation is vague for a reason—no such statute exists in Nevada.[11] Finally, Fremont's Complaint is devoid of any allegation of an oral representation by Defendants that they would pay Fremont a particular rate for its services. *See generally id.* Rather, the only

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Fremont also received an assignment of benefits for those claims but have not attached those claim forms to avoid overburdening the Court. However, those claim forms can be produced if necessary.

[11] A special statutory rate of payment scheme did pass in the 2019 Nevada Legislative Session but the scheme will not go into effect until January 1, 2020 and is not retroactively applicable to this case. **Exhibit 8** (article in the Nevada Independent discussing the passage of AB 469 and previous failed attempts to pass similar legislation regarding the rate of payment to out-of-network providers); *see also* AB 469 at § 29(2) (2019 Nevada Legislative Session) (stating that law does not go into effect until January 1, 2020).

allegation is that through Defendants' past conduct of paying for certain medical services that Fremont provided to Defendants' plan members, an implied-in-fact contract was created. *Id.* at ¶¶ 35, 37, 38.

The above admissions and omissions are critical as they demonstrate that there is no legal duty independent of ERISA on which Fremont can rely and thus element 2 of the *Davila* Test is met. As discussed more fully below, courts have held that where (1) an out-of-network medical provider lacks an express written provider agreement with the plan administrator/insurer, (2) lacks a special state statute requiring a particular rate of payment to out-of-network providers, and (3) lacks any allegation of an oral promise to pay a particular rate by the insurer/plan administrator, there is no legal duty independent of ERISA and thus the providers' rate of payment claims are completely preempted.

Courts have never found that federal and state statutes requiring hospitals to provide emergency services to *patients* create a legal duty on the part of plan administrators/insurers that is independent of ERISA. Nor have courts founds that a plan administrator/insurer's mere payment to an out-of-network provider for some of the services it provided to the administrator/insurer's plan members creates a legal duty independent of ERISA.

IV. DEFENDANTS HAVE SATISFIED BOTH ELEMENTS OF THE *DAVILA* TEST AND THUS ALL OF FREMONT'S CLAIMS ARE SUBJECT TO COMPLETE PREEMPTION

A. Legal Standard for a Motion to Remand

"The burden of establishing federal jurisdiction is upon the party seeking removal and the removal statute is strictly construed against removal jurisdiction." *Emrich v. Touche Ross & Co.*, 846 F.2d 1190, 1195 (9th Cir. 1988). Nonetheless, a defendant only needs to prove that removal was proper by a "preponderance of the evidence." *Selimaj v. City of Henderson*, No. 02:08-CV-00441LRHLRL, 2008 WL 979045, at *1 (D. Nev. Apr. 9, 2008) (applying preponderance of the evidence standard to a federal question removal); *Cerros v. N. Las Vegas Police Dep't*, No. 02:06CV00647LRH-PAL, 2006 WL 3257164, at *1 (D. Nev. Nov. 9, 2006) (same).

B. The Doctrine of Complete Preemption and the Consequences of a Finding of Complete Preemption

The doctrine of complete preemption applies when a federal statute so completely dominates a particular area that any state law claims are converted into an action arising under federal law. *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63–64, 107 S. Ct. 1542, 1546 (1987). One area where this doctrine applies is with certain claims related to employee benefit plans, such as employer sponsored health insurance. The Employee Retirement Income Security Act ("ERISA") is a "comprehensive legislative scheme" enacted to protect the interests of participants and beneficiaries in these employee benefit plans and completely preempts state law claims. 29 U.S.C. § 1001(b); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004).

As part of ERISA's comprehensive scheme, Congress created a special civil enforcement mechanism to deal with all claims related to employee benefit plans.[12] That mechanism is set forth in 29 U.S.C. § 1132(a)[13] and permits a "participant or beneficiary" to bring a special statutory ERISA claim over which federal courts have original jurisdiction. The statute reads as follows:

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

29 U.S.C. § 1132(a)(1)(B). The U.S. Supreme Court has found that this statute evidences congressional intent to completely preempt state law claims related to ERISA plans. A finding of complete preemption has two important consequences for a plaintiff's lawsuit.

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[12] ERISA defines an "employee welfare benefit plan" or "welfare plan" as follows:

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

29 U.S.C. § 1002.

[13] This section is also commonly referred to as § 502(a) of ERISA in case law discussing the issue.

First, it means that a complaint filed in state court asserting only state law claims will still be removable to federal court under federal question jurisdiction. The U.S. Supreme Court has held that "the ERISA civil enforcement mechanism [i.e. 29 U.S.C. § 1132(a)] is one of those provisions with such extraordinary pre-emptive power that it converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule." *Davila*, 542 U.S. at 209, 124 S. Ct. at 2496. Thus, state law claims that relate to an employee benefit plan are properly removed to federal court even where the complaint does not facially state an ERISA cause of action. *Tingey v. Pixley-Richards W., Inc.*, 953 F.2d 1124, 1130 (9th Cir. 1992).

Second, complete preemption means that the plaintiff's state law claims are barred and the plaintiff will only be permitted to assert a statutory cause of action under 29 U.S.C. § 1132(a)(1)(B). *Davila*, 542 U.S. at 209, 124 S. Ct. at 2495 ("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."). The second consequence is why, in addition to removing this action, Defendants have also brought a Motion to Dismiss based on the doctrine of complete preemption (ECF No. 4).

C. The *Davila* Test Is the Only Test for Determining Whether a State Law Claim is Completely Preempted and Defendants Have Satisfied It

Contrary to Fremont's contention in its Motion to Remand where it seeks to substitute an alleged "rate of payment vs. right to payment test" for the *Davila* Test, the *Davila* Test remains the only test that Defendants must satisfy to prove that Fremont's claims are subject to complete preemption under ERISA. Under the *Davila* test, a state law cause of action is completely preempted if (1) the plaintiff, "at some point in time, could have brought [the] claim under ERISA § 502(a)(1)(B)," and (2) "there is no other independent legal duty that is implicated by [the] defendant's actions." *Davila*, 542 U.S. at 210, 124 S. Ct. at 2496. The *Davila* test would be undisputedly met if an employee plan member requested coverage for a particular medical procedure, coverage was denied or only approved in part, the employee paid for the treatment herself, and the employee then brought suit against the health plan administrator for

reimbursement. *Id.* at 211, 124 S. Ct. 2497. This would be a clear example of a "beneficiary or participant" seeking to recover benefits under an employee benefit plan (see 29 U.S.C. § 1132(a)(1)(B)) and no other state law claims would be permitted that effectively sought reimbursement for medical treatment. The employee's only remedy would be a statutory ERISA claim.

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

Misic is directly on point. Fremont is a medical provider that provided medical services to employees who were members of the Defendants' health plans. Complaint at ¶¶ 18-19. Just like in *Misic*, Fremont then received an assignment of benefits from those members and requested payment directly from Defendants. This assignment gave Fremont standing to bring an ERISA claim. Because the Defendants refused to pay the amounts requested, Fremont has now brought state law claims seeking reimbursement and stands in the shoes of Defendants' members. Thus, regardless of the labels used and its attempt at artful pleading, all of Fremont's claims seek to supplement ERISA's civil enforcement mechanism (29 U.S.C. § 1132(a)(1)(B)) which is the sole pathway Congress provided for recovery and are completely preempted.

Fremont vaguely argues that *Misic* is inapposite. This is wrong. ***Misic* was a so-called "rate of payment" case** and the Court found complete preemption was appropriate. In *Misic*, just as Fremont alleges here, the insurer/administrator paid a portion of the amounts billed by the medical provider but not the entire amount. *Misic*, 789 F.2d at 1376 ("The trust paid a portion of the amount billed, but less than the full 80%."). The Court found that the terms of the ERISA

plan (requiring that the plan member be reimbursed at 80% of the usual and customary cost of medical services) were the only thing that governed the rate of payment and thus complete preemption applied. *Id.* The result should be the same here as the ERISA plans at issue do require a particular rate of payment to plan members for services from out-of-network providers like Fremont.

Realizing that the first element of the *Davila* Test is clearly satisfied,[14] Fremont focuses the majority of its Motion to Remand on attempting to disprove the second element of the test. However, due to the admissions and omissions in Fremont's Complaint, there are no legal duties independent of ERISA that are implicated in this case. The only legal duty Defendants owe to Fremont (if any) flows from the rate of payment terms of the ERISA plans and the assignments that Fremont received.

D. Fremont's Rate of Payment Case Law is Not Applicable to the Facts of This Case

Fremont has cited a number of ERISA preemption cases in its Motion to Remand that purport to discuss the importance of the distinction between claims involving the "right to payment" (which Fremont admits are completely preempted) versus the "rate of payment" (which Fremont contends are not completely preempted). However, Fremont's focus on right to payment versus rate of payment is a misreading of the facts of these cases and an attempt to distract the Court from the *Davila* test, which is satisfied here.

As explained below, every single case cited by Fremont where courts found that complete preemption did not occur involved (1) providers who failed to receive an assignment of benefits from the plan members, (2) providers who had an express written agreement with the plan administrator/insurer, (3) a state statute requiring a particular rate of payment to out-of-network providers or (4) an oral promise by the plan administrator/insurer that it would pay the out-of-network provider at a particular rate.

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[14] Under *Davila*, it is irrelevant whether Fremont has in fact asserted a statutory ERISA claim in its Complaint. If Fremont *could* have asserted such a claim due to the assignments of benefits, the first element of the *Davila* Test is met.

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 statute requiring a particular rate of payment to the out-of-network provider or an oral promise by the insurer to the out-of-network provider regarding the rate of payment would mean the second element of the *Davila* Test is not met since each of these things creates a legal duty on the part of the plan administrator/insurer that is independent of the duties owed under the ERISA plan.

Critically, it is undisputed that none of these facts are present here and thus the *Davila* Test is met and all of Fremont's state law claims are completely preempted by ERISA. Each of Fremont's allegedly favorable cases are 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 some of the cases Fremont cites, complete preemption is not found because the 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. *See e.g., Med. & Chirurgical Faculty of State of Maryland v. Aetna U.S. Healthcare, Inc.*, 221 F. Supp. 2d 618 (D. Md. 2002) (court found that the patients had not assigned their right to bring an ERISA claim to the out-of-network medical providers); *California Spine & Neurosurgery Inst. v. Bos. Sci. Corp.*, No. 18-CV-07610-LHK, 2019 WL 1974901, at *1 (N.D. Cal. May 3, 2019) (case remanded only because "there is no evidence in the record that the Patient ever assigned his or her rights to Plaintiff, the medical provider.").

Here, it is undisputed that Fremont received an assignment of benefits for all of the claims it seeks to litigate in this suit.[15] Thus, there is no question that Fremont stands in the shoes of Defendants' plan members and has standing to bring a statutory ERISA claim. Thus,

[15] See Declarations and claim forms attached to this Motion. Fremont also fails to challenge the sufficiency of the assignments in its Motion to Remand.

the first element of the *Davila* test is undisputedly met.

2. Cases Where an Express Written Provider Agreement Exists That Creates a Legal Duty Independent of the ERISA Plan

When a medical provider receives an assignment of benefits but also has a separate written agreement with the insurer/plan administrator (often called a "provider agreement") that governs the rate of reimbursement owed to that medical provider, the second element of the *Davila* test is often not met.[16] The reason is that the provider agreement creates legal duties independent of the employee ERISA plan. Here, Fremont admits in its Complaint that it is an out-of-network provider and that "There is no written agreement between [Defendants] and Fremont for the healthcare claims at issue in this litigation." Complaint at ¶¶ 17, 22. Thus, this Court should disregard any case law cited by Fremont where a written provider agreement existed as Fremont admits one does not exist here. The only legal duties owed by Defendants (if any) flow from the rights Fremont has as the assignee of Defendants' plan members. Since those rights are directly based on and related to employee benefit plans governed by ERISA, Defendants' claims are completely preempted.

3. Cases Where a Legal Duty Independent of the ERISA Plan is Created by a State Statute Requiring a Particular Rate of Payment to a Medical Provider

Fremont attempts to liken its situation to that of an in-network-provider with a provider

[16] *Blue Cross of California v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1052 (9th Cir. 1999) (The court found that the medical providers' claims were not preempted because they had an express written provider agreement with the insurer. That agreement created duties independent of the employee benefit plan and thus ERISA preemption did not apply. The court distinguished the facts before it from the facts in *Misic* (cited *supra*) where the claims were preempted because the medical provider did not have a written provider agreement with the insurer and thus was deemed to be suing on an ERISA 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) ("determination of the rate that Aetna owes Lone Star under the Provider Agreement does not require any kind of benefit determination under the ERISA plan. The fee schedules in the Member Plans in this case all refer back to the Provider Agreement."); *Connecticut State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1353 (11th Cir. 2009) (medical providers had a written provider agreement with the insurer that governed rate of payment and created independent duty).

agreement by asserting a sham implied-in-fact contract claim.[17] However, according to the case law Fremont itself cites, the only situation where such a claim has not been found to be completely preempted is where a special state statute governing the rate of payment creates the implied-in-fact contract. *Coast Plaza Doctors Hosp. v. Arkansas Blue Cross & Blue Shield*, No. CV 10-06927 DDP JEMX, 2011 WL 3756052, at *1 (C.D. Cal. Aug. 25, 2011) (California law created implied-in-fact contract between out-of-network emergency medical providers and insurers); *Med. & Chirurgical Faculty of State of Maryland v. Aetna U.S. Healthcare, Inc.*, 221 F. Supp. 2d 618 (D. Md. 2002) (Maryland had special statutory scheme requiring insurers to pay out-of-network providers for services provided to their insureds at a particular rate. Thus, there was no need to refer to the ERISA plans to determine the appropriate rate of reimbursement and complete preemption did not apply); *Emergency Servs. of Zephyrhills, P.A. v. Coventry Health Care of Fla., Inc.*, 281 F. Supp. 3d 1339 (S.D. Fla. 2017) ("The Florida statutes confer a private right of action exclusively on out-of-network emergency medical providers" and thus complete preemption did not apply); *Hialeah Anesthesia Specialists, LLC v. Coventry Health Care of Fla., Inc.*, 258 F. Supp. 3d 1323 (S.D. Fla. 2017) (no preemption of implied-in-fact contract claim because Florida statute created special duty independent of ERISA that supported the claim); *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) (claims for unjust enrichment/quantum meruit were not completely preempted "because the cause of action is predicated on a right to reimbursement created by Florida law [Fla. Stat. Ann. § 641.513(5)].").

Here, no rate of payment statute exists in Nevada that would create an implied-in-fact contract. Unlike in California, Maryland and Florida, there is no Nevada statute that either (1) requires plan administrators/insurers to pay out-of-network providers or (2) requires a particular rate of 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

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[17] *See* Defendants' Motion to Dismiss (ECF No. 4) for a detailed analysis of the sham conclusory nature of this claim.

Legislative Session.[18] Simply put, Fremont lacks a Nevada statute that could create a legal duty independent of Fremont's rights as an assignee of the Defendants' plan members. Thus, the *Davila* test is met and all of Fremont's claims are preempted.

Fremont may argue in response that the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd and NRS 439B.410, which it cites in its Complaint, provide the independent duty it needs to create an implied-in-fact contract and defeat element 2 of the *Davila* Test. 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 by insurers to out-of-network providers or say anything about the required rate of payment. Further, no court has found that federal and state statutes requiring hospitals to provide emergency services to *patients* somehow create a legal duty on the part of plan administrators/insurers that is independent of ERISA and Fremont has not cited any case law in this regard.

4. Cases Where a Legal Duty Independent of the ERISA Plan is Created by an Oral Representation by the Plan Administrator/Insurer

Legal duties independent of those owed under an ERISA plan can also sometimes be created by oral representations such as those that allegedly occurred in the *Marin* case that Fremont relies on. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 950–51 (9th Cir. 2009). In *Marin*, the patient assigned his right to seek payment from the ERISA plan administrator to a hospital. The hospital was then paid the money owed to the patient under the ERISA plan. Then, the hospital sued the plan administrator seeking more money based a phone conversation with the plan administrator where it allegedly offered to pay 90% of the medical expenses even though this was more than the rate of payment called for in the ERISA plan. Thus, the court found 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.*

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[18] *See supra*, at fn. 11.

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Here, in contrast to *Marin*, Fremont's Complaint does not allege that Defendants ever made any oral representations that they would reimburse Fremont at a particular rate (or at all for that matter). Fremont has also not alleged that it has been paid everything owed under the terms of the ERISA plans. Thus, Fremont's only right to reimbursement (if any) flows from the assignment it received from Defendants' plan members and its claims are subject to complete preemption.

5. In Cases Where the Out-of-Network Medical Provider (1) Receives an Assignment of Benefits and (2) Lacks an Express Written Agreement, Lacks a Special State Statute Governing the Rate of Payment and Lacks an Oral Promise to Pay by the Plan Administrator that Would Create a Duty Independent of ERISA, Courts Find the Medical Providers' Claims are Completely Preempted

Unsurprisingly, Fremont did not cite to the numerous 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. The Ninth Circuit's *Misic* case (discussed *supra*) is one example and additional examples are set forth here.

In *In Re Managed Care Litig.*, 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 held that the in-network providers' contractual claims were not completely preempted because they were suing under their independent contracts with the insurer. In contrast, the court found that the out-of-network providers' implied contract claims were subject to complete preemption because they received an assignment of benefits from the plan members and thus had standing to sue under ERISA. As to out-of-network providers who did not receive an assignment, the court found that their implied contract claims were not completely preempted.

Here, Fremont's situation is similar to that of the out-of-network providers in *In Re Managed Care* whose implied contract rate of payment claims were preempted because Fremont alleges that it lacks a written contract with Defendants, Fremont received an assignment of benefits and yet Fremont is attempting to escape ERISA preemption via artfully pleading an

implied-in-fact contract claim. The *In Re Managed Care* Court noted that Fremont's situation is not a close call, stating that "[v]irtually every court to consider this question has held that reimbursement and related claims involving services provided to ERISA beneficiaries on a non-participating basis [i.e. out-of-network providers like Fremont] may be pursued only through ERISA's civil enforcement provision." *Id.* at 1291 (emphasis added) (collecting cases).

Similarly, 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.*, No. 04-20858-CIV, 2004 WL 7320735, at *4 (S.D. Fla. July 1, 2004). The court rejected this "rate of payment" argument, stating:

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

Id. (emphasis added). Like the plaintiff in *Torrent & Ramos*, Fremont cannot "recast" its ERISA reimbursement claim as an implied-in-fact contract claim, unjust enrichment claim or anything else. Fremont received an assignment of benefits for every claim it submitted to Defendants and lacks a written contract or Nevada rate of payment statute that would create duties independent of the ERISA plan. Thus, the *Davila* test is met and complete preemption applies.

E. The Specific Claims Asserted by Fremont Have Repeatedly Been Found to be Subject to Complete Preemption

1. Fremont's Implied-in-Fact Contract Claim is Subject to Complete Preemption

An implied-in-fact contract claim is subject to complete preemption. *Parlanti v. MGM Mirage*, No. 2:05-CV-1259-ECR-RJJ, 2006 WL 8442532, at *6 (D. Nev. Feb. 15, 2006) (finding complete preemption for an implied-in-fact contract claim that sought to recover benefits under an ERISA plan); *In Re Managed Care Litig.*, 298 F. Supp. 2d at 1292 (out-of-network providers'

implied-in-fact contract claim was completely preempted); *Torrent & Ramos, M.D., P.A.*, 2004 WL 7320735, at *4 (same).

2. Fremont's Claim for Tortious Breach of the Implied Covenant of Good Faith and Fair Dealing is Subject to Complete Preemption

This claim attempts to "duplicate" or "supplement" the ERISA civil enforcement mechanism by seeking punitive damages against a plan administrator. Complaint at ¶ 55. Such claims are completely preempted. *Tingey*, 953 F.2d at 1131 (holding that claims against employer for breach of the implied covenant of good faith and fair dealing and insurance bad faith, among other state law claims, were preempted by ERISA); *Estate of Burgard v. Bank of America, N.A.*, 2017 WL 1273869 (D. Nev. March 31, 2017) ("[I]t is well established that breach of contract claims—whether contractual or tortious—fall within section 502(a)."); *see also Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1009 (9th Cir. 1998) ("Extracontractual, compensatory and punitive damages are not available under ERISA.") (limitation on other grounds recognized in *A.F. v. Providence Health Plan*, 157 F. Supp. 3d 899, 916 (D. Or. 2016); *Elliot v. Fortis Benefits Ins. Co.*, 337 F.3d 1138, 1146-47 (9th Cir. 2003) ("claim processing causes of action" under state law which seek non-ERISA damages are "clearly" preempted under 29 U.S.C. § 1132(a)(1)(B) of ERISA).

3. Fremont's Claim for Unjust Enrichment is Subject to Complete Preemption

Courts have specifically held that this claim is subject to complete preemption. *Torrent & Ramos, M.D., P.A.*, 2004 WL 7320735, at *4 (out-of-network providers' unjust enrichment claim was completely preempted); *Hill v. Opus Corp.*, 841 F. Supp. 2d 1070, 1086 (C.D. Cal. 2011) (unjust enrichment claim was subject to ERISA preemption).

4. Fremont's Claim for a Violation of NRS 686A.020 and 686A.310 is Subject to Complete Preemption

The Nevada Supreme Court has found that claims under the Nevada Unfair Trade Practices Act are preempted by ERISA. *Villescas v. CNA Ins. Companies*, 109 Nev. 1075, 1084, 864 P.2d 288, 294 (1993) ("We add Nevada's voice to the growing body of case law holding

state unfair insurance practice claims to be preempted by ERISA and conclude that Chapter 686A of the Nevada Insurance Code is preempted by ERISA…"); *see also Thrall v. Prudential Ins. Co., 2005 WL 8161321, at *2* (claim for violation of Nevada Unfair Claim Practices was preempted).

5. Fremont's Claim for a Violation of Nevada's Prompt Pay Statutes and Regulations is Subject to Complete Preemption

This claim alleges that Defendants violated the Nevada prompt pay statutes, including NRS 683A.0879, NRS 689A.410, NRS 689B.255, NRS 689C.485, NRS 695C.185, and NAC 686A.675, by failing to reimburse Fremont within 30 days of Fremont's requests for payment. Complaint at ¶ 78. As a remedy for this alleged violation, Fremont seeks to recover Nevada statutory penalties. *Id.* at ¶¶ 78, 81.

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

Second, courts addressing ERISA preemption of claims under similar state "prompt pay" statutes find preemption unless the medical provider lacks an assignment of benefits. *Compare Schoedinger v. United Healthcare of Midwest, Inc.*, 557 F.3d 872, 875–76 (8th Cir. 2009) (finding provider's claim for interest under Missouri prompt payment statute was preempted because provider received an assignment of benefits from the plan member); *Productive MD, LLC v. Aetna Health, Inc.*, 969 F.Supp.2d 901, 938 (M.D. Tenn. 2013) (finding Tennessee

Prompt Pay Act claim was preempted because provider brought it as assignee of plan participant) *with In re Managed Care Litig.*, 298 F.Supp.2d 1259, 1294 (S.D. Fla. 2003) (finding no preemption of providers' prompt pay claims because they did not receive an assignment of benefits).

See also America's Health Ins. Plans v. Hudgens, 742 F.3d 1319 (11th Cir. 2014) (Georgia's prompt-pay provision was preempted as applied to self-funded ERISA plans because the provision interfered with uniform administration of benefits.); *Zipperer v. Premera Blue Cross Blue Shield of Alaska*, 2016 WL 4411490 (D. Alaska, August 16, 2016) (Alaska prompt pay statute was preempted); *Houston Methodist Hosp. v. Humana Ins. Co.*, 266 F. Supp. 3d 939 (S.D. Tex. 2017) (Texas Prompt Payment of Physicians and Providers Act was preempted); *OSF Healthcare Sys. v. Contech Constr. Prod. Inc.Group Comprehensive Health Care*, No. 1:13-CV-01554-SLDJEH, 2014 WL 4724394, at *7 (C.D. Ill. Sept. 23, 2014) (Illinois prompt-pay statute preempted by ERISA as having an "impermissible connection to an ERISA plan."). There is no significant distinction between Nevada's prompt pay statute and those of other states that have been found to be preempted. These statutes seek to regulate the processing of claims under employee benefit plans which infringes on the field occupied by ERISA. This Court should adopt the above courts' reasoning and find that Nevada's prompt pay statute is preempted as well.

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

6. Fremont's Claim for a Violation of Nevada's Consumer Fraud & Deceptive Trade Practices Acts is Subject to Complete Preemption

There is no reason for this Court to deviate from other courts' decisions on this issue. *Peterson v. American Fidelity Assur. Co.*, 2013 WL 6047183 (D. Nev. Nov. 13, 2013) (finding plaintiff's claim for deceptive trade practices preempted by ERISA); *Pachuta v. Unumprovident Corp.*, 242 F. Supp. 2d 752, 764 (D. Hawaii, March 19, 2002) (finding Plaintiff's statutory claim for deceptive trade practices did not come within the ERISA savings clause as it was not

specifically directed at insurance companies and was thus preempted); *Olson v. General Dynamics Corp.*, 960 F.2d 1418, 1422–23 (9th Cir. 1991) (claim challenging oral misrepresentation regarding the level of benefits provided by a plan is preempted); *Davidian v. S. Cal. Meat Cutters Union*, 859 F.2d 134, 135 (9th Cir. 1988) (claim challenging incorrect description of the insurance benefits of an ERISA plan is preempted).

7. Fremont's Claim for a Declaratory Judgment is Subject to Complete Preemption

ERISA's civil enforcement statute specifically authorizes actions for declaratory judgment, providing that a plan participant or beneficiary can bring a civil action to "clarify any of his rights to future benefits." 29 U.S.C. § 1132(a)(1)(B); *see also Franchise Tax Board of California v. Construction Laborers Vacation Trust for S. California*, 463 U.S. 1, 27 n. 31 (1983) ("ERISA has been interpreted as creating a cause of action for a declaratory judgment"). Fremont seeks a declaratory judgment under state law regarding the correct amount of reimbursement for the medical services that it performed on Defendants' members. Complaint at ¶¶ 98-99. Such a claim clearly duplicates the relief provided by 29 U.S.C. § 1132(a)(1)(B) of ERISA and therefore is completely preempted. Again, since Fremont possesses an assignment of benefits it could have brought a declaratory judgment ERISA claim.

F. Defendants Only Need to Prove that One of Fremont's Seven Claims is Completely Preempted to Defeat Fremont's Motion to Remand Under the Doctrine of Supplemental Jurisdiction

Assuming *arguendo* that this Court found some of Fremont's claims were completely preempted but others were not, the non-preempted claims would still fall within this Court's supplemental jurisdiction because they are so related to the other claims that they form part of the same case or controversy under Article III of the United States Constitution. 28 U.S.C. §1367(a); *Beneficial Nat. Bank v. Anderson*, 539 U.S. 1, 8, 123 S. Ct. 2058, 2063, n. 3 (2003) ("Of course, a state claim can also be removed through the use of the supplemental jurisdiction statute, 28 U.S.C. § 1367(a), provided that another claim in the complaint is removable."); *see also Gaming Corp. of Am. v. Dorsey & Whitney*, 88 F.3d 536, 543 (8th Cir. 1996) ("Only those claims that fall within the preemptive scope of the particular statute, or treaty, are considered to

make out federal questions, but the presence of even one federal claim gives the defendant the right to remove the entire case to federal court.") (internal citations omitted); *Milwaukee Carpenter's District Council Health Fund v. Philip Morris*, 70 F.Supp.2d 888 (E.D. Wisc. 1999) (denying remand while noting that "[s]o long as any one claim concerned a federal question, the entire case could be removed" under the ERISA complete preemption doctrine).

In sum, for Fremont to prevail on its Motion to Remand it must show none of its seven state law claims for relief are completely preempted by ERISA. It cannot do so.

V. IN THE ALTERNATIVE, THE DEFENDANTS HAVE THE RIGHT TO CONDUCT JURISDICTIONAL DISCOVERY

As discussed above, even assuming *arguendo*, that Fremont is only asserting claims involving the rate of payment, its claims are completely preempted because there is no written contract, state statute or oral promise that would give rise to an independent legal duty on the part of Defendants to reimburse Fremont at a particular rate. Rather, the only documents governing the rate of payment to Fremont are the plan members' ERISA plans.

However, in the alternative, even if this Court agrees with Fremont's interpretation of the case law, the Motion to Remand should still be denied as Defendants are entitled to jurisdictional discovery to determine which claims involve the right to payment and are completely preempted and which claims involve the rate of payment and are not completely preempted.[19]

Defendants have a basis for jurisdictional discovery as they dispute Fremont's contention that the claims Fremont is asserting only involve the rate of payment. Defendants have evidence that thousands of the claims Fremont is asserting were denied due to the medical services not being covered under the terms of various ERISA plans.[20] Thus, even if this Court were to adopt Fremont's interpretation of the alleged "right to payment vs. rate of payment" rule, which it should not, there would still be a need for additional discovery before ruling on Fremont's

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[19] Again, Defendants disagree with Fremont's analysis of the case law and believe Fremont's claims are completely preempted regardless of whether they involve the right to payment or rate of payment. Defendants make this in the alternative argument only in an abundance of caution.

[20] *See* **Exhibit 2** at ¶ 8 (UHIC, UHS and UMR Declaration), **Exhibit 5** at ¶ 9 (SHL and HPN Declaration); **Exhibit 3** at ¶ 8 (Oxford Declaration).

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Motion to Remand.

Fremont will contend that the Court's analysis is confined to the language of Fremont's Complaint and that no additional evidence should be considered. However, this is inaccurate based on case law Fremont itself cited in its Motion to Remand.[21] In *Lone Star*, the medical provider contended that it had only asserted rate of payment claims while the plan administrator contended that some of the claims involved the right to payment. The Fifth Circuit reversed the district court's decision to remand because the evidence was unclear on this issue and ordered the district court to further develop the factual record before ruling on the motion to remand again. *Lone Star OB/GYN Assocs. v. Aetna Health Inc.*, 579 F.3d 525, 532–33 (5th Cir. 2009). Moreover, in *Lone Star* the factual record was even more developed than what this Court is currently faced with as the plaintiff in that case attached a list of the claims it was asserting to its motion to remand. *Id.* Here, Fremont seeks to use artful pleading to avoid ERISA preemption while at the same time seeking to bar the discovery that would definitively show that its claims are completely preempted and involve the right to payment. Notably, unlike the medical provider in *Lone Star*, Fremont has not attached a list of the specific claims it is asserting to its Motion to Remand.

Since Defendants have presented the Court with evidence through this Opposition that at least some of Fremont's claims involve the right to payment, Defendants are entitled to jurisdictional discovery. *See Alaska Cargo Transport, Inc. v. Alaska R.R. Corp.*, 5 F.3d 378, 383 (9th Cir. 1993) (stating the district court would have abused its discretion in denying discovery if the discovery was relevant to whether or not the court had subject matter jurisdiction); *Wells Fargo & Co. v. Wells Fargo Exp. Co.*, 556 F.2d 406, 430, n.24 (9th Cir. 1977) ("Discovery, however, should be granted where pertinent facts bearing on the question of jurisdiction are controverted or where a more satisfactory showing of the facts is necessary."); *Tradebay, LLC v. eBay, Inc.*, 278 F.R.D. 597, 601 (D. Nev. 2011) ("a district court abuses its discretion if it prevents a party from conducting discovery relevant to a potentially dispositive motion."). In

[21] *See* Motion to Remand at 7:18-21.

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sum, in the event the Court does not deny the Motion to Remand outright based on Defendants' arguments in Sections II, III and IV of this Opposition, the Motion should be denied because jurisdictional discover is necessary.

VI. FREMONT'S REQUEST FOR SANCTIONS SHOULD BE DENIED

Requests for sanctions are a serious matter and should not be tossed around cavalierly as Fremont has done here. A Court has discretion to award attorney's fees and costs under 28 U.S.C. § 1447(c) only where the removing party lacked an objectively reasonable basis for seeking removal. As demonstrated throughout this Opposition, removal was proper, the Motion to Remand should be denied and Defendants' Motion to Dismiss should be granted. Further, the statute does not permit an automatic award of attorney's fees even if a case is remanded. *Martin v. Franklin Capital Corp.*, 546 U.S. 132, 141 (2005) (citation omitted); *Paul v. Kaiser Foundation Health Plan of Ohio*, 701 F.3d 514, 523 (6th Cir. 2012) (refusing to award fees where complete preemption was a "close one.").

VII. CONCLUSION

For all the above reasons, Defendants request that the Court deny Fremont's Motion to Remand. Alternatively, Defendants request that the Court permit jurisdictional discovery before issuing a final ruling on the Motion to Remand.

Dated this 21st day of June, 2019.

/s/ Colby L. Balkenbush

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CERTIFICATE OF SERVICE

I hereby certify that on the 21 day of June, 2019, a true and correct copy of the foregoing **DEFENDANTS' OPPOSITION TO FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.'S MOTION TO REMAND** was served and filed electronically through CM/ECF to the following:

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