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APPENDIX A

IN THE SUPREME COURT OF THE STATE OF NEVADA

UNITEDHEALTHCARE INSURANCE COMPANY, A CONNECTICUT CORPORATION; UNITED HEALTHCARE 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; AND HEALTH PLAN OF NEVADA, INC., A NEVADA CORPORATION, Appellants, vs. FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., A NEVADA CORPORATION; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., A NEVADA PROFESSIONAL CORPORATION; CRUM STEFANKO AND JONES, LTD., D/B/A RUBY CREST EMERGENCY MEDICINE, A NEVADA PROFESSIONAL CORPORATION, Respondents.	No. 85525 FILED JUN 12 2025 ELIZABETH A. BROWN CLERK OF SUPREME COURT BY CHIEF DEPUTY CLERK

UNITEDHEALTHCARE INSURANCE COMPANY; UNITED HEALTHCARE 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, and FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; AND CRUM STEFANKO AND JONES, LTD., Real Parties in Interest.	No. 85656

Consolidated appeal from a district court judgment on a jury verdict in a civil action (Docket No. 85525) and original petition for a writ of mandamus or, alternatively, prohibition challenging a district court order declining to seal certain parts of the record (Docket No. 85656). Eighth Judicial District Court, Clark County; Nancy L. Allf, Judge.

Affirmed in part, reversed and remanded in part, and vacated in part in Docket No. 85525; petition denied in Docket No. 85656.

Lewis Roca Rothgerber Christie LLP and Daniel F. Polsenberg, Joel D. Henriod, and Kory J. Koerperich, Las Vegas; O'Melveny & Myers LLP and Jonathan D. Hacker and K. Lee Black II, Washington D.C.; Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC, and D. Lee Roberts and Colby L. Balkenbush, Las Vegas,
for Appellants/Petitioners.

Bailey Kennedy and Dennis L. Kennedy and Tayler Dane Bingham, Las Vegas; Lash Goldberg LLP and Justin C. Fineberg and Jonathan E. Siegelaub, Fort Lauderdale, Florida; Ahmad, Zavitsanos & Mensing, PLLC, and Jane L. Robinson, Joseph Y. Ahmad, and John Zavitsanos, Houston, Texas,
for Respondents/Real Parties in Interest.

Carbajal Law and Hector J. Carbajal, Las Vegas; Haynes and Boone, LLP, and Mark Trachtenberg, Houston, Texas,
for Amicus Curiae Emergency Department Practice Management Association.

Holland & Hart LLP and Constance L. Akridge, J. Malcolm DeVoy, and Sydney R. Gambee, Las Vegas,
for Amicus Curiae Nevada Association of Health Plans.

McLetchie Law and Margaret A. McLetchie, Las Vegas,
for Amici Curiae the Reporters Committee for Freedom of the Press and 23 Media Organizations.

BEFORE THE SUPREME COURT, EN BANC.

OPINION

By the Court, BELL, J.:

This case involves health insurance reimbursements for emergency medical services when the insurer has no contract with the medical provider. UnitedHealthCare Insurance Company; United Healthcare Services, Inc.; UMR, Inc.; Sierra Health and Life Insurance Company, Inc.; and Health Plan of Nevada, Inc. (collectively, United) are insurers or third-party administrators of health insurance. A jury determined United violated an implied-in-fact contract or unjustly enriched itself by failing to adequately compensate specific emergency medicine providers for services rendered to United's members under the Emergency Medical Treatment and Labor Act (EMTALA), and the district court entered judgment for the medicine providers. United appeals that judgment and also petitions for a writ directing the district court to seal certain court documents.

We determine substantial evidence supports the jury's verdict as to United's unjust enrichment; however, the claims for implied contract damages and damages under statute are not supported under the facts of this case. United is entitled to judgment as a matter of law on those claims. We vacate and remand for recalculation of the punitive damages award, reverse the judgment as to the prejudgment interest and attorney fees awards, and remand for a new prejudgment interest determination. We also conclude United failed to meet its burden to require sealing of admitted trial exhibits.

FACTS AND PROCEDURAL HISTORY

Federal law requires emergency medicine providers to provide emergency medical treatment to patients regardless of the patient's insurance coverage. *See* 42 U.S.C. § 1395dd (1986) (EMTALA). Fremont Emergency Services (Mandavia), Ltd.; Team Physicians of Nevada-Mandavia, P.C.; and Ruby Crest Emergency Medicine (collectively TeamHealth) staff hospital emergency departments in Nevada. Previously, TeamHealth contracted with United to provide services to United members as an in-network provider. The contract specified reimbursement rates. After failing to renegotiate this contract, on July 1, 2017, TeamHealth became an out-of-network provider for all United members. At that point, no express contractual relationship bound the parties. Even without a contract, TeamHealth continued to submit reimbursement claims directly to United, and during the disputed period between July 1, 2017, and January 31, 2021, United paid more than 75,000 of these claims. TeamHealth asserts United underpaid 11,563 of the claims for emergency medicine services. For those claims, TeamHealth billed $13.24 million and United reimbursed TeamHealth $2.84 million.

TeamHealth sued United, alleging United failed to reasonably reimburse TeamHealth based on an implied-in-fact contract between the parties or, alternatively, under a theory of unjust enrichment. TeamHealth also asserted statutory claims under the Prompt Pay and Unfair Claims Practices Acts. United removed the case to federal court, arguing all causes of action were preempted by the Employee Retirement Income Security Act (ERISA), which provides

federal guidelines for private healthcare plans. *See Fremont Emergency Servs. (Mandauia), Ltd. v. UnitedHealth Grp. Inc.,* 446 F. Supp. 3d 700, 705 (D. Nev. 2020). The federal court found no ERISA preemption and remanded the case to state court. *Id.* Subsequently, the district court, as well as this court on a petition for mandamus, also declined to set aside TeamHealth's claims as preempted by ERISA. *See United Healthcare Ins. v. Eighth Jud. Dist. Ct.,* No. 81680, 2021 WL 2769032, at *1 (Nev. July 1, 2021) (Order Denying Petition). We left open, however, the possibility that United could renew its arguments before the district court and, if necessary, on appeal after discovery. *Id.* at *2.

Prior to trial, the district court ordered United to produce claim files for all disputed claims. The district court restricted discovery on TeamHealth's current and previous in-network reimbursement agreements, clinical records, corporate structure, and cost-setting practices. The rulings restricting discovery of TeamHealth information became the basis of a later order excluding as irrelevant the same categories of evidence at trial. At the close of evidence during trial, the district court instructed the jury that United had willfully failed to produce evidence, creating a rebuttable presumption the unproduced evidence was adverse to United. Regarding documents that were disclosed, the litigation necessarily involved production, discussion, and admission of documents relating to United's business. United moved to limit media access to the courtroom. TeamHealth opposed the motion and instead suggested sealing certain documents after the conclusion of the trial. The district court denied

United's motion, but the parties stipulated to a protective order. The order classified certain United documents as "confidential" or for "attorneys' eyes only." This order remained in effect during trial and contemplated jurors as acceptable viewers. Even with the protective order, the district court made clear before trial that any admitted evidence would not be sealed. During trial, both United and TeamHealth admitted numerous documents marked "confidential" or for "attorneys' eyes only." At the time, United requested redactions of only nineteen "attorneys' eyes only" documents before the documents were admitted into evidence. United failed to object to the admission of any of the documents designated confidential into the public trial record.

The jury found United liable for breach of an implied contract, unjust enrichment, violation of the Unfair Claims Practices Act (UCPA), and violation of the Prompt Pay Act (PPA). The jury awarded TeamHealth $2,650,512 in compensatory damages, along with an additional $60 million in punitive damages. Additionally, the district court awarded $800,000 in statutory penalties under the PPA, and $12,164,363.47 in attorney fees. United moved to apply the statutory cap for punitive damages under NRS 42.005, which was denied.

United was also unsuccessful in post-trial motions. Following the trial, United moved for recalculation of the damages and for a new trial and renewed its motion for judgment as a matter of law. United moved to have various trial exhibits sealed, which TeamHealth opposed. These documents included

strategic business plans, different United plan agreements admitted at trial, internal PowerPoint presentations, and internal email chains. The district court denied United's motions but allowed sensitive documents to remain under seal pending appellate review. United appealed the judgment on various grounds and petitioned this court to require, by writ, the district court to seal certain documents containing trade secrets, and this court consolidated the two cases.

DISCUSSION

This opinion addresses two interconnected proceedings: an appeal from a civil judgment on a jury verdict and a separate writ petition challenging the district court's post-judgment decision against sealing specific court documents. This court holds the following: (1) ERISA does not preempt TeamHealth's claims, (2) United is entitled to judgment as a matter of law on TeamHealth's UCPA claims, and (3) no implied-in-fact contract existed. Under Docket No. 85525, we affirm the compensatory damages awarded for unjust enrichment and decline to grant a new trial; we vacate the punitive damages award and remand for the district court to reduce the amount of the award; and we also reverse the district court's prejudgment interest and attorney fees awards under the PPA. Under Docket No. 85656, we deny the petition because United failed to meet its burden to demonstrate that the district court manifestly abused its discretion in refusing to seal parts of the record.

This action is not preempted by ERISA

First, we address United's renewed claim that ERISA preempts this action, which we review de

novo. *See Nanopierce Techs., Inc. v. Depository Tr. & Clearing Corp.,* 123 Nev. 362, 370, 168 P.3d 73, 79 (2007). ERISA is a federal statute that regulates employee benefit plans. 29 U.S.C. § 1003(a). Generally, to create a uniform regulatory scheme, ERISA preempts state laws that relate to employee benefit plans, either completely because the claim sounds entirely in ERISA, or through conflict preemption, because state and federal law conflict. *Depot, Inc. v. Caring for Montanans, Inc.,* 915 F.3d 643, 667 (9th Cir. 2019). Neither complete nor conflict ERISA preemption applies when a state statute creates a duty independent from ERISA and does not conflict with federal law.

Early on, this court found no ERISA preemption in this case. *See United Healthcare,* 2021 WL 2769032, at *1 ("[T]he providers have alleged their own implied-in-fact contract with United establishing a *rate* of payment, separate from any assignments from health plan members or *right* to benefits from United—pleading a relationship and claim not directly 'relating to' ERISA, such that conflict preemption does not apply in this case."). Factual development of this case has failed to establish either complete or conflict ERISA preemption.

Complete ERISA preemption does not apply because the dispute here involves the amount of payment

A two-pronged test determines whether a state law-based claim is completely preempted by ERISA. *Aetna Health Inc. v. Dauila,* 542 U.S. 200, 210 (2004). Complete preemption exists when plaintiffs could have brought their claim under ERISA section 502(a),

29 U.S.C. § 1132(a), which allows for civil remedies against violations of ERISA requirements and terms of employee benefit plans, and when "there is no other independent legal duty that is implicated by a defendant's actions," meaning the claim must be based solely on the terms of an ERISA plan rather than anything outside the plan. *Dauila,* 542 U.S. at 210; *see* 29 U.S.C. § 1132. This test is conjunctive, so both elements must be met to show preemption. *Fremont,* 446 F. Supp. 3d at 704.

The Ninth Circuit has generally found claims involving a right to payment completely preempted by ERISA but claims involving the amount of payment outside the scope of section 502. *See Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Grp., Inc.,* 187 F.3d 1045, 1051 (9th Cir. 1999). Here, the dispute regards an amount of payment between United and TeamHealth. Because the dispute involves amount of payment, it falls outside the scope of ERISA section 502, and no complete preemption exists.

Conflict preemption does not exist in this context because a suit based on costs alone does not impact plan administration

Conflict preemption exists when there is a conflict between state and federal law. *Clarke v. Serv. Emps. Int'l Union,* 137 Nev. 460, 463, 495 P.3d 462, 465-66 (2021). In cases involving employee benefits, ERISA section 514(a), 29 U.S.C. § 1144, states, subject to certain exceptions, in a case of conflict, the federal law "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

A state law relates to an employee benefit plan under ERISA if the law (1) has "a connection with" the plan or (2) includes "reference to such a plan." *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins.,* 514 U.S. 645, 656 (1995) (internal quotation marks omitted). The reference prong is not at issue here. *Gobeille v. Liberty Mut. Ins.,* 577 U.S. 312, 319-20 (2016) (clarifying that when a state law acts "immediately and exclusively" on ERISA plans "or where the existence of ERISA plans is essential to the law's operation," that "reference" results in preemption (quoting *Cal. Div. of Lab. Standards Enf't v. Dillingham Constr., N.A., Inc.,* 519 U.S. 316, 325 (1997))).

A state law has a connection with ERISA if the law "governs . . . a central matter of [ERISA] plan administration," "interferes with nationally uniform plan administration," *Egelhoff v. Egelhoff,* 532 U.S. 141, 148 (2001), or "force[s] an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict[s] its choice of insurers," *Travelers,* 514 U.S. at 668. A suit based on costs alone does not impact plan administration or restrict choice of insurers. In *Travelers,* the United States Supreme Court found no ERISA preemption in a case over statutory surcharges imposed on commercial insurance members because an adverse judgment would not

> bind plan administrators to any particular choice . . . . Nor does the indirect influence . . . preclude uniform administrative practice or the provision of a uniform interstate benefit package if a plan wishes to provide one. It simply bears on the costs of benefits and the

> relative costs of competing insurance to provide them.

Id. at 659-60. Similarly, this case involves the costs of services. United never disputed its duty to provide some reimbursement to emergency medicine providers. Likewise, United identifies no wholesale change to the administration of its nationwide policies because of TeamHealth's lawsuit.

We are also not convinced the recent cases highlighted by United dictate a different conclusion. *See Bristol SL Holdings, Inc. v. Cigna Health & Life Ins.,* 103 F.4th 597, 604 (9th Cir. 2024); *Park Ave. Podiatric Care, PLLC v. Cigna Health & Life Ins.,* No. 23-1134-cv (L), 23-1135-cv (Con), 2024 WL 2813721 (2d Cir. June 3, 2024). Both *Bristol* and *Park Avenue* concern the obligation to out-of-network providers following preauthorization for nonemergency services.

Unlike in *Bristol* and *Park Avenue* where the payment disputes arose from nonemergency care, here, EMTALA required TeamHealth to provide medical services regardless of insurance status. Additionally, this case does not present any argument of a preauthorization promise to pay under an insurance contract. The sole issue in this case is the rate of reimbursement for emergency services. As a result, this case does not present an issue of conflict preemption because "cost uniformity was almost certainly not an object of pre-emption." *Travelers,* 514 U.S. at 662. TeamHealth's claims are not conflict preempted under traditional preemption analysis.

United is entitled to judgment as a matter of law on TeamHealth's claim of violation of the Unfair Claims Practices Act

Even though ERISA preemption does not apply, United is entitled to judgment as a matter of law on the UCPA cause of action because the statute does not provide TeamHealth a private right of action. We review a district court order denying judgment as a matter of law under NRCP 50(b) de novo. *Nelson v. Heer,* 123 Nev. 217, 223, 163 P.3d 420, 425 (2007). Under the UCPA, NRS 686A.310(1)(e) makes it an unfair practice to "[f]ail[. . . to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear." Historically, this statute contained no private right of action at all. *See, e.g., Tweet v. Webster,* 614 F. Supp. 1190, 1193 (D. Nev. 1985). The Nevada Legislature amended the statute in 1987 to provide for a private cause of action for the insured: "an insurer is liable to its insured for any damages sustained by the insured as a result of . . . an unfair practice." NRS 686A.310(2) (1987): 1987 Nev. Stat., ch. 470, § 1, at 1068.

TeamHealth argues this suit falls into the express private right of action granted in NRS 686A.310(2), which allows the insured to sue insurers. TeamHealth, though, is not an insured. *See Insured, Black's Law Dictionary* (11th ed. 2019) ("Someone who is covered or protected by an insurance policy."). Nor is United an insurer for TeamHealth under the plain text of NRS 686A.310(2). While TeamHealth may assert interests similar to those of an insured, the unambiguous text of the statute does not create a third-party right of action for healthcare providers.

This court, however, has never determined whether NRS 686A.310 creates implied private causes of action for parties other than the insured. We conclude it does not. "Where a statute does not expressly provide a private right of action, it may nevertheless support an implied right of action, if the Legislature intended that a private right of action may be implied." *Freeman Expositions, LLC v. Eighth Jud. Dist. Ct.,* 138 Nev. 775, 778, 520 P.3d 803, 808 (2022). To determine whether an implied private right of action exists under a statute, we consider "(1) whether the plaintiffs are of the class for whose special benefit the statute was enacted; (2) whether the legislative history indicates any intention to create or deny a private remedy; and (3) whether implying such a remedy is consistent with the underlying purposes of the legislative scheme." *Id.* at 778-79, 520 P.3d at 808 (quoting *Baldonado v. Wynn Las Vegas, LLC,* 124 Nev. 951, 958-59, 194 P.3d 96, 101 (2008)). These factors are not dispositive because "the critical factor is whether the Legislature intended to sanction a private right of action." *Id.* at 779, 520 P.3d at 808.

Applied to this case, these factors do not support an implied private right of action for TeamHealth under NRS 686A.310. First, medical service providers are not part of the class the statute was enacted to benefit. NRS Chapter 686A is titled "Trade Practices and Frauds; Financing of Premiums." The purpose of the chapter is to regulate insurance trade practices generally, not provide specific benefits to medical service providers. NRS 686A.010. In NRS 686A.310, the legislature amended the language to provide a private right of action to insureds. TeamHealth is a medical

service provider, not an insured. If the legislature had intended to provide medical service providers with a private right of action in NRS 686A.310, it could have done so expressly. Accordingly, this factor weighs against TeamHealth.

Second, legislative history favors a narrow reading of NRS 686A.310 to limit a private cause of action to the insured. Discussion of the statute at issue by the legislature was brief but focused entirely on "tighten[ing] the rights of the insured against his own carrier." Hearing on A.B. 811 (amending NRS 686A.310), Before the S. Comm. on Com. & Lab., 64th Leg., at 2114-15 (Nev., June 6, 1987) (statement of William Pat Cashill, representing the Nevada Trial Lawyers Association). Given the legislative history, we find this factor also weighs against TeamHealth.

Finally, review of the legislature's general purpose in passing NRS 686A.310 shows the purpose of the legislation was to "provide more adequate protection to the Nevada consumer by defining specifically what an unfair trade practice is and provid[e] better enforcement procedures in the interest of the Nevada consumer." Hearing on A.B. 594, Before the S. Comm. on Com. & Lab., 58th Leg., at 979 (Nev., May 16, 1975) (testimony of Milos Terzich, representing American Life Insurance and Health Insurance of America). The express purpose of the statute was to provide protection to consumers of insurance. While medical service providers may have overlapping interests, the intent of the legislation does not support finding a private cause of action for medical service providers.

Because all factors weigh against TeamHealth, we find no implied right of action for medical provider claimants under NRS 686A.310. The express language of the statute and the legislative history support limiting private rights of action under the UCPA to insureds. As a result, United is entitled to a judgment as a matter of law on this claim, and the district court erred in denying United's renewed motion.

TeamHealth failed to establish a claim of implied-in-fact contract but presented sufficient evidence to support the jury's verdict on its claim of unjust enrichment

United argues it is also entitled to judgment as a matter of law because no implied-in-fact contract existed. Additionally, United argues TeamHealth's claim of unjust enrichment is improper because TeamHealth had an adequate remedy at law, as it could pursue contract remedies against United's members, and TeamHealth did not confer any valuable benefit on United. We review both arguments in turn, concluding no implied-in-fact contract existed between TeamHealth and United, but the evidence supported the jury's verdict in favor of TeamHealth on the issue of unjust enrichment.

No implied-in-fact contract exists because TeamHealth and United did not have a meeting of the minds

While no express agreement existed between the parties, at trial the jury found an implied-in-fact contract. The existence of a contract is a question of fact this court will not disturb unless the factfinder's determination was "clearly erroneous or not based on substantial evidence." *May v. Anderson,* 121 Nev. 668,

672-73, 119 P.3d 1254, 1257 (2005). An implied-in-fact contract is a "true contract that arises from the tacit agreement of the parties." *Certified Fire Prot. Inc. v. Precision Constr., Inc.,* 128 Nev. 371, 379, 283 P.3d 250, 256 (2012) (quoting 1 Joseph M. Perillo, *Corbin on Contracts* § 1.20, at 64 (rev. ed. 1993)). To find an implied-in-fact contract, the parties must have intended to contract with exchanged promises, and the general obligations must be sufficiently clear. *Certified Fire,* 128 Nev. at 379-80, 283 P.3d at 256. An implied-in-fact contract is manifested by conduct. *Id.* Courts may fill in implied contracts without a set price term by using quantum meruit restitution, which usually is valued at market price for services rendered. *Id.*

At trial, TeamHealth asserted United's continued practice of reimbursing TeamHealth for out-of-network emergency medical services created an implied-in-fact contract for reasonable reimbursement. The jury found in TeamHealth's favor on the claim of an implied-in-fact contract.

No implied-in-fact contract can exist without an intent to contract between parties and without sufficient information to supply necessary terms. *Certified Fire,* 128 Nev. at 379-80, 283 P.3d at 256. The evidence presented at trial does not support the existence of an implied-in-fact contract because the record does not demonstrate any meeting of the minds regarding specific obligations of the parties. To the contrary, the parties were unable to agree on material terms of a new contract, which led to TeamHealth becoming an out-of-network provider. Even though United paid TeamHealth after the parties' express

contract terminated, the payments were not made pursuant to an implied contract but rather independent legal obligations of each party: TeamHealth provided services required under the EMTALA, and United met obligations to its policyholders who would have been statutorily required to pay outside any contract between United and TeamHealth. TeamHealth presented no evidence of independent promises exchanged between United and TeamHealth.

Because the jury verdict finding an implied-in-fact contract was not supported by the evidence, we find the district court erred by failing to grant judgment as a matter of law on the breach of contract claim.

The evidence at trial supported TeamHealth's unjust enrichment claim

United argues it had no duty to provide payment for emergency medicine services to members, and no duty was created when TeamHealth providers treated emergency patients. TeamHealth argues United was unjustly enriched from United's underpaying and TeamHealth's business practice to not bill patients individually, resulting in economic benefit to United.

This is an issue of first impression in our court. For guidance, we turn to decisions of other courts and to the Restatement (Third) of Restitution and Unjust Enrichment. Both persuade us unjust enrichment applies to TeamHealth's claims.

Unjust enrichment occurs when a plaintiff "confers a benefit on the defendant, the defendant appreciates such benefit, and there is 'acceptance and retention by the defendant of such benefit under circumstances such that it would be inequitable for him

to retain the benefit without payment of the value thereof.'" *Certified Fire,* 128 Nev. at 381, 283 P.3d at 257 (quoting *Unionamerica Mortg. & Equity Tr. v. McDonald,* 97 Nev. 210, 212, 626 P.2d 1272, 1273 (1981)). The Southern District of New York considered a nearly identical case in *Emergency Physician Services of New York v. UnitedHealth Group, Inc.,* 749 F. Supp. 3d 456 (S.D.N.Y. 2024). In *Emergency Physician,* no contract existed between the insurer and hospital, but hospitals were statutorily obligated through EMTALA to provide treatment and services to those patients who came to emergency departments, regardless of insurance status. *Id.* at 462-63. The hospitals alleged they were being underpaid for the emergency services provided. *Id.* at 464.

The federal court emphasized the difference between unjust enrichment claims in cases involving elective care and in those involving emergency care. *Id.* at 472-73. In cases where a hospital is required by law to render emergency care, the court noted that "an insurance company is unjustly enriched if it fails to pay the hospital in full for the costs incurred in rendering the necessary treatment to the [insureds]." *Id.* (quoting *N.Y C. Health & Hosps. Corp. v. Wellcare of N.Y., Inc.,* 937 N.Y.S.2d 540, 545 (Sup. Ct. 2011)).

The Restatement (Third) of Restitution and Unjust Enrichment also supports allowing an unjust enrichment claim under the current circumstances. Unjust enrichment claims are appropriate where one party performs another's contractual duty if the balance of equities favors restitution. *See* Restatement (Third) of Restitution & Unjust Enrichment § 22 cmt. g (Am. L. Inst. 2011) ("At the margins of the rule of §

22(2)(b) are cases in which the claimant has performed another's *contractual* duty to support a third person, or in which the duty of support might be characterized as moral rather than legal.").

The Restatement provides an illustration supporting unjust enrichment as a proper claim in the context of a dispute for payment for medical services. *Id.* § 22 cmt. g, illus. 10. The illustration explains when a contract between parties—hospital and insurer—expires and is not renewed and the hospital continues to provide services to the insurer's insureds, no implied contract exists to obligate the parties to pay and accept payment at either the rate previously agreed upon or any higher rate demanded by the hospital; instead, the hospital has a claim for unjust enrichment measured by "the reasonable value of the services rendered by Hospital." *Id.*

Evidence at trial showed United benefited from TeamHealth's practice not to individually bill or balance bill patients. "Balance billing" is a practice where the patient is responsible for paying the difference between the bill submitted by the medical provider and the payment received from the insurance company. *Marcus v. Rouillard,* No. CV 19-8057-GW-AGRx, 2022 WL 22573481, at *2 (C.D. Cal. 2022). United had a contractual duty to its insureds to pay reasonable rates for out-of-network emergency care. TeamHealth elicited testimony from United at trial that United benefited when TeamHealth did not bill United insureds for the balance between what United paid and what TeamHealth billed. ("It's a benefit when our patients are not being balance billed."). This results in a benefit for United because United could

determine the amount to pay for emergency medical services, while its members were not billed for the balance. Under the circumstances, TeamHealth was entitled to bring a claim for unjust enrichment asserting United did not provide full payment.

TeamHealth's claims involve emergency medical services, not elective health care. TeamHealth was statutorily obligated under EMTALA to provide treatment to emergency patients. We conclude that when a medical provider is required to provide emergency care, the provider may have a claim for unjust enrichment if the insurance company fails to reimburse the provider for the reasonable value of the services provided to its insureds.

We decline to grant a new trial

United argues if it is not entitled to judgment as a matter of law on all claims, it is entitled to a new trial under NRCP 59 based on evidentiary rulings at trial. Particularly, United argues the district court erred in excluding various forms of evidence. Additionally, United alleges the district court erred in instructing the jury on spoliation. None of these issues warrants relief.

We find no abuse of discretion in the district court's evidentiary rulings because there was no implied-in-fact contract and United was not precluded from introducing evidence sufficient to support its defense

United challenges four evidentiary rulings made by the district court: (1) exclusion of evidence of in-network reimbursement rates TeamHealth accepted from other insurers, (2) exclusion of evidence of prior

negotiations with TeamHealth to demonstrate the failed agreement, (3) exclusion of evidence to demonstrate the rate of reimbursement set by Medicare was reasonable, and (4) exclusion of evidence relating to TeamHealth's costs and profits. United attempted to introduce all excluded evidence to establish a reasonable value of emergency medicine services provided.

We review a district court's decision to admit or exclude evidence for an abuse of discretion, and we will not interfere with the district court's exercise of discretion absent a showing of palpable abuse. *M.C. Multi-Farn. Deu., LLC v. Crestdale Assocs., Ltd.,* 124 Nev. 901, 913, 193 P.3d 536, 544 (2008). All relevant evidence is admissible at trial unless otherwise excluded by the rules of evidence or other law. NRS 48.025. Evidence is relevant if it has "any tendency to make the existence of any fact that is of consequence to the determination of the action more or less probable than it would be without the evidence." NRS 48.015.

The district court did not abuse its discretion in excluding evidence of in-network rates between TeamHealth and other insurers

United sought to admit evidence of the in-network reimbursement rates TeamHealth accepted from other insurers during the disputed period. The district court understood this case to be "basically a collection case" to determine the reasonable value of services rendered by TeamHealth. Because the parties had no express contract, the district court found the other TeamHealth in-network contracts irrelevant. In-network reimbursement rates are negotiated, unlike out-of-network relationships where providers

have no contractual agreement with an insurer. What parties expressly agree to may or may not relate to an objectively reasonable value for services; a party may accept a higher or lower emergency medicine reimbursement rate based on other provisions in the contract. *See Geddes v. United Staffing All. Emp. Med. Plan,* 469 F.3d 919, 930 (10th Cir. 2006) (explaining in-network rates are negotiated for reimbursements below the prevailing market rate).

Here, for example, United sought to introduce evidence indicating TeamHealth entered into an in-network agreement with another insurance company for an all-inclusive ER visit rate of $320 per visit. United paid reimbursements of more than $320 on some of the challenged claims. Yet, TeamHealth's willingness to enter into a flat rate reimbursement agreement as part of an in-network contractual agreement does not necessarily reflect the reasonable value of services. Because of the limited relevance of this evidence, we cannot conclude the district court abused its discretion in excluding evidence of in-network rates between TeamHealth and other insurers.

The district court did not abuse its discretion in excluding evidence of prior contract negotiations between TeamHealth and United

United sought to introduce evidence of its own prior contract negotiations with TeamHealth. The district court excluded this evidence of prior negotiations because proposed rates during negotiations need not be reasonable. Under most circumstances, allowing failed contract negotiations to be admitted would suggest a party could reject a contract and then

retroactively bind the offeror to its original offer. Additionally, contract negotiations are often complex, and parties may make significant concessions for certain contract terms. As noted by the district court, offers made during contract negotiations do not necessarily reflect the market value for services and would typically be of limited evidentiary value. Accordingly, the district court did not abuse its discretion in excluding the contract negotiation evidence.

The district court did not abuse its discretion in excluding evidence of Medicare rates being used as the reasonable or industry standard

United objects to the district court's exclusion of evidence of Medicare reimbursement rates as a baseline for what is reasonable or largely accepted by insurance providers. United argues this exclusion prejudiced its ability to defend against TeamHealth's claims because Medicare rates would establish such rates as the industry standard. The district court, in its broad discretion, excluded "[a]ny evidence, argument, or testimony that Medicare or non-commercial reimbursement rates are the reasonable rate, [and] that providers accept it most of the time." The district court did not exclude all evidence of Medicare reimbursement rates, but more specifically excluded evidence of Medicare reimbursement rates being used to determine or establish such rates as "reasonable" or industry standard. United was permitted to argue at trial that its reimbursement rate being 164% of the Medicare reimbursement rate was reasonable.

Medicare rates—notably determined by the government as opposed to fluctuating with market prices—do not alone determine reasonability of rates

in a commercial transaction. *See Baker Cnty. Med. Servs., Inc. v Aetna Health Mgmt., LLC,* 31 So. 3d 842, 845-46 (Fla. Dist. Ct. App. 2010). The district court did not abuse its discretion by excluding arguments claiming Medicare rates were reasonable or the industry standard.

The district court did not abuse its discretion in excluding evidence of cost and profit in favor of analyzing measurements under the market value

United also objects to the district court's exclusion of evidence of TeamHealth's costs and profits in providing the disputed care. United relies on *Certified Fire* for the proposition that evidence of costs is generally relevant to a reasonable value determination. *Certified Fire,* 128 Nev. at 381 n.3, 283 P.3d at 257 n.3. When explicitly considering difficult questions regarding "medical treatment," the Restatement notes "in most cases of quantum meruit, . . . a liability [is] measured by market value." Restatement (Third) of Restitution & Unjust Enrichment § 20 cmt. c (Am. L. Inst. 2011). Given the nature of the claim, the district court did not abuse its discretion in excluding the specific cost and profit evidence as that evidence would not necessarily establish market value of the services.

Additionally, the record does not reflect any prejudice to United. Even if the district court erred in failing to allow cost evidence, United cannot show it was prejudiced by the exclusion of the cost testimony because witness testimony provided an estimate for a reasonable value of the reimbursement rate. United elicited testimony criticizing TeamHealth's billed charges as being arbitrarily high, with some testimony demonstrating TeamHealth set their bill to the

80th percentile of typical payments for services. Ultimately, the jury found a reasonable value of reimbursement somewhere between TeamHealth's billed charges and United's determined values, and closer to the value determined by United. The jury returned a verdict of $2,650,512, far less than the $15 million TeamHealth requested for reimbursement for services provided.

Despite lacking clarity, the jury instruction on spoliation did not amount to reversible plain error

During discovery, United failed to produce numerous documents, notwithstanding five orders to produce. The district court found this conduct to be willful, and that, by omission, "there has been an effort by United to keep [TeamHealthl from discovering information and having access to witnesses." Based on that finding, the district court instructed the jury that United had willfully suppressed evidence:

> Willful suppression means the willful or intentional spoliation of evidence and requires the intent to harm another party or their case through its destruction and not simply the intent to destroy evidence. When a party seeking the presumption's benefit has demonstrated that the evidence was destroyed with intent to harm another party or their case, the presumption that the evidence was adverse applies .... If not rebutted, the jury is required to presume that the evidence was adverse to the destroying party.

No objections were made to the instruction given to the jury. Generally, failing to object to a jury instruction precludes appellate review unless there is plain error. NRCP 51(c); *Cook v. Sunrise Hosp. & Med. Ctr., LLC,* 124 Nev. 997, 1001-02, 194 P.3d 1214, 1216-17 (2008). Here, United is not entitled to relief because the jury instruction conflated the concepts of suppression and spoliation but correctly stated the law.

We review a court's decision to give a particular instruction for an abuse of discretion. *Bass-Davis v. Davis,* 122 Nev. 442, 447, 134 P.3d 103, 106 (2006). We review de novo whether an instruction provides an incorrect statement of the law. *Cook,* 124 Nev. at 1003, 194 P.3d at 1217. If a jury instruction misstates the law, reversal is warranted only when, "but for the error, a different result may have been reached." *Id.* at 1006, 194 P.3d at 1219 (citing *Pfister v. Shelton,* 69 Nev. 309, 250 P.2d 239 (1952)); *see Walker v. Groot,* 867 F.3d 799, 803-04 (7th Cir. 2017) (discussing plain error review of jury instructions under the federal counterpart to NRCP 51(c)).

The record supports the trial court's determination that United willfully suppressed the evidence requested after multiple attempts by TeamHealth to obtain the information. Willfulness is generally a question of fact. *Abbott v. City of Henderson,* 140 Nev., Adv. Op. 3, 542 P.3d 10, 14 (2024). When a party has adequate notice and time to preserve and produce evidence, but fails to do so, the evidence is willfully suppressed. *Bass-Davis,* 122 Nev. at 452, 134 P.3d at 109-10.

Here, the instruction issued by the district court failed to differentiate between destruction and suppression. An act of destruction, or spoliation, involves the failure to preserve evidence that a party knows or reasonably should know is relevant to actual or anticipated litigation. *MDB Trucking, LLC v. Versa Prods. Co.,* 136 Nev. 626, 630, 475 P.3d 397, 402 (2020). An act of suppression occurs when evidence is intentionally withheld or concealed by a party. *See Compass Bank v. Morris Cerullo World Evangelism,* 104 F. Supp. 3d 1040, 1059 (S.D. Cal. 2015) (finding willful suppression of evidence when a party hid highly relevant and clearly discoverable evidence and repeatedly was not forthcoming with evidence).

Because the acts differ, differentiating between destruction and suppression would provide for a clearer instruction. *See generally MDB Trucking,* 136 Nev. at 632, 475 P.3d at 404. Even so, the legal result is the same—both willful suppression and willful destruction of evidence call for a rebuttable presumption instruction to be given. *See id.* If the presumption is not rebutted, the jury is required to presume that the evidence was adverse to the destroying or suppressing party. *Bass-Davis,* 122 Nev. at 448, 134 P.3d at 107.

United failed to object to the instruction at trial and failed to establish plain error. Despite its lack of clarity about the mechanism, the instruction stated the correct law, and United cannot demonstrate that the outcome would have been different with a clearer instruction.

We remand to the district court to reduce the amount of punitive damages

The jury awarded $60 million in punitive damages in addition to the $2.6 million award of compensatory damages. A plaintiff may recover punitive damages for the "breach of an obligation not arising from contract" when clear and convincing evidence of "oppression, fraud or malice, express or implied," exists. NRS 42.005(1). The jury's award must be overturned if "the amount of damages awarded is *clearly* disproportionate to the degree of blameworthiness and harmfulness inherent in the oppressive, fraudulent or malicious misconduct of the tortfeasor under the circumstances of a given case." *Bongiovi v. Sullivan,* 122 Nev. 556, 582, 138 P.3d 433, 451 (2006) (quoting *Ace Truck & Equip. Rentals, Inc. v. Kahn,* 103 Nev. 503, 509, 746 P.2d 132, 136-37 (1987)).

In examining the award of punitive damages here, we first conclude an unjust enrichment claim can support punitive damages. While this court has not affirmed a punitive damages award in an unjust enrichment action before, nothing in Nevada law prohibits an award of punitive damages on an unjust enrichment claim. The Restatement (Third) of Restitution and Unjust Enrichment notes that "there is no intrinsic inconsistency in a judgment that reinforces disgorgement of wrongful gain with an explicitly punitive award," § 51 cmt. k (Am. L. Inst. 2011), and caselaw supports that liability in restitution for unjust enrichment is not an obligation arising from a contract for purposes of California's statutory analog to NRS 42.005(1), *id.* illus. 26 & associated reporters'

note (citing *Ward v. Taggart,* 336 P.2d 534, 538 (Cal. 1959)).

Punitive damages are recoverable when a plaintiff proves the defendant is "guilty of oppression, fraud or malice, express or implied." *Bongiovi,* 122 Nev. at 581, 138 P.3d at 450-51 (quoting NRS 42.005(1)). To justify punitive damages in this case, United's conduct must have exceeded "mere recklessness or gross negligence." *Wyeth v. Rowatt,* 126 Nev. 446, 473, 244 P.3d 765, 783 (2010) (quoting *Countrywide Home Loans, Inc. v. Thitchener,* 124 Nev. 725, 742-43, 192 P.3d 243, 254-55 (2008)).

Here, the jury was presented with sufficient evidence of implied malice on the part of United to support the jury's determination that punitive damages were warranted. For example, TeamHealth presented evidence that United used a seemingly objective third-party service called Data iSight to set rates while secretly paying out based on predetermined amounts, which TeamHealth argued constitutes fraud. Data iSight was discussed extensively at trial by a witness for United, who explained Data iSight was a pricing tool to help determine how much should be paid for out-of-network medical bills. Data iSight has a pricing methodology that will take a bill, reprice it dependent on a reasonable rate, and send it back to United. TeamHealth presented evidence that United manipulated the calculations to be based on Medicare rates instead of reasonable national benchmarking reimbursement rates.

TeamHealth also argues there is evidence of oppression because United reimbursed TeamHealth at

rates far below similarly situated emergency medicine providers. This resulted in injury to emergency medical providers by not providing accurate information as to what the medical provider could expect as payment from United.

Finally, TeamHealth points to evidence of United's input into a "Yale Study" to create a narrative that emergency medicine providers were overbilling. TeamHealth presented evidence at trial that United had heavily involved itself in the editing of the study prior to its release, even going so far as to remove United's name entirely from the study after the article produced negative media attention. While removing its own name, United's senior executives decided to include TeamHealth by name as one of the entities negatively impacting the cost of emergency room visits and hospital admissions. Because evidence supported the determination that United's conduct exceeded mere recklessness or gross negligence, we will not disturb the jury's decision to award punitive damages.

Even so, we must consider the amount of punitive damages awarded. NRS 42.005(1). Nevada statutory law generally limits punitive damages to "[t]hree times the amount of compensatory damages awarded to the plaintiff if the amount of compensatory damages is $100,000 or more." NRS 42.005(1)(a).

In addition to the statutory cap, the court must consider due process in confirming an award of punitive damages. *Bongiovi,* 122 Nev. at 582, 138 P.3d at 451. The "ratio between compensatory and punitive damages" is a "central feature" of the "due process analysis." *Exxon Shipping Co. v. Baker,* 554 U.S. 471,

507 (2008). The Supreme Court has indicated a punitive damages award with a ratio that can be categorized as "grossly excessive" when compared to compensatory damages violates the Due Process Clause of the Fourteenth Amendment. *BMW of N. Am., Inc. v. Gore,* 517 U.S. 559, 568 (1996) (internal quotation marks omitted); *State Farm Mut. Auto. Ins. v. Campbell,* 538 U.S. 408, 416 (2003). When compensatory damages are "already substantial, a ratio of 1:1 may be the most the Constitution will permit." *Lompe v. Sunridge Partners, LLC,* 818 F.3d 1041, 1069 (10th Cir. 2016).

We have previously determined the guideposts established by the Supreme Court in *Gore,* 517 U.S. at 574-75, are the proper standards for reviewing excessiveness. *Bongiovi,* 122 Nev. at 583, 138 P.3d at 452. These guideposts include the degree of reprehensibility of the defendant's conduct, the ratio of punitive damages to compensatory damages, and the sanctions for comparable misconduct. *Id.* We will discuss each of those in turn.

First, the degree of reprehensibility should reflect "the enormity of [the defendant's] offense." *Id.* at 575 (quoting *Day v. Woodworth,* 54 U.S. 363, 371 (1851)). For example, "'trickery and deceit' are more reprehensible than negligence." *Id.* at 576 (citation omitted) (quoting *TXO Prod. Corp. v. All. Res. Corp.,* 509 U.S. 443, 462 (1993)). In *Gore,* the harm inflicted by the defendant—alleged fraudulent sale of a repaired vehicle represented as new—was purely economic in nature and the award issued on a 500:1 ratio was grossly excessive for the harm caused. *Gore,* 517 U.S. at 563, 582-83.

Conversely, in *TXO Products,* the Supreme Court found a punitive award issued on a ratio of 526:1 was substantial, but when considering the value of potential future harm, did not defy "constitutional sensibilities." 509 U.S. at 459-62 (quoting *Pac. Mut. Life Ins. Co. v. Haslip,* 499 U.S. 1, 18 (1991)).

Second, courts should consider the ratio between punitive awards and compensatory damages. *Gore,* 517 U.S. at 580. No precise mathematical formula determines what ratio is constitutionally acceptable. *Id.* at 582. A higher ratio may be justified in cases where it is difficult to determine the monetary value of an injury. *Id.* This court has previously held punitive damages awarded on a 1:1 ratio "not excessive because [the punitive damages were] both reasonable and proportionate to the amount of harm to [the plaintiff] and to the compensatory damages award." *ETT, Inc. v. Delegado,* No. 46901, 2010 WL 3246334, at *5 (Nev. Apr. 29, 2010) (Order of Affirmance).

The final guidepost from *Gore* is comparing the disparity between the punitive damages award with any civil penalties that could be imposed for comparable misconduct. 517 U.S. at 583. Criminal penalties have also been used as reference in determining whether a punitive damages award was excessive, because criminal penalties demonstrate the seriousness of the State's views on the wrongful action. *State Farm,* 538 U.S. at 428 (citing *Gore,* 517 U.S. at 583, and *Haslip,* 499 U.S. at 23). A possible criminal sanction "does not automatically sustain a punitive damages award," however. *Id.* Insurance-related violations under NRS Title 57 are misdemeanors carrying

a $1,000 fine, with some limited exceptions. NRS 679A.180(1); NRS 193.150.

While the damage here was entirely economic, TeamHealth presented some evidence that United manipulated data to make it seem as if the reimbursements were objectively set and reasonable, when in reality, they were not. The jury awarded $60 million in total punitive damages in addition to the $2,650,512 total compensatory damages. The judgment provides specific figures for each separate defendant, but the overall ratio equates to roughly 22.6:1, significantly exceeding both the Nevada statutory maximum ratio and the federally established due process maximum. Additionally, the high amount of punitive damages appears to be based in part on trial evidence about United's relationship with its insureds and United's conduct during litigation rather than only United's conduct aimed at TeamHealth. We find this award to be grossly excessive and a violation of the Due Process Clause under the Fourteenth Amendment.

Considering the facts and circumstances of this case, we find that an award of punitive damages in the maximum amount allowed by NRS 42.005(1)(a)—a ratio of 3:1—would violate due process, given the economic nature of the harm and the sophistication of the parties. Accordingly, we vacate the award of $60 million and remand to the district court to reduce the award of punitive damages to a 1:1 ratio of actual to punitive damages for each separate defendant.

The Prompt Pay Act does not apply to claims of disputed reimbursement amounts

The district court awarded TeamHealth additional damages under the PPA: first, $800,000 of prejudgment interest at a penalty rate provided for by statute on late-paid claims; and second, attorney fees in an amount exceeding $12 million. The PPA places an obligation on insurers and third-party administrators to "approve or deny a claim relating to health insurance coverage within 30 days" and to pay the full amount of the approved, payable amount. NRS 683A.0879(1). Facially, the PPA does not cover claims when the amount paid is disputed because the PPA speaks only categorically of approval, denial, and payment. *See Emergency Dep't Physicians P.0 v. United Healthcare, Inc.,* 507 F. Supp. 3d 814, 825 (E.D. Mich. 2020) (concluding Michigan's similarly worded prompt pay act regulates how quickly claims must be reimbursed, while other statutes regulate the amount to be paid). Here, TeamHealth asserts only that United under-reimbursed for the disputed claims, not that United failed to timely administer those claims. Because the legal claim here involves only amount of payment, we reverse the judgment as to the prejudgment interest awarded against United under the PPA and remand for a new determination of prejudgment interest.

In addition to the penalty-rate prejudgment interest imposed for violation of the PPA, the district court awarded TeamHealth $12,683,044.41 in attorney fees under the PPA and NRS 18.010(2). Given that we have determined the PPA does not apply here, NRS 18.010(2) would be the sole basis for an award of at-

torney fees. NRS 18.010(2) authorizes an award of attorney fees to the prevailing party if (1) they have "not recovered more than $20,000," or (2) the court finds a claim "or defense of the opposing party was brought or maintained without reasonable ground" or was intended to harass. TeamHealth recovered substantially more than $20,000, and the district court made no findings of frivolity or harassment. Accordingly, there is no basis for the awarded attorney fees, and the award is reversed.

United did not meet its burden to require sealing

United has also petitioned this court for a writ of mandamus or prohibition to prevent the district court from releasing certain proprietary information in the public docket. We exercise our discretion to consider United's petition for a writ of mandamus. *Smith v. Eighth Jud. Dist. Ct.,* 107 Nev. 674, 677, 818 P.2d 849, 851 (1991) (noting it is within this court's discretion to consider a mandamus petition). Still, because United failed to demonstrate extraordinary relief is warranted, we decline to issue the requested relief. *See id.*

The district court generally has discretion on its initial decision to seal. *See FTL Displays, LLC v. Blackout Inc.,* No. 82461-COA, 2022 WL 1772544, at *1 (Nev. Ct. App. May 27, 2022) (Order of Affirmance) (applying an abuse of discretion standard to review a sealing decision). While public access is favored, "th[e] court retains supervisory power over its records and possesses inherent authority to deny public access when justified." *Howard v. State,* 128 Nev. 736, 744, 291 P.3d 137, 142 (2012). The party seeking to seal a

record or document carries the burden of demonstrating sufficient reason to deny access. *Id.*

Here, United failed to meet its burden to demonstrate sealing is necessary to protect its trade secrets because the contested documents were admitted into the public record without objection during trial. The district court acted within its discretion.

Parties have an obligation to attempt to protect their sensitive documents at trial. *See Littlejohn v. Bic Corp.,* 851 F.2d 673, 680-81 (3d Cir. 1988) (indicating attempts must be taken in public trial to preserve confidentiality interest in documents). While United was granted a protective order over certain documents pretrial, the protective order was not sufficient to protect documents admitted at trial, as the district judge made clear: "I will not seal anything that's admitted." Even with this knowledge, United failed to object to the admission of certain documents at trial and only sought to seal the courtroom for the admission of particularly sensitive documents. United cannot now seek to seal a broader category of admitted evidence. *United States v. Park Place Assocs., Ltd.,* 563 F.3d 907, 921 (9th Cir. 2009) (holding when a party fails to timely assert a right, that right is forfeited). United's failure to object to the public admission of these documents waives any ability to now seek sealing.

Moreover, the district court did not abuse its discretion in its order regarding trial exhibits. A court has no mandate to seal. Still,

> [i]n any civil or criminal action, the court shall preserve the secrecy of an alleged trade secret

> by reasonable means, which may include, without limitation: (1) [g]ranting protective orders in connection with discovery proceedings; . . . [or] (3) [s]ealing the records of the action . . . .

NRS 600A.070.

The district court's order to seal is grounded in the evidence. The sealing order includes a 130-page appendix addressing each page of the documents on which United sought sealing. In seeking writ relief, United speaks in only general and conclusory arguments that do not supersede our principles favoring public access to records. United seems to suggest that TeamHealth's agreement to not oppose a sealing motion entitles United to the sought-after protections. But "[t]he parties' agreement alone does not constitute a sufficient basis for the court to seal or redact court records." SRCR 3(4). TeamHealth's nonopposition does not entitle United to sealing, and the motion still must adhere to the regular requirements for relief, including preservation.

United also did not seek an evidentiary hearing until after the district court ruled on the sealing motion. Accordingly, United cannot challenge the lack of an evidentiary hearing. *Cf Nelson v. Eighth Jud. Dist. Ct.,* 138 Nev. 824, 831, 521 P.3d 1179, 1186 (2022) ("Given the lack of specific factual or credibility disputes, the district court did not abuse its discretion in deciding the matter without an evidentiary hearing."). No per se rule requiring an evidentiary hearing before a sealing decision exists in Nevada law. *See Hopkins v. Selznick,* No. 49387, 2009 WL 3190347, at *2 (Nev. Sept. 28, 2009) (Order of Affirmance). United

rested on its legal arguments and two declarations. If United believed an evidentiary hearing was necessary, United should have requested the hearing prior to the court's ruling. We conclude that the district court did not manifestly abuse its discretion in denying United's motion to seal and United failed to properly preserve the issue. As a result, United has failed to show it is entitled to extraordinary relief. United's petition is denied.

CONCLUSION

We determine sufficient evidence supports the jury's verdict as to TeamHealth's unjust enrichment claim against United for the reimbursement of emergency services provided and determine no new trial is warranted. Under Docket No. 85525, we affirm the compensatory damages award of $2,650,512. We also find evidence supported an award of punitive damages by the jury; however, looking at Nevada law and constitutional principles, we find the amount awarded was excessive. Accordingly, we vacate the punitive damages award and remand with instructions to enter a new award based on a 1:1 ratio of compensatory to punitive damages. Because the PPA does not apply here, we reverse the prejudgment interest and attorney fees awards; we remand for a new determination of prejudgment interest. Further, on remand, the district court should grant United's motion for judgment as a matter of law on TeamHealth's breach of contract and UCPA claims. Under Docket No. 85656, we decline to issue the requested writ relief regarding record sealing and lift the extended stay from March 14, 2023.

/s/_____, J.
Bell

/s/_____, J.
Herndon

/s/_____, J.
Pickering

/s/_____, J.
Parraguirre

/s/_____, J.
Stiglich

/s/_____, J.
Cadish

/s/_____, J.
Lee

APPENDIX B

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

Case Non.: A-19-792978-B

Dept. No.: XXVII

ORDER DENYING DEFENDANTS' RENEWED MOTION FOR JUDGMENT AS A MATTER OF LAW

Hearing Date: June 29, 2022

Hearing Time: 10:00am

OF NEVADA, INC., a Nevada corporation,

Defendants.

This matter came before the Court on June 29, 2022 on defendants UnitedHealthcare Insurance Company ("UHIC"); United Health Care Services, Inc. ("UHS"); UMR, Inc.; Sierra Health and Life Insurance Co., Inc. ("SHL"); and Health Plan of Nevada, Inc. ("HPN") (collectively, "Defendants" or "United")'s Renewed Motion for Judgment as a Matter of Law (the "Motion"). Patricia Lundvall, McDonald Carano LLP, and Jane Langdell Robinson, Joseph Y. Ahmad, Kevin Leyendecker, and Jason McManis, Ahmad, Zavitsanos & Mensing, P.C., appeared on behalf of plaintiffs Fremont Emergency Services (Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); and Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest" and collectively the "Health Care Providers"). Daniel Polsenberg, Lewis Roca Rothgerber Christie LLP, Colby Balkenbush, Weinberg, Wheeler, Hudgins, Gunn & Dial LLC, and Jeffrey Gordon, O'Melveny & Myers LLP, appeared on behalf of Defendants. After argument on the Prompt Pay Act, the parties elected to submit the remainder of the motion to the Court on the briefs without further argument. *See* EDCR 2.23(c).

The Court, having considered the Motion, the Health Care Providers' opposition, the reply, the record in this case, and the argument of counsel at

the hearing on this matter, and good cause appearing, finds and orders as follows:

FINDINGS OF FACT

1. On November 29, 2021, the jury, after hearing the evidence at trial, found in favor of Plaintiff for every cause of action, including the Breach of Implied in Fact Contract and Unjust Enrichment. The jury awarded Plaintiffs economic damages totaling $2,650,512.

2. On December 7, 2021, the jury found in favor of Plaintiffs, awarding punitive damages totaling $60,000,000.

3. Substantial evidence exists on the record to support the verdicts against all defendants.

4. The evidence at trial included claim files demonstrating thousands of instances in which the Health Care Providers cared for the members of all five defendants, including the charges that were billed for those visits and the amount that Defendants paid. *See*, *e.g.*, PX473 (Columns V and AB identifying parties that adjudicated claim); *see also* 11/18/21 Tr. at 225:18–226:13 (testimony of Bruce Deal that United produced claims data across five defendants).

5. Plaintiffs introduced evidence supporting the conclusion that all defendants were engaged in driving down emergency-care reimbursements to unfair and unreasonable rates with a motivation to increase their own profit. Testimony showed that UHIC and UHS engaged in a campaign to abolish the industry-standard approach (based on FAIR

Health) and "get clients off R&C/Fair Health." PX368 at 7; 11/3/21 Tr. at 50:21–51:1; 11/12/21 Tr. at 14:9–13, 17:1–9. They sought to use alternatives that allowed them to charge clients for additional "shared savings" fees that were unavailable if clients used FAIR Health. 11/3/21 Tr. at 49:5–9, 50:21–51:1. The revenue UHIC and UHS generated from shared savings fees for a given claim was calculated as up to 50% of the difference between a provider's billed charge and the amount United paid. PX010 at 60; 11/12/21 Tr. at 201:14–17. In other words, the less it paid to healthcare providers, the more shared savings revenue United received from the client. *Id.*; *see also* 11/8/21 Tr. at 149:17–150:24.

6. Ms. Hare testified that SHL and HPN paid the same reimbursement for all emergency-care visits, regardless of severity. 11/16/21 Tr. at 156. Exhibits showed this universal payment was low. *See*, *e.g.*, PX473B-1; PX473C; PX473 at rows 6418, 6472, 6491, 6562, 6777, 9314, 9320, 10771, 11121, 11126; 11/16/21 Tr. at 157:10–18.

7. Mr. Ziemer testified about UMR's own cost-savings program, which resulted in low payments to the Health Care Providers. 11/15/21 Tr. at 190:8–12; 207:20–208:19, 231:20–232:19. Exhibits supported the Health Care Providers' arguments that UMR's cost-savings approach was unfair and random. PX256, PX473A, PX473B.

8. The jury found that the Plaintiffs and Defendants had implied-in-fact contracts with each other. The jury further found that Defendants all engaged in unfair claims practices in connection with the payment of the Health Care Providers' claims.

9. The Health Care Providers introduced evidence that Defendants' unfair claims practices caused them direct harm. The jury agreed and awarded damages to Plaintiffs against Defendants for those violations.

10. The evidence at trial supported the conclusion that when Defendants acted as third-party administrators, they still determined the rates that would be paid to the Health Care Providers. 11/10/21 Tr. at 75:10–21; 11/16/21 Tr. at 22:18–21.

11. The evidence supported the conclusion that Defendants did not dispute their liability for their members' claims, although they disputed the amounts the Health Care Providers requested as payment for those claims. The Health Care Providers submitted claims for payment, and Defendants paid each claim at a lower amount.

12. Defendants acknowledged that they manage so many claims that they rely on automation to help administer them. 11/15/21 Tr. at 20:7–19; see also id. at 75:22–76:2; 217:3–17.

13. The evidence supports the jury's conclusions that Mr. Haben, Mr. Ziemer, and Ms. Hare were all aware of the policies by which Defendants determined the rates of payment to the Health Care Professionals. Each one also qualified as an officer, director, or department head: Mr. Haben of UHS and UHIC; Mr. Ziemer for UMR; and Ms. Hare for SHL and HPN. Specifically, Mr. Haben testified that he was in charge of out-of-network payments for UHS and UHIC. 11/10/21 Tr. 13:5–7. Mr. Ziemer was vice

president of customer solutions and in charge of setting reimbursement strategies for UMR. 11/15/21 Tr. at 182:24–10. And Ms. Hare testified that she was in charge of claim reimbursement for SHL and HPN. 11/16/21 Tr. at 133:1–7. These witnesses' testimony also showed that they were familiar with the manner in which their respective companies set reimbursements. 11/12/21 Tr. at 20:3–17; 11/15/21 Tr. at 250:15–252:19.

14. The evidence further supported the conclusion that each of Defendants developed reimbursement methodologies that were calculated to systematically underpay the Health Care Providers' claims.

15. The evidence supported the conclusion that the relationship between Defendants and the Health Care Providers is characterized by unequal bargaining power, with Defendants in the more powerful position. This is because the Health Care Providers must treat Defendants' members without regard to ability to pay and can only seek reimbursement after they have already provided the service at issue.

16. Defendants' representatives testified that each Defendant has a duty to pay a reasonable reimbursement amount. 11/15/21 Tr. at 36:17–22; *id.* at 203:8–12; 11/16/21 Tr. at 203:19–24. Despite that obligation, UHIC, UHS, and UMR implemented MultiPlan's Data iSight service and moved clients away from paying reasonable and customary rates. PX368 at 7; 11/3/21 Tr. at 50:21–51:1; *see also* PX243 (correspondence from Paradise to Haben evaluating UMR out-of-network reimbursement);

11/15/2021 Tr. at 208:7–19 (testimony of Ziemer describing UMR's use of Data iSight). They knew that Plaintiffs and other healthcare providers did not agree to this, "proposing a move over time towards non-secured (i.e. not a contracted discount) reductions . . . ." PX244 at 1.

17. Plaintiffs introduced evidence that while SHL and HPN did not use the same cost reduction programs, the rates they paid were even lower. *See* PX473C. Moreover, the evidence showed that SHL and HPN were on notice that they had not paid a reasonable value in accordance with the Affordable Care Act. PX348; PX 325; 11/15/21 Tr. at 160:20–10; PX314. The evidence further showed that Defendants' motivation for reducing out-of-network reimbursement rates was to increase their profits. PX243; PX477 at 3–4; 11/2/21 Tr. at 161:6–8; PX342 at 16, 20; PX478 at 14.

18. The evidence showed that Defendants' conduct harms Plaintiffs, emergency-care providers on whom the community depends, and thus risks the quality of care available to the public. 11/19/21 Tr. at 32:17–33:4. The evidence further supported the conclusion that Defendants targeted Plaintiffs, who (unlike medical practice groups without a national affiliation) have the ability to push back against Defendants' policies. 11/17/21 Trial Tr. at 38:20–24 (testimony of Deal that Defendants reimbursed Plaintiffs $245 per claim on average and $528 to other providers in Nevada).

19. The Health Care Providers provided evidence that Defendants claimed to treat emergency-care providers fairly when that was not true. PX163 at

82 ("SHL recognizes that claim problems occur from time to time. We appreciate our physicians and providers bringing them to our attention. We handle these claims as expeditiously as we can. Reasonable procedural guidelines are established to manage them."); PX322 (advising Congress about adequate levels of reimbursement for out-of-network emergency services); *see also id.* at 80; PX165 at 180, 182. Evidence at trial also showed Defendants blamed doctors—and specifically practices affiliated with TeamHealth—for driving up medical costs, while at the same time United's own physician-staffing group charged rates far in excess of Plaintiffs' billed charges. PX079 at (authorizing identification of TeamHealth in media publication about surprise medical bill study); 11/18/21 Tr. at 225:9–17 (Plaintiffs' billed charge of $1,428 for 99285 CPT code); *id.* at 277:15–20 (Sound Physicians charge of $1,761 for 99285 CPT code).

20. The evidence at trial showed that Defendants held themselves out as performing fair and objective reimbursement determinations. PX142 at 42 (UHIC certificate of coverage); PX120 at 86 (UHS summary plan description); PX296 at 81 (UMR summary plan description); PX163 at 80 (SHL provider manual) PX165 at 180 (HPN provider manual); PX444 at 2 (UHS explanation of benefits). But trial evidence supported the conclusion that Defendants' real reimbursement decisions were driven primarily by profits rather than objectivity or fairness.

21. The Health Care Providers introduced evidence that Defendants' unfair practices directly

harmed Plaintiffs. Trial evidence supported the conclusion that while Defendants have reduced their reimbursement rates, they have also deployed policies designed to discourage provider resistance and unfairly deny appeals. *See, e.g.,* PX243 ("We also generate additional savings by not running the claims through U&C but rather driving all OON claims to a more aggressive pricing and managing appeals to try to hold the member harmless) (emphasis added); PX375 at 2 (representing to providers that claim was processed using Data iSight, "which utilizes cost data if available (facilities) or paid data (professionals)"); PX170A (showing the profits United could make by using Data iSight instead of UCR, taking into consideration a low number of expected appeals); P470 (United rejecting an appeal because "this claim has been reviewed and reimbursed using Data iSight"); PX163 at 82 ("SHL recognizes that claim problems occur from time to time. We appreciate our physicians and providers bringing them to our attention. We handle these claims as expeditiously as we can. Reasonable procedural guidelines are established to manage them."). Plaintiffs also provided evidence of Defendants' significant market share in Nevada, underscoring the magnitude of the harm. P089 at 58 ("Sierra/United membership totaling 80% of the Clark County, Nevada market share").

22. Evidence also supported the jury's conclusion that Defendants knew of the probable harmful consequences of their wrongful acts, and willfully and deliberately failed to act to avoid those conse-

quences. As detailed above, Plaintiffs offered evidence that Defendants deliberately drove down reimbursement rates to increase their sizeable profits—without regard to the harm their policies caused emergency-care providers or the public who depends on those providers. As mentioned above, Plaintiffs further offered evidence that Defendants deliberately targeted Plaintiffs for harm because of their association with TeamHealth. 11/17/21 Trial Tr. at 38:20–24.

23. The jury found that Defendants' conduct was malicious, oppressive, and/or fraudulent and reprehensible enough to warrant the award of punitive damages. That finding was supported by extensive testimony and documentary evidence in the record.

24. Plaintiffs presented evidence that they provided emergency-care services to Defendants' members and that they also provided other benefits to Defendants, such as submitting claims in the form Defendants preferred and committing not to balance bill Defendants' members. 11/16/21 Tr. at 67:2–19, 68:6–13, 69:14–70:5 (agreement not to balance bill); 11/22/21 Tr. at 115:1–117:25 (Plaintiffs' claims submissions process using Form 1500); PX168 at 58 (requirements to submit claim using CMS 1500 forms); PX163 at 90–91 (same for SHL); PX165 at 192–93 (same for HPN). In exchange, Defendants acknowledged that they had an obligation to reimburse Plaintiffs and that the reimbursement amount should be reasonable. 11/15/21 Tr. at 36:17–22, 132:23–133:33, and 203:8–12; 11/16/21 Tr. at 203:19–23.

25. Put another way, the evidence at trial supported the conclusion that Defendants acknowledged that the Health Care Providers had provided valuable services to Defendants and their members, and that Defendants owed an obligation to reimburse the Health Care Providers a reasonable price. The evidence also supported the conclusion that Defendants understood its obligation to reimburse providers for the providers' emergency-care services to Defendants' members to be a continuing obligation.

26. In February 2020, the United States District Court for the District of Nevada determined that ERISA is inapplicable to the claims in this case, because the legal claims are based on Defendants' underpayment of claims which it had determined were payable and paid, i.e., a dispute over the proper rates of payment rather than the right to payment. This Court and the Nevada Supreme Court have also rejected Defendants' ERISA preemption arguments. June 24, 2020 Order Denying Defendants' Motion to Dismiss First Amended Complaint; July 1, 2021 Order Denying Petition for Writ of Mandamus.

27. The evidence discussed here includes only examples from the trial. The Court has considered all evidence admitted at trial in reaching the conclusions herein.

CONCLUSIONS OF LAW

28. Under Rule 50, Defendants must show that a reasonable jury would not have a legally sufficient evidentiary basis to find for the Health Care Providers. NRCP 50(a), (b). The court's power to grant

judgment as a matter of law should be cautiously exercised. *Dudley v. Prima*, 84 Nev. 549, 551, 445 P.2d 31, 32 (1968). Conflicting evidence alone is not grounds to reverse a jury's verdict; if a reasonable jury could draw inferences from the evidence to support the verdict, the verdict must not be reversed. *See Reyburn Lawn & Landscape Designers, Inc. v. Plaster Dev. Co.*, 127 Nev. 331, 344, 255 P.3d 268, 277 (2011) ("Judgment as a matter of law should not be granted when there is conflicting evidence on material issues.").

Evidence against SHL, HPN, and UMR

29. Substantial evidence exists on the record to support the verdicts against all Defendants.

30. Defendants challenge in particular the evidence against SHL, HPN, and UMR. The Court finds that substantial evidence in the record supports the verdict against each of these defendants as well as UHIC and UHS.

31. The jury heard evidence that supported the Health Care Providers' arguments, including that the Health Care Providers provided services to Defendants and their members, Defendants understood that they had an obligation to reimburse the Health Care Providers, Defendants were benefited by the Health Care Providers' actions, and without justification, Defendants failed to reimburse the Health Care Providers a reasonable amount for their services.

32. The evidence in the record is sufficient to support the verdict. Defendants are not entitled to judgment as a matter of law on this ground.

Unfair Claims Practices Act

33. NRS.686A.020 broadly prohibits any "person" from engaging in unfair claims practices:

> 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.

NRS 686A.020. The language of the statute does not limit who may bring a claim.

34. Neither *Gunny v. Allstate Ins. Co.*, 108 Nev. 344, 830 P.2d 1335 (1992) nor *Fulbrook v. Allstate Ins. Co.*, Nos. 61567 & 62199, 2015 WL 439598 (Nev. Jan. 30, 2015) (unpublished disposition) holds that the Unfair Claims Practices Act does not create a private right of action against insurers in favor of third-party claimants like the Health Care Providers. Rather, it was the lack of a legally redressable harm, not the lack of a contractual relationship, that doomed standing for the plaintiffs in those cases. In addition, while a contractual relationship is not necessary to establish standing, the finding of implied contracts between Plaintiffs and Defendants also supports Plaintiffs' standing here.

35. Moreover, the plain language of NRS 686A.310 does not prohibit a third party, such as the Health Care Providers, from raising claims under the Act, but instead provides permissively that claims may be asserted by the Commissioner or the 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."). Notwithstanding the language of NRS 686A.310(2), the Nevada Supreme Court has expressly recognized the potential availability of claims asserted by third parties who are not insureds when standing can otherwise be established. *Torres v. Nev. Direct Ins. Co.*, 131 Nev. 531, 541, 353 P.3d 1203, 1211 (Nev. 2015) (citing *Gunny*, 830 P.3d at 1336) (noting that it has "intimated in dicta in *Gunny* that a third-party who is a specific intended beneficiary of an insurance policy might have a sufficient relationship to support a bad faith claim.").

36. Therefore, the Court concludes that the Health Care Providers have standing under the Unfair Claims Practices Act.

37. As discussed above, NRS 686A.020 establishes that all persons are prohibited from engaging in "any practice which is defined in NRS 686A.010 to 686A.310, inclusive, as, or determined pursuant to NRS686A.170 to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance." The statute does not carve out liability for TPAs.

38. Further, it would not make sense to carve TPAs from liability under the Unfair Claims Practices Act. NRS 686A.310 prohibits the failure "to effectuate prompt, fair and equitable settlements of claims in which the liability of the insurer has become reasonably clear." It is the administrator, not the self-funding employer, responsible for effectuating the prompt, fair and equitable settlement of

claims. This fact is evidenced by the implementation of "shared saving"-type programs by UHS, UHC, and UMR. PX010 at 60; PX256; 11/10/21 Tr. at 71:7–9; 11/12/21 Tr. at 188:22–189:19. Excluding TPAs from the reach of the Unfair Claims Practices Act would lead to an absurd result.

39. Nevada has patterned NRS 686A.310 after the National Association of Insurance Commissioners ("NAIC") model Unfair Claim Settlement Practices Act ("UCSPA"), but modified the model rule in an important distinction to permit a private right of action under Nevada law. *See* Nevada Lawyer, *Nevada's Unfair Claims Settlement Practices Act NRS 686A.310*, Michael C. Mills, Esq. (March 2013) at p.1. The NAIC Model Act identifies an insurer as any "person . . . and any other legal entity engaged in the business of insurance, including agents, brokers, adjusters, and third party administrators." This same conclusion about including third party administrators as liable for unfair claims settlement practices can be gleaned from Nevada's insurance statutes. This makes sense because such companies are the ones who settle claims.

40. In turn, NRS 679A.130 makes it clear that third party administrators engage in the business of insurance, subjecting them to liability under NRS 686A.310.

> "Transacting insurance" defined. In addition to other aspects of insurance operations to which provisions of this Code by their terms apply, "transact" with respect to a business of insurance includes any of the following, by

> mail or otherwise or whether or not for the purpose of profit:
>
> 1. Solicitation or inducement.
>
> 2. Negotiations.
>
> 3. Effectuation of a contract of insurance.
>
> 4. Transaction of matters subsequent to effectuation and arising out of such a contract.

NRS 679A.130 (emphasis added).

41. Further, the purposes of the Nevada insurance statute include to "[i]mplement the public interest in the business of insurance," "[i]nsure that policyholders, claimants and insurers are treated fairly and equitably," and "[p]revent misleading, unfair and monopolistic practices in insurance operations." NRS 679A.140.

42. *Albert H. Wohlers & Co. v. Bartgis*, 114 Nev. 1249, 969 P.2d 949 (1998) is not to the contrary. Wohlers was in a joint venture with an insurer, Allianz Life Insurance Company of North America. *Id.* at 959. Allianz, not Wohlers, issued the policy and determined how much would be covered and paid. *Id.* at 954–55. These facts are not analogous to the facts here and *Wohlers* is not applicable.

43. Therefore, all Defendants are subject to liability under the Unfair Claims Practices Act.

44. NRS 686A.310(1)(e) does not require that a specific dollar value can be assigned to every claim without reasonable dispute at the time of settlement. If that were true, the statutory language

would not include the words "fair and equitable." The statutory language recognizes that there may be disputes about the exact dollar amount that should be paid. The standard is not whether an insurer can be held to an exact number, but whether its settlements were "fair and equitable."

45. Further, the statute does not require negotiation over every claim for liability. Such a requirement does not appear in the plain language of the statute, nor would it be consistent with its purpose. This is demonstrated in this case by the fact that the Defendants manage such a large volume of claims that they rely on automation to help administer them. 11/15/21 Tr. at 20:7–19; see also *id.*at 217:3–17. Requiring further negotiation of every claim would create an unreasonable and wasteful burden, especially in cases like this in which a very large volume of relatively small-dollar claims is at issue. The Court declines to graft such a requirement onto the statute's plain language.

46. The Court finds Defendants' cases, which involve good-faith disputes, are factually distinguishable and do not apply here.

47. NRS 686A.270 does not require that an officer, director, or department head must personally administer each disputed claim to satisfy the requirement that they knowingly permitted the failure to settle those claims fairly and equitably. Such a requirement would not be consistent either with the statute's plain language, its purpose, or common sense. Rather, it is sufficient for an officer, director, or department head to be aware of and permit the policies that systematically resulted in unfair and

inequitable settlement of claims. *See* NRS 686A.270; *My Left Foot Children's Therapy LLC v. Certain Underwriters at Lloyd's London Subscribing to Policy No. HAH15-0632*, No. 2:15-cv-01746-MMD-VCF, 2021 WL 1093094, at *5 (D. Nev. March 22, 2021) (where claims handler was following policies, procedures, and authority implemented by the chief underwriting officer and department head, the insurance company effectively approved the claims mishandling at issue).

48. The jury's finding that an officer, director, or department head was aware of and permitted the policies that systematically resulted in unfair and inequitable settlement of claims was supported by the evidence. Mr. Haben, Mr. Ziemer, and Ms. Hare were all in charge of the relevant reimbursement programs and were aware of the policies at issue. While Ms. Hare resisted characterizing herself as a department head, the evidence supported the jury's conclusion that her position over claim reimbursement qualified her as a department head for purposes of the statute.

49. The Court need not determine whether Defendants are correct that the Health Care Providers must show harm from the claims process itself. The Health Care Providers introduced evidence that each of the Defendants developed reimbursement methodologies that were calculated to systematically underpay the Health Care Providers' claims. This is a harm from the claims process itself.

50. *Yusko v. Horace Mann Servs. Corp.*, No. 2:11-cv-00278-RLH-GWF, 2012 WL 458471 (D. Nev. Feb. 10, 2012) is distinguishable from this case. In

Yusko, a casualty insurance case, the defendant insurance company had already paid the policy limits to the insured. Therefore, the court found that no wrongful processing or other bad conduct by the defendant could have harmed the plaintiff, because she was not entitled to anything else under the policy.

51. The jury's findings of Defendants' liability under the Unfair Claims Practices Act are supported by the evidence. Defendants are not entitled to judgment as a matter of law on this cause of action.

Punitive Damages

52. For the reasons set out above, UHS and UMR are subject to the Unfair Claims Practices Act and therefore are not exempt from punitive damages on this cause of action.

53. Although the Nevada Supreme Court has held that punitive damages are not available for breach of contract claims, it has not imposed that restriction on the Unfair Claims Practices Act. See *Ins. Co. of the West v. Gibson Title Co., Inc.,* 122 Nev. 455, 464, 134 P.3d 698, 703 (2006) ("[T]he award of punitive damages cannot be based upon a cause of action sounding *solely* in contract.") (emphasis added). The gravamen of unfair claims practices is not just the breach of an obligation, but the failure to treat the plaintiff fairly. *See* NRS 686A.310. That is particularly true in the context of a relationship with unequal bargaining power, such as in this case. This unequal power distinguishes this situation from ordinary contracting scenarios.

54. In this Court's previous order denying the Motion to Dismiss the First Amended Complaint, this Court observed that if the Nevada Supreme Court were to determine that a contractual relationship would be required to have standing to assert a claim for Unfair Claims Practices, such a claim had been asserted in this case. Order Denying Motion to Dismiss FAC ¶ 68. That is not the same thing as holding that a claim under the Unfair Claims Practices Act sounds solely in contract. The critical question for standing under *Gunny* is not the existence of a contract, but whether the plaintiffs suffered cognizable harm. *Gunny v. Allstate Ins. Co.*, 108 Nev. 344, 345–46, 830 P.2d 1335, 1335–36 (1992). The evidence supports that requirement here.

55. Defendants argue that the "ordinary way" an insurer may be held liable for punitive damages is through tortious breach of the implied covenant of good faith and fair dealing in the insurance context. However, that is not the only method whereby insurers may be found liable for punitive damages, as this Court has already determined.

56. The Court rejects the argument that because Defendants paid some amount on every claim, there can be no malice or oppression as a matter of law. There is no basis for the idea that any amount of payment, no matter how low, would eliminate malice, oppression, or fraud as a matter of law.

57. The punitive damages award is equally supported by the unjust enrichment claim. Although punitive damages are not available for breach-of-contract claims, the same restriction does not apply

to an unjust enrichment claim, because unjust enrichment only applies in the absence of a contract. See *Ins. Co. of the West,* 122 Nev. at 464, 134 P.3d at 703 ("[T]he award of punitive damages cannot be based upon a cause of action sounding *solely* in contract.") (emphasis added); *Leasepartners Corp. v. Robert L. Brooks Tr. Dated Nov. 12, 1975*, 113 Nev. 747, 755–56, 942 P.2d 182, 187 (1997) ("[a]n action based on a theory of unjust enrichment is not available when there is an express, written contract, because no agreement can be implied when there is an express agreement.").

58. Unlike a claim for breach of contract, unjust enrichment "is grounded in the theory of restitution, not in contract theory." *Schirmer v. Souza*, 126 Conn. App. 759, 765, 12 A.3d 1048 (2011). Therefore, punitive damages may be available when appropriate based on the defendant's conduct. *See, e.g.*, *Hester v. Vision Airlines, Inc.*, 687 F.3d 1162 (9th Cir. 2012); *Bavelis v. Doukas*, No. 2:17-CV-00327, 2021 WL 1979078, at *3 (S.D. Ohio May 18, 2021) (affirming punitive damages award based on a theory of unjust enrichment).

59. Defendants have not presented a legal or evidentiary basis sufficient to support their motion for judgment as a matter of law on the punitive damages. Ample evidence supports the jury's finding of fraud, oppression, and/or malice. The punitive damages are supported by the law and by extensive testimony and documentary evidence in the record. Defendants are not entitled to judgment as a matter of law on punitive damages.

Implied-in-Fact Contract

60. "[T]o find a contract implied-in-fact, the fact-finder must conclude that the parties intended to contract and promises were exchanged, the general obligations for which must be sufficiently clear. It is at that point that a party may invoke quantum meruit as a gap-filler to supply the absent term." *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 379–80, 283 P.3d 250, 257 (2012).

61. The Court rejects Defendants' argument that an implied contract requires an agreement between the parties that Defendants would pay the Health Care Providers' full billed charges. Under *Certified Fire*, Plaintiffs could succeed either by showing that Defendants acknowledged an obligation to pay a reasonable price, or if the parties did not agree on a price, the jury could infer that Defendants were obligated to pay a reasonable price. *Certified Fire*, 128 Nev. at 381, 283 P.3d at 256.

62. *Steele v. EMC Mortg. Corp.*, No. 59490, 129 Nev. 1154, 2013 WL 5423081 (Sept. 20, 2013) (unpublished disposition) is distinguishable. In *Steele*, the defendant's contract was with the plaintiff's father, the plaintiff herself did not provide any additional goods or services, and there was no evidence that defendant understood it had any contractual obligation to plaintiff. Here, the evidence supported the jury's conclusion that Defendants acknowledged and understood that Plaintiffs regularly provided services to Defendants' members and provided Defendants and their members with other benefits, and that United had an obligation to pay Plaintiffs for those services. *Steele* is inapplicable.

63. Although "[a] valid contract cannot exist when material terms are lacking or are insufficiently certain and definite[,] [a] contract can be formed, however, when the parties have agreed to the material terms, even though the contract's exact language is not finalized until later." *May v. Anderson*, 121 Nev. 668, 672, 119 P.3d 1254, 1257 (2005); *see also Brinkerhoff v. Foote*, 132 Nev. 950, 387 P.3d 880 (2016) (unpublished disposition). "Which terms are essential 'depends on the agreement and its context and also on the subsequent conduct of the parties, including the dispute which arises and the remedy sought." *Certified Fire*, 128 Nev. at 378, 283 P.3d at 255 (quoting RESTATEMENT (SECOND) OF CONTRACTS § 131, cmt. g (1981)); *see also Aliya Medcare Fin., LLC v. Nickell*, No. CV1407806MMMSHX, 2015 WL 11089594, at *9 (C.D. Cal. May 28, 2015) (interpreting Nevada law).

64. As already mentioned, the Nevada Supreme Court has explicitly acknowledged that "quantum meruit [for an implied-in-fact contract] fills the price term when it is appropriate to imply the parties agreed to a reasonable price" and "[w]here such a contract exists, then, quantum meruit ensures the laborer receives the reasonable value, usually market price, for his services." *Certified Fire*, 128 Nev. at 379–80, 283 P.3d at 256 (citing 1 Dan B. Dobbs, *Dobbs Law of Remedies* § 4.2(3) (2d ed. 1993)); *see Sierra Development Co. v. Chartwell Advisory Group, Ltd.*, 325 F. Supp. 3d 1102, 1106 (D. Nev. 2018) ("quantum meruit may be employed as a gap-filler to supply absent terms"); *Mielke v. Standard Metals Processing, Inc.*, No. 2:14-CV-1763 JCM

(NJK), 2015 WL 1886709, *5 (D. Nev. April 24, 2015) (same); *Risinger v. SOC LLC*, 936 F. Supp. 2d 1235, 1246-47 (D. Nev. 2013) (same); *see also Commonwealth Land Title Ins. Co. v. Iota Indigo, LLC*, No. 2:13-cv-01837-RFB-PAL, 2015 WL 4647863, *4 (D. Nev. Aug. 5, 2015).

65. The jury had sufficient evidence to find the required elements of an implied contract. Defendants are not entitled to judgment as a matter of law on the implied-in-fact contract claim.

Unjust Enrichment

66. The existence of an implied-in-fact contract does not preempt an unjust enrichment claim.

67. Nevada law permits recovery for unjust enrichment where a plaintiff provides an indirect benefit to the defendant that defendant accepts without adequate compensation, recognizing that benefit in an unjust enrichment claim can be indirect.

68. In addition, the doctrine of election of remedies prevents a plaintiff from obtaining inconsistent *remedies*, or from recovering twice for the same injury. *J.A. Jones Const. Co. v. Lehrer McGovern Bovis, Inc.*, 120 Nev. 277, 288–89, 89 P.3d 1009, 1017 (2004) (The "doctrine of election of remedies applies only to *inconsistent* remedies. . . . . [T]he district court can determine, after trial, if a duplicate recovery has been obtained on two theories of recovery . . . .") (emphasis in original). The judgment in this case does not award the Health Care Providers recovery for both unjust enrichment and the implied-contract claim. Therefore, even if the implied-con-

tract finding served as a bar to the unjust-enrichment claim, there would nonetheless be no conflict in remedies.

69. Defendants are not entitled to judgment as a matter of law on the unjust enrichment claim.

Prompt-Pay Act

70. The Plaintiffs have a private right of action under the Prompt-Pay Act. The Health Care Providers' Prompt-Pay claim is based on the Nevada Healthcare Prompt-Pay Statutes set forth in 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), and NRS 695C.185 (HMO). Each statute provides as follows:

> NRS 683A.0879 Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements. [Effective through December 31, 2019.]
>
> 1. Except as otherwise provided in subsection 2, an administrator shall approve or deny a claim relating to health insurance coverage within 30 days after the administrator receives the claim. If the claim is approved, the administrator shall pay the claim within 30 days after it is approved. Except as otherwise provided in this section, if the approved claim is not paid within that period, the administrator shall pay interest on the claim at a

> rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.
>
> ***
>
> 4. An administrator shall not pay only part of a claim that has been approved and is fully payable.
>
> 5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

71. Subsections 4 and 5 appear in each Nevada Healthcare Prompt-Pay Statute. *See* NRS 689A.410; NRS 689B.255; NRS 689C.485; NRS 695C.185.

72. NRS 690B.012, a casualty prompt-pay statute, is not applicable. Similarly, *Allstate Ins. Co. v. Thorpe*, 123 Nev. 565, 571, 170 P.3d 989, 993 (2007) does not apply here because its ruling is limited to NRS 690B.012. Unlike NRS 690B.012, the Healthcare Prompt-Pay statutes refer explicitly to the availability of costs and attorneys' fees in court actions, demonstrating the availability of a cause of action in court. *See Arora v. Eldorado Resorts Corp.*, No. 2:15-cv-00751-RFB-PAL, 2016 WL 5867415, at *8 (D. Nev. Oct. 5, 2016) ("the provision within the [wage] statute for the payment of 'attorney fee[s]'

further supports an implied private right of action. There would be no need for such allowance within the language of the statute if a private right of action were not implied."); *see Neville v. Eighth Judicial Dist. Court*, 133 Nev. 777, 783, 406 P.3d 499, 504 (2017) (stating it would be absurd to think that the Legislature intended a private cause of action to obtain attorney fees for an unpaid wages suit but no private cause of action to bring the suit itself).

73. It is not a defense to a prompt-pay claim that some amount of payment (regardless of size) was made within thirty days. The relevant statutes provide that an insurer or administrator "shall not pay only a part of a claim that has been approved and is fully payable." *See* NRS 683A.0879(4); NRS 689A.410(4); NRS 689B.255(4); NRS 689C.485(4); and NRS 695C.185(4). The jury was instructed in accordance with the statutes' provisions; jury instruction 38 required the jury to find that Defendants "failed to fully pay, within 30 days of submission of the claim, a claim that was approved and fully payable." The evidence supports the jury's finding that Defendants failed to do so.

74. Further, the Prompt-Pay Act does not require administrative exhaustion. NRS 679A.170 provides that specific provisions relative to a particular type of insurance prevail over generalized provisions. Therefore, Defendants' references to general-applicability statutes are inapposite.

75. Defendants are not entitled to judgment as a matter of law under the Prompt-Pay Act.

ERISA

76. As previously found by the United States District Court for the District of Nevada, ERISA is inapplicable to the claims in this case. This Court reached the same conclusion, and the Nevada Supreme Court denied Defendants' petition for writ of mandamus on that ground. June 24, 2020 Order Denying Defendants' Motion to Dismiss First Amended Complaint; July 1, 2021 Order Denying Petition for Writ of Mandamus. Defendants do not show why this Court should or could revisit that ruling at this stage. *See Geissel v. Galbraith*, 105 Nev. 101, 103, 769 P.2d 1294, 1296 (1989) ("Under the doctrine of the law of the case, where an appellate court states a [principle] or rule of law in deciding a case, that rule becomes the law of the case and is controlling both in the lower courts and on subsequent appeals, so long as the facts remain substantially the same.").

77. The claims in this case are based on Defendants' underpayment of claims which they had already determined to be payable and did pay some amount on. In other words, this case involves a dispute over the proper rate of payment rather than the right to payment.

78. The United States Supreme Court has addressed this issue and concluded that there is no conflict preemption when it is the rate of payment that is at issue. *See Rutledge v. Pharmaceutical Care Mgmt. Assoc.*, 141 S. Ct. 474, 478, 208 L. Ed. 2d 327 (2020) (Arkansas statute regulating the price of drugs covered under pharmacy benefit plans "has neither an impermissible connection with nor

reference to ERISA and is therefore not preempted"). *Rutledge* makes clear that "not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan. That is especially so if a law merely affects costs." *Id.* at 480. *See also De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 816, 117 S. Ct. 1747 (1997) (concluding that ERISA didn't preempt a state tax on gross receipts for patient services that simply increased the cost of providing benefits). The same reasoning applies here.

79. Moreover, disputes concerning rates of payment do not fall within ERISA's scope and are not subject to complete preemption. *Marin Gen. Hosp.*, 581 F.3d 941, 948 (9th Cir. 2009); *see also California Spine & Neurosurgery Inst. v. Boston Scientific Corp.*, No. 18-CV-07610-LHK, 2019 WL 1974901, at *3 (N.D. Cal. May 3, 2019) ("Under Ninth Circuit law, ERISA does not preempt claims by a third party [medical provider] who sues an ERISA plan not as an assignee of a purported ERISA beneficiary, but as an independent entity claiming damages.").

80. Defendants are not entitled to judgment as a matter of law on the ground of ERISA preemption.

Conclusion

81. Any of Defendants' arguments in their Renewed Motion for Judgment as a Matter of Law not specifically addressed herein are likewise found to be without merit. The Court considered all of the defenses raised, the arguments made, the law, and

the evidence. Defendants are not entitled to judgment as a matter of law on any ground.

ORDER

IT IS HEREBY ORDERED that Defendants' Renewed Motion for Judgment as a Matter of Law is denied.

Dated this 12th day of October, 2022

/s/ Nancy L. Allf
9A9 2D5 868D 58EF
Nancy Allf
District Court Judge

[Attorneys and Certificate of Service Intentionally Omitted]

APPENDIX C

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	Case Non.: A-19-792978-B Dept. No.: XXVII **JUDGMENT**

OF NEVADA, INC., a Nevada corporation,

Defendants.

This action came on for trial before the Court and a jury, the Honorable Nancy L. Allf, District Judge, presiding, and the issues having been duly tried and the jury having duly rendered its verdicts.

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that Plaintiff Fremont Emergency Services (Mandavia) Ltd. recover a total of $23,169,133.81from the Defendants listed below, in the respective amounts listed below, with post-judgment interest thereon as provided by law from the date of written notice of this Judgment being entered until paid, together with its costs of action and attorneys' fees, if any, in amounts to be determined hereafter.

Defendant	Actual Damages	Prompt Pay Damages	Punitive Damages	Judgment
United Healthcare Insurance Company	$478,686.26	$157,046.68	$4,500,000	$5,135,732.94
United Health Care Services Inc.	$771,406.35	$251,359.37	$4,500,000	$5,522,765.72
UMR, Inc.	$168,949.51	$49,891.88	$2,000,000	$2,218,841.39
Sierra Health and Life Insurance Company Inc.	$1,007,374.49	$254,978.14	$5,000,000	$6,262,352.63
Health Plan of Nevada Inc.	$23,765.68	$5,675.45	$4,000,000	$4,029,441.13

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiff Team Physicians of Nevada-Mandavia P.C. recover a total of $20,111,844.85 from the Defendants listed below, in the respective amounts listed below, with post-judgment interest thereon as provided by law from the date of written notice this Judgment being entered until paid, together with its costs of action and attorneys' fees, if any, in amounts to be determined hereafter.

Defendant	Actual Damages	Prompt Pay Damages	Punitive Damages	Judgment
United Healthcare Insurance Company	$42,803.36	$13,836.81	$4,500,000	$4,556,640.17
United Health Care Services Inc.	$40,607.19	$10,875.36	$4,500,000	$4,551,482.55
UMR, Inc.	$485.37	$137.83	$2,000,000	$2,000,623.20
Sierra Health and Life Insurance Company Inc.	$1,783.85	$512.04	$5,000,000	$5,002,295.89
Health Plan of Nevada Inc.	$598.83	$204.21	$4,000,000	$4,000,803.04

IT IS FURTHER ORDERED, ADJUDGED AND DECREED that Plaintiff Crum Stefanko and Jones Ltd. dba Ruby Crest Emergency Medicine recover a total of $20,148,895.30 from the Defendants listed below, in the respective amounts listed below, with post-judgment interest thereon as provided by law from the date of written notice of this Judgment being entered until paid, together with its costs of action and attorneys' fees, if any, in amounts to be determined hereafter.

Defendant	Actual Damages	Prompt Pay Damages	Punitive Damages	Judgment
United Healthcare Insurance Company	$32,972.03	$10,442.16	$4,500,000	$4,543,414.19
United Health Care Services Inc.	$69,447.39	$20,845.46	$4,500,000	$4,590,292.85
UMR, Inc.	$7,911.57	$2,353.04	$2,000,000	$2,010,264.61
Sierra Health and Life Insurance Company Inc.	$3,438.63	$1,089.67	$5,000,000	$5,004,528.30
Health Plan of Nevada Inc.	$281.49	$113.87	$4,000,000	$4,000,395.36

IT IS SO ORDERED.

Dated this 9th day of March, 2022.

/s/ Nancy L. Allf
519 56D 37C6 D5AF
Nancy Allf
District Court Judge

[Attorneys and Certificate of Service Intentionally Omitted]

APPENDIX D

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	Case Non.: A-19-792978-B Dept. No.: XXVII **ORDER DENYING DEFENDANTS' MOTION FOR JUDGMENT AS A MATTER OF LAW** Hearing Date: November 18, 2021 Hearing Time: 8:30am

OF NEVADA, INC., a Nevada corporation,

Defendants.

This matter came before the Court on November 18, 2021 on defendants UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Sierra Health and Life Insurance Co., Inc.; and Health Plan of Nevada, Inc.'s (collectively, "Defendants") Motion for Judgment as a Matter of Law (the "Motion"). Pat Lundvall, McDonald Carano LLP; and John Zavitsanos, Joe Ahmad, Jane Robinson, Kevin Leyendecker, Jason McManis, Michael Killingsworth, Ahmad, Zavitsanos, Anaipakos, Alavi & Mensing, P.C., appeared on behalf of plaintiffs Fremont Emergency Services (Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest" and collectively the "Health Care Providers"). D. Lee Roberts, Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC; Lee Blalack, Dimitri Portnoi and Jeffrey E. Gordon, O'Melveny & Myers LLP; and Dan Polsenberg, Lewis Roca Rothgerber Christie LLP appeared on behalf of defendants United Healthcare Insurance Company; United Health Care Services Inc., dba UnitedHealthcare; UMR, Inc., dba United Medical Resources; Sierra Health And Life Insurance Company, Inc. and Health Plan Of Nevada, Inc. (collectively "Defendants" or "United").

The Court, having considered the Motion, the Health Care Providers' oral opposition, the Health

Care Providers' Trial Briefs Regarding (1) Punitive Damages for Unjust Enrichment Claim, (2) Nevada Unfair Settlement Practices Applicability, (3) Elements of Unfair Insurance Practices Act, (4) Price as Material Term (collectively, the "Trial Briefs"), the record, and the argument of counsel at the hearing on this matter, and good cause appearing, finds and orders as follows:

1. The central issue in this case is whether United allowed the Health Care Providers a reasonable out-of-network reimbursement rate for approximately 11,500 health insurance claims. This case is not about right to payment, but rather the rate of payment.

2. The Health Care Providers assert that United is obligated to them under four causes of action and are liable for punitive damages based on United's malicious, oppressive and fraudulent conduct.

3. On November 17, 2021, United filed a Motion pursuant to NRCP 50(a), contending that:

a. There Is No Evidence to Support Any of TeamHealth Plaintiffs' Claims Against SHL, HPN, or UMR;

b. Defendants Are Entitled to Judgment as a Matter of Law on TeamHealth Plaintiffs' Cause of Action Under the Nevada Unfair Insurance Practices Act;

c. There Is No Evidence That Supports an Award of Punitive Damages;

d. Defendants Are Entitled to Judgment as a Matter of Law on TeamHealth Plaintiffs' Claim for Breach of Implied-in-Fact Contract;

e. Defendants Are Entitled to Judgment as a Matter of Law on TeamHealth Plaintiffs' Prompt Pay Act Claim; and

f. TeamHealth Plaintiffs' Causes of Action Are Preempted by ERISA Motion at Section II(A)-(F), respectively.

4. NRCP Rule 50(a) provides:

> (a) **Judgment as a Matter of Law**.
>
> (1) **In General**. If a party has been fully heard on an issue during a jury trial and the court finds that a reasonable jury would not have a legally sufficient evidentiary basis to find for the party on that issue, the court may:
>
> > (A) resolve the issue against the party; and
> >
> > (B) grant a motion for judgment as a matter of law against the party on a claim or defense that, under the controlling law, can be maintained or defeated only with a favorable finding on that issue.

5. A Rule 50(a) motion does not test the legal sufficiency of the claims, but whether there is a sufficient evidentiary basis to find for the Health Care Providers.

6. Sections IIB(1), B(2), C(1), C(2), E(1), E(2), and (F) of United's Motion contain purely legal arguments which are inappropriate basis for a Rule 50(a) motion.

Unfair Claims Settlement Practices, NRS 686A.310

7. The definition of who is liable under NRS 686A.020 and .310 is broad in that provides:

> ***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.

NRS 686A.020.

8. Neither *Gunny v. Allstate Ins. Co.*, 108 Nev. 344, 830 P.2d 1335 (1992) nor *Fulbrook v. Allstate Ins. Co.*, No. 61567, 2015 WL 439598 (Nev. Jan. 30, 2015) stand 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 the Health Care Providers.

9. Nor is a contractual relationship required to establish standing to assert a claim for violation of the Unfair Insurance Practices Act. *Gunny* provides that the proper inquiry is not whether a contractual relationship exists, but instead whether the plaintiff has suffered a legally redressable harm.

10. Further, United already raised this standing argument to this Court in its prior motion to dismiss. Not only did this Court reject United's argument as to each United Defendant, the Nevada Supreme Court affirmed this Court's decision in response to United's Petition for Writ of Prohibition, or, Alternatively, Mandamus, challenging this Court's order denying a motion to dismiss wherein the Court rejected United's argument regarding the applicability of *Gunny v. Allstate Ins. Co.*, 108 Nev. 344, 346, 830 P.2d 1335, 1336 (1992) and determined that United's argument 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" lacked merit. *Id.* at COL ¶ 68.

11. The Health Care Providers have elicited testimony about policy setting from United executives representing each defendant: Mr. Haben on behalf of UnitedHealthcare Insurance Company and UnitedHealthcare Services; Mr. Ziemer, UMR's Vice President of customer solutions and reimbursement strategies; and Ms. Hare on behalf of Sierra and HPN.

12. The Health Care Providers have elicited oral testimony and introduced documentary evidence that each United defendant recognizes the Health Care Providers are entitled to a reasonable reimbursement rate and evidence supporting the Health Care Providers' claim that defendants' failed to pay a reasonable reimbursement rate.

13. The Court has further considered and incorporates the arguments in the Health Care Providers' Trial Briefs on this issue.

14. The Court finds that a reasonable jury has a legally sufficient evidentiary basis to find for the Health Care Providers on this issue.

Punitive Damages

15. Under NRS 42.005(1), "[e]xcept as otherwise provided in NRS 42.007, in an action for the breach of an obligation not arising from contract, where it is proven by clear and convincing evidence that the defendant has been guilty of oppression, fraud or malice, express or implied, the plaintiff, in addition to the compensatory damages, may recover damages for the sake of example and by way of punishing the defendant."

16. Although the Nevada Supreme Court has held that punitive damages are not available for *breach of contract* claims, no such restriction exists for a claim of unjust enrichment, which, by its terms and United's own arguments throughout the course of this litigation, is not based on a contract. *See Ins. Co. of the West v. Gibson Title Co., Inc.*, 122 Nev. 455, 464, 134 P.3d 698, 703 (2006) ("[T]he award of punitive damages cannot be based upon a cause of action sounding **solely** in contract.") (emphasis added); *see also Peri & Sons Farms, Inc. v. Jain Irr., Inc.*, 933 F. Supp. 2d 1279, 1294 (D. Nev. 2013) ("Punitive damages are not available under Nevada law for contract-based causes of action); *Leasepartners Corp. v. Robert L. Brooks Tr. Dated Nov. 12, 1975*, 113 Nev. 747, 755–56, 942 P.2d 182, 187 (1997)

("[a]n action based on a theory of unjust enrichment is not available when there is an express, written contract, because no agreement can be implied when there is an express agreement."). Federal court decisions are in accord. *See e.g. Hester v. Vision Airlines, Inc.*, 687 F.3d 1162 (9th Cir. 2012); *Bavelis v. Doukas*, No. 2:17-CV-00327, 2021 WL 1979078, at *3 (S.D. Ohio May 18, 2021) (affirming punitive damages award based on a theory of unjust enrichment).

17. Unjust enrichment "is grounded in the theory of restitution, not in contract theory." *Schirmer v. Souza*, 126 Conn. App. 759, 765, 12 A.3d 1048 (2011).

18. Similarly, for the reasons already expressed herein, the cause of action under the Unfair Claims Practices Act does not sound in contract and punitive damages are available under that claim as well, and the claim is applicable to all defendants.

19. NRS 42.001(1) defines "Conscious disregard" as "the knowledge of the probable harmful consequences of a wrongful act and a willful and deliberate failure to act to avoid those consequences."

20. NRS 42.001(2) defines "fraud" as "an intentional misrepresentation, deception or concealment of a material fact known to the person with the intent to deprive another person of his or her rights or property or to otherwise injure another person."

21. NRS 42.001(3) defines "malice, express or implied" as "conduct which is intended to injure a person or despicable conduct which is engaged in with

a conscious disregard of the rights or safety of others."

22. NRS 42.001(4) defines "oppression" as "despicable conduct that subjects a person to cruel and unjust hardship with conscious disregard of the rights of the person."

23. *Countrywide Home Loans, Inc. v. Thitchener*, 124 Nev. 725, 192 P.3d 243 (2008) provides the framework for punitive damages conduct.

24. The Health Care Providers have introduced evidence that a jury could deem to constitute malice, oppression and/or fraud, express or implied, including but not limited to:

a. United's representatives testified that United has a duty to pay a reasonable reimbursement amount and the origin of the duty, that is found in the legal claims that he Health Care Providers have asserted.

b. The United representatives testified that United has not paid a reasonable value in accord with the Affordable Care Act because the Affordable Care Act sets the minimum, and that Affordable Care Act has language concerning usual and customary rates. And each and every one of the Defendants have identified, expressly by Ms. Hare, Mr. Ziemer, Mr. Haben and Ms. Paradise, that, in fact, they did not include usual and customary in the analysis determining reimbursement rates under United's various out-of-network programs; and Ms. Hare testified that defendants Sierra Health and Life and Health Plan of Nevada did not have out-of-network reimbursement programs, but that they too

did not use usual and customary as a foundation for determining reasonable value. Additionally, there is testimony that United has violated the Affordable Care Act. A jury could determine that this testimony identifies conduct that is oppressive and fraudulent

c. United's representatives testified, expressly or inferentially, that the motivation for reducing out-of-network reimbursement rates was to underscore and to increase the amount of profits that United was enjoying or to try to save money allegedly for their administrative services clients and keep it in the context of third party administrator fees from a shared savings program.

d. The Health Care Providers have presented evidence that there are negative consequences if United underpays emergency room providers, including potentially jeopardizing what is defined as the safety net of our community: emergency department doctors, practitioners and clinicians. If they are underpaid, the quality of emergency services is diminished according to the testimony that has been elicited.

e. Further, written documentary evidence presented to the jury states that United has an obligation to pay billed charges.

f. United received advice from their internal regulatory and compliance department. PX 314. Ms. Hare testified that SHL and HPN received provider services. Mr. Ziemer identified that UMR also received support from United's provider services. In that email, United identified the obligation under

the Affordable Care Act and how the law provides a minimum floor, yet United representatives' testimony demonstrates United did something different than what the law required.

25. The Health Care Providers have introduced evidence that a jury could conclude that United was deliberately placing United's interest over that safety net of community. Based on the testimony and other evidence, the Court concludes that there are sufficient facts such that the jury could find United engaged in oppressive, fraudulent and/or malicious conduct.

26. The Court also does not find that the Health Care Providers have waived their claim for punitive damages under either an unjust enrichment or Nevada state law statutory basis.

27. The Court has further considered and incorporates the arguments in the Health Care Providers' Trial Brief on this issue.

28. The Court finds that a reasonable jury has a legally sufficient evidentiary basis to find for the Health Care Providers on this issue.

Implied-in-Fact Contact

29. "[T]o find a contract implied-in-fact, the fact-finder must conclude that the parties intended to contract and promises were exchanged, the general obligations for which must be sufficiently clear. It is at that point that a party may invoke quantum meruit as a gapfiller to supply the absent term." *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. At 379–80, 283 P.3d 250, 256 (2012).

30. Although "[a] valid contract cannot exist when material terms are lacking or are insufficiently certain and definite[,] [a] contract can be formed, however, when the parties have agreed to the material terms, even though the contract's exact language is not finalized until later." *May v. Anderson*, 121 Nev. 668, 672, 119 P.3d 1254, 1257 (2005); *see also Brinkerhoff v. Foote*, 132 Nev. 950, 387 P.3d 880 (2016). "Which terms are essential 'depends on the agreement and its context and also on the subsequent conduct of the parties, including the dispute which arises and the remedy sought." *Id*. (quoting RESTATEMENT (SECOND) OF CONTRACTS § 131, cmt. g (1981)); *see also Aliya Medcare Fin., LLC v. Nickell*, No. CV1407806MMMSHX, 2015 WL 11089594, at *9 (C.D. Cal. May 28, 2015) (interpreting Nevada law).

31. The Nevada Supreme Court explicitly acknowledged that "quantum meruit [for an implied in fact contract] fills price term when it is appropriate to imply the parties agreed to a reasonable price" and "[w]here such a contract exists, then, quantum meruit ensures the laborer receives the reasonable value, usually market price, for his services." *Certified Fire Prot.*, 128 Nev. at 379–80, 283 P.3d 250, 256 (2012), citing 1 Dan B. Dobbs, *Dobbs Law of Remedies* § 4.2(3) (2d ed. 1993)).

32. The Health Care Providers have presented evidence that they are obligated to treat United's members under the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd and NRS 439B.410; that they will submit claims the way United has asked for claims to be

submitted and they agreed not to balance bill United's members. This part of the agreement is also evidenced by both parties' spreadsheets identifying the at-issue claims and indications that United acknowledged its obligation to pay for the identified members and did indeed pay.

33. The Court concludes that the Health Care Providers have made a *prima facie* case on their implied contract claim as to all Defendants because the conduct was to submit a claim to United, the claim was adjudicated and then paid. The Health Care Providers are obligated under law to provide the services and United's representatives admitted on the stand that they have a duty to pay a reasonable amount for out-of-network emergency services. The Healthcare Providers performed medical services for United's insureds and submitted claims to them for payment on their platform. The Healthcare Providers also agreed not to balance bill their insureds. The Healthcare Providers submit that was an offer in the form of conduct. United adjudicated those claims accepting responsibility of payment for its insureds, including an acknowledgement that the insured was covered for the work performed, and paid something. It is that conduct the Healthcare Providers submit forms an implied contract. The parties dispute the value of the services performed. The price term is what remains at issue in this case for the jury to decide.

34. The Court has further considered and incorporates the arguments in the Health Care Providers' Trial Brief on this issue.

35. The Court finds that a reasonable jury has a legally sufficient evidentiary basis to find for the Health Care Providers on this issue.

Nevada Prompt Pay Statutes

36. The Health Care Providers' fourth claim for relief is premised on United's alleged violation of the NV Healthcare Prompt Pay Statutes set forth in 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), and NRS 695C.185 (HMO). Each statute provides as follows:

> NRS 683A.0879 Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements. [Effective through December 31, 2019.]
>
> 1. Except as otherwise provided in subsection 2, an administrator shall approve or deny a claim relating to health insurance coverage within 30 days after the administrator receives the claim. If the claim is approved, the administrator shall pay the claim within 30 days after it is approved. Except as otherwise provided in this section, if the approved claim is not paid within that period, the administrator shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions,

> on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.
>
> ***
>
> 4. An administrator shall not pay only part of a claim that has been approved and is fully payable.
>
> 5. ***A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section***.

Subsections 4 and 5 appear in each NV Healthcare Prompt Pay Statute.[1]

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[1] **NRS 689A.410 Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements. [Effective through December 31, 2019.]**

> ***
>
> 4. An insurer shall not pay only part of a claim that has been approved and is fully payable.
>
> 5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section

NRS 689B.255 Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements. [Effective through December 31, 2019.]

> ***

37. United relies on an inapplicable prompt pay statute, NRS 690B.012 (the "Casualty Prompt Pay Statute"), only applicable to casualty insurance that does not provide for a private right of action. United's reliance on *Allstate Ins. Co. v. Thorpe*, 123 Nev. 565, 571, 170 P.3d 989, 993 (2007) in an effort to support its Motion is misplaced because *Allstate's*

---

4. An insurer shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

NRS 689C.485 Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements. [Effective through December 31, 2019.]

***

4. A carrier shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

NRS 695C.185 Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements. [Effective through December 31, 2019.]

***

4. A health maintenance organization shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

ruling is limited to NRS 690B.012 and is wholly inapplicable to the Health Care Providers' claims.

38. The Casualty Prompt Pay Statute is categorically different than the NV Health Care Prompt Pay Statutes which provide: "***A court*** shall award costs and reasonable attorney's fees to the prevailing party ***in an action brought pursuant to this section.***"[2]

39. The Court concludes that the Health Care Providers were not required to exhaust administrative remedies, if any, prior to commencement of this action.

40. The Court finds that a reasonable jury has a legally sufficient evidentiary basis to find for the Health Care Providers on this issue.

41. The Court has further considered and incorporates the arguments in the Health Care Providers' Trial Briefs on this issue.

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[2] *Arora v. Eldorado Resorts Corp.*, No. 2:15-cv-00751-RFB-PAL, 2016 WL 5867415, at *8 (D. Nev. Oct. 5, 2016) ("the provision within the [wage] statute for the payment of 'attorney fee[s]' further supports an implied private right of action. There would be no need for such allowance within the language of the statute if a private right of action were not implied."); *see Neville v. Eighth Judicial District Court*, 133 Nev. 777, 783 (2017) (stating it would be absurd to think that the Legislature intended a private cause of action to obtain attorney fees for an unpaid wages suit but no private cause of action to bring the suit itself);

ERISA

42. As this Court has stated in its prior Orders, this is a rate of payment case, not a right of payment case.

43. The Court has previously considered and rejected United's ERISA conflict preemption argument, as has the Nevada Supreme Court in connection with United's writ petition.

44. For the reasons previously expressed by the Court and incorporated herein, the Court does not find merit in the United's argument and the Court concludes that none of the Health Care Providers' claims are preempted.

45. The Court finds that a reasonable jury has a legally sufficient evidentiary basis to find for the Health Care Providers on this issue.

Accordingly,

ORDER

IT IS HEREBY ORDERED that the Motion is DENIED in full for the reasons stated herein, on the record at the November 18, 2021 hearing and contained in the Health Care Providers' Trial Briefs.

Dated this 5th day of January, 2022

/s/ Nancy L. Allf
349 12D A4C9 24C1
Nancy Allf
District Court Judge

[Attorneys and Certificate of Service Intentionally Omitted]

APPENDIX E

IN THE SUPREME COURT OF THE STATE OF NEVADA

UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTH CARE SERVICES, INC.; UMR, INC.; OXFORD HEALTH PLANS, INC.; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; SIERRA HEALTHCARE OPTIONS, INC.; HEALTH PLAN OF NEVADA, INC.; AND UNITEDHEALTH GROUP, 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. and FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; AND CRUM STEFANKO AND JONES, LTD. Real Parties in Interest.	No. 81680

ORDER DENYING PETITION

This is an original petition for a writ of mandamus challenging a district court order denying a motion to dismiss.

The real parties in interest, Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada-Mandavia, P.C., and Crum Stefanko and Jones, Ltd. (collectively, the providers), performed emergency medical services for health plan members of United Healthcare Insurance Company, United Health Care Services, Inc., UMR, Inc., Oxford Health Plans, Inc., Sierra Health and Life Insurance Company, Inc., Sierra Health-Care Options, Inc., Health Plan of Nevada, Inc., and UnitedHealth Group, Inc. (collectively, United), as required by federal law, without an express provider agreement. The providers assert that they submitted the claims to United, United accepted the claims for payment, but then United underpaid for their services.

The providers filed suit, pleading the existence of an implied-in-fact contract and unjust enrichment, among other theories. United then removed the case to federal court, on the basis that the Employee Retirement Income Security Act of 1974 ("ERISA") "completely preempted" the claims pursuant to 29 U.S.C. § 1132. The United States District Court disagreed, remanding the case to state court. United next moved to dismiss the complaint, renewing its complete preemption argument, and arguing that conflict preemption pursuant to 29 U.S.C. § 1144(a) (codifying § 514 of ERISA), required dismissal because the providers claims "re-

lated to" an employee benefit plan. United also argued that the providers failed to state a claim pursuant to NRCP 12(b)(5). The district court denied the motion, and then this petition, seeking a writ of mandamus directing the district court to grant the motion, followed.

Mandamus is a purely discretionary, and extraordinary, remedy. *State, Dep't of Transp. v. Thompson,* 99 Nev. 358, 360, 662 P.2d 1338, 1339 (1983). This court will grant a petition for mandamus only where "it is clearly the [legal] duty of [the district court] judge to do the act sought to be coerced," Thomas Carl Spelling, A *Treatise on Injunctions and Other Extraordinary Remedies* 1230 (2d ed. 1901), *cited with approval in Walker v. Second Judicial Dist. Court,* 136 Nev., Adv. Op. 80, 476 P.3d 1194, 1196 (2020), and no adequate legal remedy at law exists, *Pan v. Eighth Judicial Dist. Court,* 120 Nev. 222, 224, 88 P.3d 840, 841 (2004). Judicial economy is the lodestar. *Smith v. Eighth Judicial Dist. Court,* 113 Nev. 1343, 1345, 950 P.2d 280, 281 (1997). This petition does not meet these demanding criteria.

First, neither theory of ERISA preemption established a legal duty to dismiss the complaint. To support its complete preemption argument, United relies on a federal district court case, *Emergency Grp. of Ariz. Pro. Corp. v. United Healthcare, Inc.,* 2020 WL 1451464 (D. Ariz. Mar. 25, 2020), *rev'd,* 2021 WL 816071 (9th Cir. Mar. 3, 2021) (unpublished), in which it *initially* prevailed under near-identical facts, before the Ninth Circuit reversed the district

court's decision. Otherwise, the providers have alleged their own implied-in-fact contract with United establishing a *rate* of payment, separate from any assignments from health plan members or *right* to benefits from United—pleading a relationship and claim not directly "relating to" ERISA, such that conflict preemption does not apply in this case. *Mem'l Hosp. Sys. v. Northbrook Life Ins. Co.,* 904 F.2d 236, 245-249 (5th Cir. 1990) (holding that ERISA preempts state law claims if (1) the claims address areas of exclusive federal concern; and (2) the claims directly affect the relationship among the traditional ERISA entities); *see Rutledge v. Pharm. Care Mgmt. Ass'n,* 141 S. Ct. 474, 480, (2020) ("ERISA does not pre-empt state *rate regulations* that merely increase costs or alter incentives for ERISA plans . . . ." (emphasis added)).

Second, United has not established that the law clearly obligated the district court to dismiss the entirety of the providers' complaint for failure to state a claim pursuant to NRCP 12(b)(5). The district court was required to accept the providers allegations as true and draw all inferences in favor of the providers. *Buzz Stew, LLC v. City of N. Las Vegas,* 124 Nev. 224, 227-28, 181 P.3d 670, 672 (2008). The providers alleged an implied-in-fact contract to provide emergency medical services to United's plan members in exchange for payment at a usual and customary rate, and that United breached this contract by not doing so. As the theory suggests, these determinations are factually intensive and ill-suited for a motion to dismiss or writ proceeding. *Certified Fire Prot. Inc. v. Precision Constr.,* 128

Nev. 371, 379, 283 P.3d 250, 256 (2012) ("[T]he *fact-finder* must conclude that the parties intended to contract and promises were exchanged . . . ." (emphasis added)); *James Hardie Gypsum (Nev.) Inc. v. Inquipco,* 112 Nev. 1397, 1401, 929 P.2d 903, 906 (1996) *disapproved of on other grounds Sandy Valley Assocs. v. Sky Ranch Estates Owners Ass'n,* 117 Nev. 948, 35 P.3d 964 (2001) ("Intent to make an offer or an acceptance is a question of fact.").

Finally, though some of the providers' claims appear questionable, United can renew its arguments in a motion for summary judgment and on appeal after development of the factual record—adequate remedies in the ordinary course of law. *See Rawson v. Ninth Judicial Dist. Court,* 133 Nev. 309, 316, 396 P.3d 842, 847 (2017). Because the case must continue, at least partially, judicial economy is not well served by considering the writ. In other words, it is appropriate to leave further legal and factual development to "the judicial body best poised to do so and [thereby not] unnecessarily limit[] the record[] for this court's [eventual] appellate review." *Walker*, 476 P.3d at 1199.

Therefore, we ORDER the petition DENIED.

/s/_____, J.
Cadish

/s/_____, J.
Pickering

/s/_____, J.
Herndon

cc: Hon. Nancy L. Allf, District Judge
Weinberg, Wheller, Hudgins, Gunn & Dial, LLC
McDonald Carano LLP/Las Vegas
Eighth District Court Clerk

APPENDIX F

DISTRICT COURT
CLARK COUNTY, NEVADA

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

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.

This matter came before the Court on June 5 and 9, 2020 on the (1) Motion to Dismiss Plaintiffs' First Amended Complaint ("Motion"); and (2) Supplemental Brief in Support of Motion To Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim For Relief ("Supplement") filed by defendants UnitedHealth Group, Inc., UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Oxford Health Plans, Inc. (the foregoing United entities are referred to as the "UH Parties"); Sierra Health and Life Insurance Co., Inc.; Sierra Health-Care Options, Inc.; and Health Plan of Nevada, Inc. (Sierra Health, Sierra Health-Care and Health Plan of Nevada are referred to as the "Sierra Affiliates") (UH Parties and Sierra Affiliates are collectively referred to as "United"). Pat Lundvall, Amanda M. Perach and Kristen T. Gallagher, McDonald Carano LLP, appeared on behalf of plaintiffs Fremont Emergency Services (Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby

Crest Emergency Medicine ("Ruby Crest" and collectively the "Health Care Providers"). D. Lee Roberts, Jr. and Colby L. Balkenbush, Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC, appeared on behalf of United.

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

FINDINGS OF FACT RELEVANT TO THE COURT'S DECISION

Procedural History

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

2. As the Health Care Providers allege, all of these legal claims are based on United's underpay-

ment of claims which it had determined were payable and paid, *i.e.*, a dispute over the proper rates of payment rather than the right to payment. Compl. ¶ 27.

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

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

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

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

7. Given the procedural posture of the action, the Federal District Court directed the Health Care

Providers to file an amended motion to remand, which they did on January 18, 2020 (ECF No. 49).

8. After completed briefing, the Federal District Court granted the Amended Motion to Remand, expressly rejecting United's argument that the Health Care Providers' claims were completely preempted by ERISA, the same arguments that United reasserts in the Motion to Dismiss pending before the Court. The Federal District Court recognized the Ninth Circuit has distinguished between claims involving the "right to payment" and claims involving the "proper "amount of payment." *Marin General Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 948 (9th Cir. 2009); *Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Grp., Inc.*, 187 F.3d 1045, 1051 (9th Cir. 1999). The Federal District Court found that the Health Care Providers' claims fall outside the scope of Section 502(a) of ERISA, failing the first prong of the test articulated by *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004) because they:

> [D]o not contend they are owed an additional amount from the patients' ERISA plans." Instead, they allege these claims arise from their alleged implied-in-fact contract with United.
>
> United attempts to distinguish the implied-in-fact contract from other types of contracts referenced in the case law. (ECF No. 64). However, Nevada courts have found that implied-in-fact agreements and express agreements have the same legal effects. *See Magnum Opes Constr. v. Sanpete Steel Corp.*,

> 2013 WL 7158997 (Nev. 2013); *Certified Fire Prot. Inc. v. Precision Constr.*, 283 P. 3d 250, 256 (Nev. 2012). Consequently, the court finds that plaintiffs' claims fall outside the scope of § 502(a) of ERISA, failing prong 1 of the Davila test.

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

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

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

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

Relevant Allegations Concerning the Relationship Between the Parties and the Dispute

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

13. Defendants ("United") are large health insurance companies and claims administrators. FAC ¶¶

6-13. United provides healthcare benefits to its members ("United's Members"), including coverage for emergency care. FAC ¶¶ 19, 33.

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

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

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

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

18. United is responsible for administering and/or paying for certain emergency medical services provided by Fremont which are at issue in the

litigation. FAC ¶¶ 6-13. United provides, either directly or through arrangements with providers such as hospitals and Fremont, healthcare benefits to its members. FAC ¶ 19.

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

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

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

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

23. The Health Care Providers also allege a Nevada state law claim for civil racketeering ("NV RICO") against United because they have been financially harmed by an orchestrated scheme crafted and implemented by an Enterprise consisting of United and third parties including National Care Network, LLC dba Data iSight ("Data iSight")

to artificially and fraudulently reduce payment rates and manipulate the related benchmark pricing data to "support" United's position.

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

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

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

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

d. Defendants then proposed a contractual rate for their employer funded plans that was roughly half the average reasonable rate at which Defendants have historically reimbursed providers - a drastic and unjustified discount from what Defendants have been paying the Health Care Providers on their non-participating claims in these plans,

and an amount materially less than what Defendants were paying other contracted providers in the same market. FAC ¶ 94.

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

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

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

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

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

j. Defendants falsely claim that their new rates comply with the law because they contracted with a purportedly objective and transparent third

party, Data iSight, to process the Health Care Providers' claims and to determine reasonable reimbursement rates. FAC ¶ 100.

k. Data iSight is the trademark of an analytics service used by health plans to set payment for claims for services provided to Defendants' Members by non-participating providers. Data iSight is owned by National Care Network, LLC, a Delaware limited liability company with its principal place of business in Irving, Texas. Data iSight and National Care Network, LLC will be collectively referred to as "Data iSight." Data iSight is a wholly-owned subsidiary of MultiPlan, Inc., a New York corporation with its principal place of business in New York, NY. MultiPlan acts as a Rental Network "broker" and, in this capacity, has contracted since as early as June 1, 2016 with some of the Health Care Providers to secure reasonable rates from payors for the Health Care Providers' non-participating emergency services. The Health Care Providers have no contract with Data iSight, and the Non-Participating Claims identified in this action are not adjudicated pursuant to the MultiPlan agreement. FAC ¶ 101.

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

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

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

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

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

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

r. As further evidence of Defendants' scheme to use their market power to the detriment of the Health Care Providers and other emergency provider groups that are part of the TeamHealth organization, in August 2019, UHG advised at least one Florida medical surgical facility (the "Florida Facility") that Defendants will not continue negotiating an in-network agreement unless the Florida Facility identifies an in-network anesthesia provider. The current out-of-network anesthesia provider is part of the TeamHealth organization. Defendants'

threats to discontinue contract negotiations prompted the Florida Facility's Chief Operating Officer to send TeamHealth a "Letter of Concern" on August 14, 2019. Defendants' threats and leverage are aimed at intentionally interfering with existing contracts and with a goal of reducing TeamHealth's market participation. FAC ¶ 108.

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

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

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

27. The Health Care Providers further allege:

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

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

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

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

e. Also in 2009, for the same conduct, defendants UnitedHealth Group, Inc., United HealthCare Insurance Co., and United HealthCare Services, Inc. paid $350 million to settle class action claims

alleging that they underpaid non-participating providers for services in *The American Medical Association, et al. v. United Healthcare Corp., et al.*, Civil Action No. 00-2800 (S.D.N.Y.). FAC ¶ 75.

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

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

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

i. As stated on Defendants' website (https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits) for nonparticipating provider claims, the relevant United Health Group affiliate will "in many cases" pay the lower of a provider's actual billed charge or "the reasonable and customary amount," "the usual customary and reasonable amount," "the prevailing rate," or other similar terms that base payment on what health care providers in the geographic area are charging. FAC ¶ 79.

28. Based on the foregoing and a review of all of the allegations in the FAC, the Court finds that each of the Health Care Providers' causes of action

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

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

CONCLUSIONS OF LAW

ERISA Preemption

ERISA Overview

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

31. "The comprehensive and reticulated statute, contains elaborate provisions for the regulation of employee benefit plans." *Skillin*, 226 Cal. Rptr. 3d 505, 509. It sets forth reporting and disclosure obligations for plans, imposes a fiduciary standard of care for plan administrators, and establishes schedules for the vesting and accrual of pension benefits."

Massachusetts v. Morash, 490 U.S. 107, 112–113, 109 S. Ct. 1668 (1989).

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

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

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

Complete Preemption

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

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

3. Complete preemption is a jurisdictional doctrine and cannot be used to obtain dismissal of a state law claim on a Rule 12(b)(5) motion to dismiss. *Owayawa v. Am. United Life Ins. Co.*, CV 17-5018-JLV, 2018 WL 1175106, at *3 (D.S.D. Mar. 5, 2018) ("[A]lthough complete preemption...can be used to invoke federal question jurisdiction, Defendants cannot use [the doctrine] as a ground for dismissing Plaintiffs' claims under Federal Rule of Civil Procedure 12(b)(6)."); *Summit Estate, Inc. v. Cigna Healthcare of Cal., Inc.*, Case No. 17-CV-03871, 2017 WL 4517111, at *13 (N.D. Cal. Oct. 10, 2017) (complete preemption under § 1132(a) is "really a jurisdictional rather than a preemption doctrine….[and was] created...as a basis for federal question removal jurisdiction under 28 U.S.C. § 1441(a)."); *Marin Gen. Hosp.*, 581 F.3d at 945 (complete preemption under ERISA is not a ***defense*** to a state law claim); *Mid-Town Surgical Ctr., L.L.P. v. Humana Health Plan of Tex., Inc.*, 16 F. Supp. 3d 767, 779 (S.D. Tex. 2014) ("complete preemption ***is not grounds for dismissal***, but instead a mechanism to confer federal jurisdiction on a state-law claim that is in fact an ERISA claim."); *Autonation, Inc. v. United Healthcare Ins. Co.*, 423 F.Supp.2d 1265, 1268 (S.D. Fla. 2006) (complete preemption is a jurisdictional doctrine which converts state law claims into federal claims for purposes of removal, but does not dismiss claims).

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

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

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

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

8. *Davila* provides complete preemption applies only where: (1) a plaintiff "could have brought his claim under ERISA § 502(a)(1)(B)," and (2) "no other independent legal duty . . . is implicated by a defendant's actions." *Id.* at 210. The test is conjunctive; a claim is completely preempted only if both

prongs are satisfied. *McCulloch Orthopaedic Surgical Servs., PLLC v. Aetna Inc.*, 857 F.3d 141, 146 (2d Cir. 2017).

9. Regarding the first *Davila* prong, the Court concludes that the Health Care Providers' claims challenge the ***rates*** of reimbursement paid for covered healthcare services, rather than the right to reimbursement for such services, therefore they do not fall within the scope of § 502(a)(1)(B). FAC ¶¶ 1, 26; 1 n.1 ("The Health Care Providers also do not assert any claims…with respect to the right to payment under any ERISA plan."); *Conn. State Dental Ass'n.*, 591 F.3d at 1349-50; *Lone Star OB/GYN Associates v. Aetna Health Inc.*, 579 F.3d 525, 531 (5th Cir. 2009); *Montefiore*, 642 F.3d at 325; *CardioNet Inc. v. Cigna Health Corp.*, 751 F.3d 165, 177-78 (3d Cir. 2014); *Blue Cross of Cal.*, 187 F.3d at 1051 (affirming remand of health care providers' state law claim for breach of contract because the dispute was "not over the right to payment, which might be said to depend on the patients' assignments to the Providers, but the amount, or level, of payment, which depends on the terms of the provider agreements."); s*ee also Garber v. United Healthcare Corp.*, 2016 WL 1734089, at *3-5 (E.D.N.Y. May 2, 2016); *Long Island Thoracic Surgery, P.C. v. Building Serv. 32BJ Health Fund*, 2019 WL 5060495, at *2 (E.D.N.Y. Oct. 9, 2019); *Premier Inpatient Partners LLC v. Aetna Health & Life Ins. Co.*, 371 F. Supp. 3d 1056, 1068-74 (M.D. Fla. 2019); *Gulf-to-Bay Anesthesiology Assocs. v. UnitedHealthCare of Fla., Inc.*, 2018 WL 3640405, at *3 (M.D. Fla. July 20,

2018); *Hialeah Anesthesia Specialists, LLC v. Coventry Health Care of Fla., Inc.*, 258 F. Supp. 3d 1323, 1327-30 (S.D. Fla. 2017); *N. Jersey Brain & Spine Ctr. v. MultiPlan, Inc.*, 2018 WL 6592956, at *7 (D.N.J. Dec. 14, 2018); *E. Coast Advanced Plastic Surgery v. AmeriHealth*, 2018 WL 1226104, at *3 (D.N.J. Mar. 9, 2018).

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

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

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

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

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

14. The Court does not find merit in United's argument that the claims asserted in the FAC are preempted because an implied-in-fact agreement is different than a written, oral or quasi contract. In Nevada, implied-in-fact agreements and express agreements stand on equal footing. *See Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371,

379, 283 P.3d 250, 256 (2012) (an implied-in-fact contract "is a true contract that arises from the tacit agreement of the parties."); *Smith v. Recrion Corp.*, 91 Nev. 666, 668, 541 P.2d 663, 665 (1975) ("Both express and implied contracts are founded on an ascertained agreement."); *Magnum Opes Const. v. Sanpete Steel Corp.*, 2013 WL 7158997 (Nev. Nov. 1, 2013) (quoting 1 Williston on Contracts § 1:5 (4th ed. 2007) (noting that the legal effects of express and implied-in-fact contracts are identical); *Cashill v. Second Judicial Dist. Court of State ex rel. Cty. of Washoe*, 128 Nev. 887, 381 P.3d 600 (2012) (unpublished) ("The distinction between express and implied in fact contracts relates only to the manifestation of assent; both types are based upon the expressed or apparent intention of the parties."). As a result, the Court concludes that implied-in-fact agreements are treated the same as written, oral and quasi contracts in Nevada and, consequently, the caselaw rejecting ERISA preemption for claims arising out of such contracts equally applies to implied-in-fact agreements.

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

16. The Court also does not find merit in United's argument that the state law claims threaten to disrupt nationally uniform plan administration by "seeking to use state law claims to force the plans to pay more." Motion at 3:22-23. Other courts have similarly rejected United's argument, finding that "state law claims brought by health care providers

against plan insurers too tenuously affect ERISA plans to be preempted." *Lordmann Enters., Inc. v. Equicor, Inc.*, 32 F.3d 1529, 1533 (11th Cir. 1994); *Glastein v. Aetna, Inc.*, 2018 WL 4562467, at *3 n.4 (D.N.J. Sept. 24, 2018) (collecting cases); *Rocky Mountain Holdings LLC v. Blue Cross and Blue Shield of Fla., Inc.*, 2008 WL 3833236, at *5 (M.D. Fla. Aug. 13, 2008) (collecting cases); *Med. & Chirurgical Facility of the State of Md. v. Aetna U.S. Healthcare, Inc.*, 221 F. Supp. 2d 618, 619-20 (D. Md. 2002) (collecting cases).

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

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

Conflict Preemption

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

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

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

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

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

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

25. The Supreme Court has limited the parameters of § 514(a) preemption to two categories of state laws. *Gobeille*, 136 S.Ct. at 943. Those categories

are: (1) laws "with a reference to ERISA plans," which include laws which "act[ ] immediately and exclusively upon ERISA plans . . .or where the existence of ERISA plans is essential to the law's operation," and (2) laws with "an impermissible connection with ERISA plans, meaning a state law that governs a central matter of plan administration or interferes with nationally uniform plan administration." *Id.*

26. The Ninth Circuit has made it clear that § 514(a) does not apply to claims brought by third-party healthcare providers, like the Health Care Providers here. *Morris B. Silver M.D., Inc. v. Int'l Longshore & Warehouse etc.*, 2 Cal. App. 5th 793, 799, 206 Cal. Rptr. 3d 461, 466 (Ct. App. 2016); *Providence Health Plan*, 385 F.3d at 1172; *Abraham v. Norcal Waste Sys., Inc.*, 265 F.3d 811, 820–21 (9th Cir.2001); *Blue Cross of Cal.*, 187 F.3d at 1052–53; *see also The Meadows v. Employers Health Ins.*, 47 F.3d 1006, 1008 (9th Cir. 1995) (stating that § 1144(a) does not preempt "claims by a third-party who sues an ERISA plan not as an assignee of a purported ERISA beneficiary, but as an independent entity claiming damages").

27. Other jurisdictions have also made it clear that § 514(a) claims by third-party providers arising out of analogous circumstances to those asserted by Health Care Providers here, are not preempted. *See, e.g., Memorial Hosp. System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 243–246 (5th Cir. 1990) (holding hospital's claim for deceptive and unfair practices arising from representations regarding coverage not preempted and articulating two-factor test); *see also*

Access Mediquip LLC v. UnitedHealthcare Ins. Co., 662 F.3d 376, 385 (5th Cir. 2011) ("The state law underlying Access's misrepresentation claims does not purport to regulate what benefits United provides to the beneficiaries of its ERISA plans, but rather what representations it makes to third parties about the extent to which it will pay for their services."); *Depot, Inc. v. Caring for Montanans, Inc.*, 915 F.3d 643, 667 (9th Cir. 2019), *cert. denied*, 140 S. Ct. 223 (2019) ("State-law claims are based on other independent legal duties when they are in no way based on an obligation under an ERISA plan and would exist whether or not an ERISA plan existed.") (citing *Marin Gen. Hosp.*, 581 F.3d at 950) (internal alteration omitted).

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

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

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

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

32. Therefore, the Court concludes that the Health Care Providers have not pled claims for ERISA benefits. *See Blue Cross of California Inc. v. Insys Therapeutics Inc.*, 390 F. Supp. 3d 996, 1004 (D. Ariz. 2019) (holding that state-law claims for common law fraud, misrepresentation, negligent misrepresentation, unjust enrichment, civil conspiracy, tortious interference with contract, and statutory claims for unfair and deceptive competition and practices were not subject to conflict preemption); *Spinedex v. Physical Therapy, U.S.A., Inc. v. Arizona*, No. 04-CV-1576-PHX-JAT, 2005 WL 3821387, at *8 (D. Ariz. Nov. 9, 2005); *Almont Ambulatory Surgery Center, LLC v. UnitedHealth Grp., Inc.*, 121 F. Supp. 3d 950, 962-71 (C.D. Cal. 2015); *Scripps Health v. Schaller Anderson, LLC*, No. 12-

CV-252-AJB(DHB), 2012 WL 2390760, at *2-*6 (S.D. Cal. Jun. 22, 2012); *Ass'n of N.J. Chiropractors v. Aetna, Inc.*, No. CIV.A. 09-3761 JAP, 2012 WL 1638166, at *5-7 (D.N.J. May 8, 2012); *United Healthcare Servs., Inc. v. Sanctuary Surgical Ctr., Inc.*, 5 F. Supp. 3d 1350, 1363 (S.D. Fla. 2014)); *Aetna Life Ins. Co. v. Huntingdon Valley Surgery Ctr.*, 2015 WL 1954287, at *10 (E.D. Pa. Apr. 30, 2015) (holding that the out-of-network provider claims for unjust enrichment and breach of contract were not preempted by ERISA because the plaintiff's state law claims were independent of the ERISA beneficiaries' rights under any ERISA plan); *Jewish Lifeline Network, Inc. v. Oxford Health Plans (NJ), Inc.*, 2015 WL 2371635, at *3 (D.N.J. May 18, 2015) (ERISA preemption "does not foreclose a plaintiff from pleading a state law claim based on a legal duty that is independent from ERISA or an ERISA-governed plan").

33. The United States Supreme Court and more recent Ninth Circuit cases have declined to adopt a literal interpretation of the "relates to" language. In *New York State Conference of Blue Cross & Blue Shield Plans*, 514 U.S. at 654, 115 S. Ct. at 1671, the court clarified that the "starting presumption" is that Congress does not intend to supplant state law. *See also Bertoni v. Stock Bldg. Supply*, 989 So. 2d 670, 674–75 (Fla. Dist. Ct. App. 2008). It went on to describe the "relates to" language of the preemption statute as "unhelpful," and instructed that one is instead to look "to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* at 656, 115

S.Ct. 1671. The *Travelers* court noted that in light of the objectives of ERISA and its preemption clause, Congress intended to preempt "state laws providing alternative enforcement mechanisms" for employees to obtain ERISA plan benefits. *Id.* at 658, 115 S.Ct. 1671; *see also Egelhoff v. Egelhoff ex rel. Breiner*, 121 S. Ct. 1322, 1327 (2001) ("But at the same time, we have recognized that the term "relate to" cannot be taken "to extend to the furthest stretch of its indeterminacy," or else "for all practical purposes pre-emption would never run its course).

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

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

Blau v. Del Monte Corp., 748 F.2d 1348 (9th Cir. 1984) (nonunion salaried employees brought suit against employer for benefits under employee welfare plan); *Parlanti v. MGM Mirage*, No. 2:05-CV-1259-ECR-RJJ, 2006 WL 8442532, at *1 (D. Nev. Feb. 15, 2006) (plaintiff directly sued former employer over supplemental executive retirement plan).

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

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

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

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

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

NRCP 12(b)(5) Legal Standard

41. Rule 8(a)(2) of the Nevada Rules of Civil Procedure states that a complaint shall contain "a short and plain statement of the claim showing that the pleader is entitled to relief." NRCP 8(a)(2). Thus, Nevada is a notice-pleading state and a pleading is liberally construed to "place into issue matter which is fairly noticed to the adverse party." *Chavez v. Robberson Steel Co.*, 94 Nev. 597, 598, 584 P.2d 159,

160 (Nev. 1978); *Hay v. Hay*, 100 Nev. 196, 198, 678 P.2d 672, 674 (1984). In other words, so long as the "adverse party has adequate notice of the nature of the claim and relief sought," trial courts should allow a pleading to survive any challenge asking for dismissal. *Hay*, 100 Nev. at 198, 678 P.2d at 674; *see also Liston v. Las Vegas Metro. Police Dept.*, 111 Nev. 1575, 1579, 908 P.2d 720, 723 (1995).

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

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

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

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

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

The Health Care Providers' Claims

Breach of Implied-in-Fact Contract

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

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

of dealing involving hundreds of transactions over several years, Defendants and Plaintiff manifested an intent to be bound and agreed to material terms of an implied contract.").

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

49. The Health Care Providers allege an implied-in-fact agreement exists between the Health Care Providers and Defendants, specifically alleging that "there is no written agreement between Defendants and the Health Care Providers for the healthcare claims at issue in this litigation; the Health Care Providers are therefore designated as a 'non-participating' or 'out-of-network' provider for all of the claims at issue." FAC ¶ 20; *see also* FAC ¶¶ 189-206.

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

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

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

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

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

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

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

56. The Court does not find merit to United's argument that *Aluevich v. Harrah's*, 99 Nev. 215, 218, 660 P.2d 986, 987 (1983) stands for the proposition

that this claim for relief cannot apply to sophisticated parties in the commercial realm.

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

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

Alternative Claim for Unjust Enrichment

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

60. The overwhelming majority of cases considering this issue conclude that where a state allows for an indirect benefit to provide the basis for an unjust enrichment claim, a claim of unjust enrichment against an insurer is actionable. *See Emergency Physicians LLC v. Arkansas Health & Wellness Health Plan, Inc.*, No. 4:17-CV-00492-KGB, 2018 WL 3039517, at *5 (E.D. Ark. Jan. 31, 2018) (finding

that because Texas law allows for an indirect benefit to sustain a claim for unjust enrichment, a claim for unjust enrichment based on indirect benefits received by insurer for services provided to insureds was actionable); *Bell v. Blue Cross of California*, 131 Cal. App. 4th 211, 221, 31 Cal. Rptr. 3d 688, 695–96 (2005) (emergency provider had standing to assert quantum meruit claim against payor because "he who has 'performed the duty of another by supplying a third person with necessaries…is entitled to restitution…"); *El Paso Healthcare System, Ltd. v. Molina Healthcare of New Mexico*, 683 F.Supp.2d 454, 461–462 (W.D. Tex. 2010) (insurer "receive[d] the benefit of having its obligations to its plan members, and to the state in the interests of plan members, discharged."); *Appalachian Reg'l Healthcare vs. Coventry Health & Life Ins.* Co., 2013 WL 1314154 at *4 (E.D. Ky. Mar. 28, 2013) (granting summary judgment to provider on unjust enrichment claim where plaintiff's services allowed managed care organization to discharge its duty to provide coverage to Medicaid patients); *Fisher v. Blue Cross Blue Shield of Texas, Inc.*, 2011 WL 11703781, at *8 (N.D. Tex. June 27, 2011) (defendant insurer received the benefit of having its obligations to its plan members discharged.); *Forest Ambulatory Surgical Associates, L.P. v. United Healthcare Ins. Co.*, 2013 WL 11323600, at *10 (C.D. Cal. March 12, 2013) ("Plaintiff sufficiently stated a claim upon which relief can be granted because the allegations ... establish that Defendants received the benefit of having their obligations to the [policyholders] discharged."); *River Park Hosp., Inc. v. BlueCross BlueShield of Tennessee, Inc.*, 173 S.W.3d 43, 58-59

(Tenn. Ct. App. 2002) (MCO was unjustly enriched by hospital's emergency services provided to the insurer's enrollees); *New York City Health & Hosps. Corp. v. Wellcare of New York*, Inc., 35 Misc. 3d 250, 251, 937 N.Y.S.2d 540, 541, 546 (2011) (non-contracted hospital's unjust enrichment claim for systematic underpayment for emergency services by MCO should not be dismissed under New York law).

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

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

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

63. Under NRS 686A.020, "[a] person shall not engage in this state in any practice which is defined

in NRS 686A.010 to 686A.310, inclusive, as, or determined pursuant to NRS 686A.170 to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance."

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

65. The plain language of NRS 686A.310 does not prohibit a third party, such as the Health Care Providers, from raising claims under NRS 686A.310, but, instead, provides that claims may be asserted by the Commissioner and an insured. NRS 686A.310(2) ("In addition to any rights or remedies available to the Commissioner, an insurer is liable to its insured for any damages sustained by the insured as a result of the commission of any act set forth in subsection 1 as an unfair practice.").

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

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

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

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

Violations of Nevada Prompt Pay Statutes and Regulations

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

Laws"). Thus, for all submitted claims, United was obligated to pay the Health Care Providers the usual and customary rate within 30 days of receipt of the claim.

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

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

73. As a result, the FAC adequately alleges that United has failed to reimburse the Health Care Providers at the usual and customary rate within 30 days of submission of the claims as the Nevada Insurance Code requires. If established, United is liable to the Health Care Providers for statutory penalties.

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

75. To the extent any of United's other arguments specific to its Motion regarding the Health Care Providers' claim for Violations of Nevada Prompt Pay statutes and regulations are not specifically addressed herein, the Court considered all of

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

Violations of Nevada Consumer Fraud & Deceptive Trade Practices Acts

76. The Nevada Deceptive Trade Practices Act (DTPA) prohibits United from engaging in "deceptive trade practices," including but not limited to (1) knowingly making a false representation in a transaction; (2) violating "a state or federal statute or regulation relating to the sale or lease of goods or services"; (3) using "coercion, duress or intimidation in a transaction"; and (4) knowingly misrepresent the "legal rights, obligations or remedies of a party to a transaction." NRS 598.0915(15), 598.0923(3), 598.0923(4), NRS 598.092(8), respectively.

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

78. The Health Care Providers sufficiently allege that United has violated the DTPA and the Consumer Fraud Statute through its acts, practices, and omissions described in the FAC, including but not limited to (a) wrongfully refusing to pay the Health Care Providers for the medically necessary, covered emergency services the Health Care Providers provided to Members in order to gain unfair leverage against the Health Care Providers now that they are out-of-network and in contract negotiations to potentially become a participating provider under

a new contract in an effort to force the Health Care Providers to accept lower amounts than it is entitled for its services; and (b) engaging in systematic efforts to delay adjudication and payment of the Health Care Providers' claims for its services provided to United's members in violation of their legal obligations. FAC ¶ 246.

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

80. Even if this Court were to require that this claim be subject to heightened pleading standards, the Court concludes that the Health Care Providers pled the claim for violation of DTPA with particularity. FAC ¶ 246; *see also* ¶¶ 25, 57, 65.

81. The Health Care Providers sufficiently allege that United violated "a state or federal statute or regulation relating to the sale or lease of goods or services" with allegations that United has violated NRS 679B.152, NRS 686A.020, 686A.310, NRS 683A.0879 (third party administrator), NRS 689A.410 (Individual Health Insurance), NRS 689B.255 (Group and Blanket Health Insurance), NRS 689C.485 (Health Insurance for Small Employers), NRS 695C.185 (HMO) and NAC 686A.675 by failing to timely pay claims submitted at a usual and customary rate within 30 days of receipt of the claim. FAC ¶¶ 243-249. The Health Care Providers expressly state that the UH Parties began to violate

these provisions in July 2017 (FAC ¶ 254) and the Sierra Affiliates in March 2019 (*id.* ¶ 255) and continue to violate such provisions through the present date. Nothing further is required to establish that this claim is actionable. As such, the Health Care Providers sufficiently allege this portion of the DTPA claim.

82. The Health Care Providers also sufficiently allege that the DPTA has been violated by United's use of "coercion, duress or intimidation in a transaction." FAC ¶ 244. Specifically, the Health Care Providers allege that United is "wrongfully refusing to pay the Health Care Providers for the medically necessary, covered emergency services the Health Care Providers provided to Members in order to gain unfair leverage against the Health Care Providers now that they are out-of-network and in contract negotiations to potentially become a participating provider under a new contract in an effort to force the Health Care Providers to accept lower amounts than it is entitled for its services." FAC ¶ 246.

> 83. Further, the Health Care Providers allege: Defendants paid some claims at an appropriate rate and others at a significantly reduced rate which is demonstrative of an arbitrary and selective program and motive or intent to unjustifiably reduce the overall amount Defendants pay to the Health Care Providers. Defendants implemented this program to coerce, influence and leverage business discussions with the Health Care Providers to become a participating provider at

> significantly reduced rates, as well as to unfairly and illegally profit from a manipulation of payment rates.

FAC ¶ 65.

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

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

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

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

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

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

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

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

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

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

94. The Health Care Providers allege that the provision of services to United's Members was not voluntary and the loss the Health Care Providers have suffered was unexpected given that United is refusing to pay usual and customary rates and the reasonable value of the services provided despite previously doing so. Thus, the Court concludes that, accepting all allegations of the Health Care Providers as true, the Health Care Providers are not active participants in United's fraudulent conduct and are

"victims" under NRS 41.600(1) even if the definition of "victim" is limited in the way United proposes.

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

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

Declaratory judgment

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

Violation of NRS 207.350 et seq. (NV RICO)

98. Under Nevada law, any person who is injured in his business or property by reason of any violation of NRS 207.400 has a cause of action against a person causing such injury for three times the actual damages sustained. NRS 207.470(1).

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

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

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

100. In order to recover, three conditions must be met: (1) the plaintiff's injury must flow from the defendant's violation of a predicate Nevada RICO act; (2) the injury must be proximately caused by the defendant's violation of the predicate act; and (3) the plaintiff must not have participated in the commission of the predicate act. *Allum v. Valley Bank of Nevada*, 109 Nev. 280, 283, 849 P.2d 297, 299 (1993).

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

102. While Nevada's civil RICO statutes are patterned after the federal RICO statutes, Nevada's statute differs in some respects. *Hale v. Burkhardt,*

104 Nev. 632, 634-635, 764 P.2d 866, 867-868 (1988).

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

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

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

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

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

plaintiff alleged a third party had relied on the defendants' false statements).

108. The proximate causation analysis is concerned with: (1) whether plaintiff would have difficulty showing its damages flowed from defendant conduct; (2) whether there is a risk of double recovery; and (3) whether others are positioned to make the same claims. *Holmes* at 503 U.S. at 269. These factors emphasize that proximate cause is "a flexible concept that does not lend itself to a black-letter rule that will dictate the result in every case." *Takeda Pharmaceuticals Co. Ltd.*, 2019 WL 6484263, at *5.

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

the Health Care Providers only seek to recover their damages.

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

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

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

113. Further, the Court does not find merit to United's argument that there is a risk of double recovery because the Health Care Providers only seek recovery for emergency services they rendered and no one else is positioned to make the same Nevada civil RICO claims regarding the emergency services at issue in this case. *Holmes*, 503 U.S. at 266-268.

114. The Court also considered, and rejects, United's argument that (1) the civil racketeering allegations fail because the alleged underpayment has no causal connection to alleged misrepresentations as the Health Care Providers are required to provide emergency care under federal and state law; and (2) United previewed its scheme, resulting in a

break in the causal connection. Supplement at 5:14-6:3. Both of arguments misunderstand the proximate cause inquiry.

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

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

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

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

generally fail to satisfy the pleading standards under Rule 8(a) or 9(b)."

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

120. Section 205.377 provides, in part:

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

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

122. The Court finds that the Health Care Providers sufficiently allege the elements for two fraud-based predicate acts in violation of NRS 205.377 (multiple transactions involving fraud or deceit in

course of enterprise or occupation) and for obtaining possession of money or property by false pretenses.

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

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

125. With respect to the claim under NRS 207.360(28), the Health Care Providers sufficiently allege that the Enterprise intended to defraud the Health Care Providers through written false representations (*see, e.g., id.* ¶¶ 126, 177-178), causing the Health Care Providers' reliance thereon (*see, e.g., id.* ¶¶ 111, 183-185). FAC ¶¶ 123-126; *see also* ¶¶ 149-188.

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

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

NRS 200.463(1).

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

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

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

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

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

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

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

133. Further the FAC provides sufficient factual allegations, namely that United and third-party entities, including Data iSight have joined together to falsely claim to provide transparent, objective and

geographically-adjusted determinations of reimbursement rates; and they illegally conduct the affairs of the Enterprise, and/or control the Enterprise through a pattern of unlawful activity. *Id.* ¶¶ 112, 115, 124.

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

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

Accordingly, good cause appearing, therefor,

ORDER

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

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

DATED this 24th day of June, 2020

/s/ Nancy L. Allf
Nancy Allf
District Court Judge
A7B FD7 9E00 6B2D

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[Intentionally omitting Certificate of Service]

APPENDIX G

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	**Electronically Filed Apr 18 2023 11:09PM Elizabeth A. Brown Clerk of Supreme Court** 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	Case No. 85656

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.

APPEAL
from the Eighth Judicial District Court, Clark County
The Honorable Nancy L. Allf, District Judge
District Court Case No. A-19-792978

APPELLANTS' OPENING BRIEF

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* * * *

V.

TEAMHEALTH'S LEGAL CLAIMS ARE ALL PREEMPTED BY ERISA

United submits that TeamHealth's entire case is preempted by ERISA, foreclosing any need for the analyses already discussed. United asserts this argument last only because this Court already considered

the argument preliminarily on United's petition for interlocutory review and suggested that despite ERISA's broad preemptive force, TeamHealth had "alleged" its "own implied-in-fact contract with United establishing a rate of payment, separate from any assignments from health plan members or right to benefits from United," and that the alleged contract—if proven—would establish "a relationship and claim not directly 'relating to' ERISA." Dkt. No. 81680, Order Denying Petition, Doc. No. 21-18915, filed July 1, 2021, at 3. Given that preliminary determination, United has principally addressed that alleged "separate" implied-in-fact contract on its own terms, along with other "independent" claims asserted by TeamHealth under Nevada law. But United respectfully submits that, properly analyzed, TeamHealth's causes of action are *not*, in fact, independent of the health plans that United insures or administers, and thus can only proceed as a claim for plan benefits under ERISA itself.

A. ERISA Preempts State-Law Claims That Relate to Employee Benefit Plans or Seek to Enforce Plan Rights and Obligations

"The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). With comprehensive regulation comes broad remedies and penalties. *Id.* (citing 29 U.S.C. § 1001(b)); *see* 29 U.S.C. §§ 1131-35.

Congress ensured uniform nationwide regulation of benefit plans in two ways. First, Congress made civil enforcement provisions set forth in ERISA § 502(a), 29 U.S.C. § 1132(a), "the exclusive vehicle for

actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." *Pilot Life*, 481 U.S. at 52. Accordingly, when a state-law cause of action "duplicates, supplements, or supplants the ERISA civil enforcement remedy," the claim is "completely preempted" and may proceed only as an ERISA claim and only in federal court. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004).

Second, when a state-law claim "relates to" an ERISA-governed plan, the claim is preempted and cannot proceed. 29 U.S.C. § 1144(a) (ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan"). A state law "relates to an ERISA plan" within the meaning of this provision "if it has a connection with or reference to such a plan." *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (quotation omitted). A state-law claim in turn has an impermissible "connection with" an ERISA plan when the claim seeks to govern "a central matter of plan administration" or "interferes with nationally uniform plan administration," or when "acute, albeit indirect, economic effects of the state law force an ERISA plan to adopt a certain scheme of substantive coverage." *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 319–20 (2016) (quoting *Egelhoff*, 532 U.S. at 148). Alternatively, state law makes "reference to" an ERISA plan when it "acts immediately and exclusively upon" ERISA plans, or "where the existence of ERISA plans is essential to the law's operation." *Id.* (quoting *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997)). These principles apply not only to statutes, but also to state common-law

claims that relate to ERISA-governed plans in the same way. *See Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 57 (1987); *Aetna Life Insurance Co. v. Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000).

Decisions of the U.S. Supreme Court addressing "relates to" preemption help delineate the rule's scope. In *Gobeille*, the Court found an impermissible connection with ERISA plans in a Vermont statute requiring health insurers, including ERISA plans, "to report detailed information about the administration of benefits," which was "a fundamental ERISA function." 577 U.S. at 325. In *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983), the Court held that a generally applicable anti-discrimination statute was preempted because it required ERISA plans to pay specific benefits not required under federal law. *Id.* at 106-09. By contrast, the Court found no preemption of a New York statute that imposed surcharges on hospital patients not covered by insurance because it only "indirectly" affected plans by changing the economics of their coverage decisions, but did not "bind plan administrators to any particular choice." *Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 659-60 (1995). Similarly, the Court found no preemption of an Arkansas statute requiring pharmacy benefit managers "to reimburse pharmacies at or above their acquisition costs" because it did "not require plans to provide any particular benefit to any particular beneficiary in any particular way." *Rutledge v. Pharm. Care Mgmt. Ass'n*, 141 S. Ct. 474, 482 (2020).

B. TeamHealth's Causes of Action "Relate To" ERISA-Governed Plans and Effectively

Challenge United's Plan Administration Activities

Each of TeamHealth's four causes of action is preempted under ERISA §§ 514(a) and 502(a).

This Court has already held that UCPA claims are preempted because they impose obligations on ERISA-governed plans:

> 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 when applied to a valid ERISA plan.

Villescas v. CNA Ins. Cos., 109 Nev. 1075, 1084, 864 P.2d 288, 294 (1993); *see Estate of Burgard v. Bank of Am.*, N.A., 2:15-CV-00833-RFBPAL, 2017 WL 1273869, at *9 (D. Nev. Mar. 31, 2017) (reaffirming *Villescas* as applied to UCPA and bad faith claims); *Brandner v. UNUM Life Ins. Co. of Am.*, 152 F. Supp. 2d 1219, 1228 (D. Nev. 2001) (collecting cases).

The same logic applies to TeamHealth's PPA claims, which likewise would impose a payment obligation on ERISA governed benefit plans. If the PPA applies at all, it would only be because United had "approved" a benefit claim pursuant to the relevant ERISA plan. *E.g.*, NRS 689B.255(1). Accordingly, there "simply is no cause of action if there is no plan," and thus the cause of action is preempted. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990). Courts have held that a similar statute in New York—requiring prompt payment of benefit claims where the

obligation to pay is "reasonably clear"—in effect creates a cause of action "to recover for monies owed pursuant to [an ERISA plan]" and is therefore preempted. *Neurological Surgery, P.C. v. Siemens Corp.*, 2017 WL 6397737, at *5-6 (E.D.N.Y. Dec. 12, 2017) (collecting cases); *see Norman Maurice Rowe, M.D., M.H.A., L.L.C. v. Oxford Health Ins. Co., Inc.*, 77 Misc. 3d 958, 962-63 (N.Y. Sup. Ct. 2022). The Fifth Circuit likewise found that ERISA preempted the Texas PPA. *N. Cypress Med. Ctr. Operating Co., Ltd. v. Cigna Healthcare*, 781 F.3d 182, 201 (5th Cir. 2015). There is no basis for a different result in Nevada.

TeamHealth's implied-in-fact contract and unjust enrichment claims also are preempted. This Court preliminarily concluded otherwise as to the implied-in-fact contract claim, at least as alleged by TeamHealth, *see supra* Facts at C.2, but subsequent proceedings clearly revealed the extent to which all of TeamHealth's causes of action were intertwined with United's plan obligations and benefit-processing activities.

Common-law claims are preempted by ERISA not only when they "contradict written ERISA plan provisions," but also when they "would, as a practical matter, result in an amendment or modification of a plan." *Wong v. Flynn-Kerper*, 999 F.3d 1205, 1207 (9th Cir. 2021); *see Blau v. Del Monte Corp.*, 748 F.2d 1348, 1356–57 (9th Cir. 1984), *abrogated on other grounds in Dytrt v. Mountain States Tel. & Tel. Co.*, 921 F.2d 889, 894 n.4 (9th Cir. 1990); *Lafferty v. Solar Turbines Int'l*, 666 F.2d 408, 409 (9th Cir. 1982); *Dependahl v. Falstaff Brewing Corp.*, 653 F.2d 1208, 1215-16 (8th

Cir. 1981).[22] As TeamHealth argued the implied-in-fact contract and unjust enrichment claims at trial, those causes of action plainly sought to alter United's plan obligations and benefit-processing conduct both directly and in practical effect.

As shown above in the discussion of the legal claims on their merits, both required TeamHealth to establish that it conferred a benefit on United by "discharging" (fully or in part) its obligations to plan members. *See supra* at II.A–B; *see also Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co.*, 967 F.3d 218, 241-42 (3d Cir. 2020) (unjust enrichment claim requires proof that healthcare provider conferred benefit on health insurer by discharging its plan obligations). Those obligations, of course, exist only because of the plans and they are defined solely by the plans' terms. And if TeamHealth's conduct wholly or partially discharged United's plan obligations, then it necessarily either altered the plan terms specifying United's duties, or relieved United of its duty to perform under the plan. Either way, the direct connection between TeamHealth's legal claims and United's plan obligations is inescapable. *See Norman Maurice Rowe, M.D., M.H.A., L.L.C. v. Oxford Health Ins. Co., Inc.*, 77 Misc. 3d 958, 962 (N.Y. Sup. Ct. 2022) (holding that non-network provider's claims for breach of independent contract, unjust enrichment, and estop-

[22] *Wong* involved a federal common-law estoppel claim, but its reasoning about the effect of the claim on plan terms shows why state-law claims with the same effect necessarily relate to the plan. The other cited cases all hold that ERISA § 514 preempts state common-law claims that would alter plan obligations.

pel were preempted because "the only way to determine whether [the provider's] claims were administered properly is to review the terms of the governing ERISA Plan").

The interference with United's administrative duties is not just implicit; the clash between those duties and the final judgments entered below is quite explicit. For example, the plan documents prescribe certain specific duties with respect to non-network services, including instructing the administrator to exclusively use specific methodologies for reimbursing out-of-network benefit claims (142App.35,264–143App.35,445; 37App.9,058–63, 9069–70), and in some instances, dictating a specific out-of-network reimbursement rate (40App.9,961–62.) For example, the Wal-Mart benefit plan required United to reimburse non-network claims at 125% of Medicare, yet the jury verdict would compel the plan to increase reimbursements to more than 300% of Medicare. 76App.18,914; 37App.9,044–50. The judgment thus flatly overrides the terms of the Wal-Mart plan and any other plan similarly requiring reimbursement at rates lower than the judgment compels. The judgment thereby contravenes such plans' efforts to control costs of non-network services—costs that are inevitably passed through to the plan's beneficiaries, either as direct charges for services or as reduced plan benefits.

The judgments obstruct the performance of other administrative duties as well. For example, HPN and SHL specifically structured their benefit claims processing systems to reimburse providers in accordance

with plan requirements, not in accordance with providers' unilateral demands. (40App.9,967.) Compliance with the reimbursements required by the judgment would require these entities to reconfigure their plan administrative systems, imposing undesired costs on sponsors and ultimately plan beneficiaries. (40App.9,960–62, 9,966–67, 9,969; 41App.10,018–19, 10,021–23.) The judgment's direct interference with plan administrative functions confirms the judgment's impermissible connection with ERISA plans.

Finally, that connection is sharply underscored by the unjustified and highly prejudicial spoliation instruction United suffered at trial. As discussed above, that instruction was based on United's failure to fully produce all the health plan documents for the thousands of plans put at issue in TeamHealth's benefit claims. *See supra* at I.B. It is impossible for TeamHealth to defend that instruction while simultaneously asserting that its legal claims had no connection with the very plan documents that provoked the instruction.

As tried by TeamHealth, in short, its causes of action were not solely about establishing its independent "right to payment" disconnected from the plans themselves, as TeamHealth has previously argued to avoid ERISA preemption. The trial was *all about* the health plans, including both the duties and restrictions they imposed on United. Trial thus confirmed that TeamHealth's causes of action had a clear—and clearly impermissible—connection with the United-ERISA-governed plans. They are accordingly preempted.

C. ERISA's Insurance "Savings Clause" Does Not Save TeamHealth's Legal Claims From Preemption

TeamHealth cannot avoid preemption of its state-law claims by invoking ERISA's "saving clause," which provides that § 514(a)'s express "relates to" preemption clause does not apply to "any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(a). The savings clause itself is conditioned by a clawback "deemer" clause, which provides that an ERISA-governed employee benefit plan itself cannot be "deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts." *Id.* § 1144(b)(2)(B). Given the deemer clause, TeamHealth has no plausible argument that its state-law claims are saved from preemption as to self-funded plans for which United serves as a TPA. In that situation, the state-law claims act directly on the plan itself: they explicitly increase reimbursements the plan itself must make and they functionally alter the terms that govern United's administrative operations.

TeamHealth's state-law claims involving insured plans are preempted as well. When a state-law claim "seeks remedies for the improper processing of a claim for benefits under an ERISA-regulated plan," the savings clause does not apply at all, because ERISA *separately* makes its remedies for improper claims-processing "exclusive" of all competing state remedies, even if they are otherwise laws that "regulate insurance." *Pilot Life*, 418 U.S. at 52; *see Davila*, 542 U.S.

at 217-18 ("even a state law that can arguably be characterized as 'regulating insurance' will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme").

For the reasons already discussed, TeamHealth's state-law causes of action cannot be disentangled from the health plans that United insured and administered: they explicitly challenge the manner in which United administered benefits under the plan, and seek to challenge—and change—the manner in which United processes nonnetwork benefits under those plans. Because TeamHealth's causes of action would impose liability for United's performance of claims-processing and other administrative functions that "are central to, and an essential part of, the uniform system of plan administration contemplated by ERISA," *Gobeille*, 577 U.S. at 323, the claims "pose an obstacle to the purposes and objectives of Congress" and thus are not subject to the saving clause, *Davila*, 542 U.S. at 217 (quoting *Pilot Life*, 481 U.S. at 52).

* * * *

Dated this 18th day of April, 2023.

[signatures and certificate of service intentionally omitted]

APPENDIX H

DISTRICT COURT
CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA	Case Non.: A-19-792978-B Dept. No.: 27 **HEARING REQUESTED** **DEFENDANTS' RENEWED MOTION FOR JUDGMENT AS A MATTER OF LAW**

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.

* * * *

G. TeamHealth Plaintiffs' Causes of Action Are Preempted by ERISA

Under ERISA § 514, a state-law claim conflicts with ERISA and is expressly preempted if it "relates to" an employee benefit plan governed by ERISA. 29 U.S.C. § 1144(a). This action is undoubtedly related to employee benefit claims, and all of TeamHealth Plaintiffs' causes of action are preempted by ERISA.

Plaintiffs' claims are conflict preempted because they seek to compel thousands of different ERISA-governed plans administered by Defendants to pay them their unilaterally set charges without reference to the specific benefit rates established by the terms of each governing health plan—and without any of the plans ever having agreed to pay anything other than the plan benefit rates. For instance, if the governing plan adopted an out-of-network program that limited the member's benefit for out-of-network ER service to 200% of Medicare, any judgment finding that Nevada common law imposes an obligation on

Defendants to pay the TeamHealth Plaintiffs their full billed charges, substantially above that out-of-network benefit, necessarily conflicts with the terms of the ERISA plan. D5499 (plan document instructing to use OCM exclusively); 11/10/2021 Tr. 126:4–131:4 (Mr. Haben testified that testimony discussing the plan document contained in D5499 required the OCM program to price out-of-network claims); 11/15/2021 Tr. 136:22-140:12 (Ms. Paradise testified that the usual and customary language in P146, a certificate of coverage for a fully insured plan, did "not suggest . . . that the physician reasonable and customary program established by FAIR Health would be used to reimburse an[] out-of-network emergency service"); *id.* 137:25-138:7 (Ms. Paradise testified that plan document must be reviewed to determine what out-of-network program applies); 11/16/2021 Tr. 142:24-143:6 (Ms. Hare testified that plan documents dictate out-of-network reimbursement); *id.* 148:12-18 (Ms. Hare testified that HPN's & SHL's claims processing system is designed to reimburse claims based on plan documents and not full billed charges). But ERISA requires the Defendants to "specify the basis on which payments are made to and from [their plans]" and to administer their plans "in accordance with the documents and instruments governing the plan[s]." 29 U.S.C. § 1102(b)(4); 29 U.S.C. § 1104(a)(1)(D). Any verdict that awards remedies in excess of what Defendants owed under the governing plans would be contrary to ERISA.

ERISA preempts any state law that would, as Plaintiffs request, rewrite the terms of the governing health plans to require payment for out-of-network

ER services at amounts higher than permitted by the plans. Indeed, it is well established that ERISA preempts implied-in-fact contract claims such as the TeamHealth Plaintiffs. *Aetna Life Ins. Co. v. Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000) ("We have held that ERISA preempts common law theories of breach of contract implied in fact…"); *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1356 (9th Cir. 1984) (breach of implied-in-fact contract claim was conflict preempted), *abrogated on other grounds in Dytrt v. Mountain States Tel. & Tel. Co.*, 921 F.2d 7889, 7894 n.4 (9th Cir. 1990); *Parlanti v. MGM Mirage*, 2:05-CV-1259-ECR-RJJ, 2006 WL 8442532, at *6 (D. Nev. Feb. 15, 2006) (breach of contract claim conflict preempted).

*** * * ***

Dated this 6th day of April, 2022.

[signatures and certificate of service intentionally omitted]

APPENDIX I

DISTRICT COURT
CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA	Case Non.: A-19-792978-B Dept. No.: 27 **HEARING REQUESTED** **DEFENDANTS' MOTION FOR JUDGMENT AS A MATTER OF LAW**

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.

* * * *

F. TeamHealth Plaintiffs' Causes of Action Are Preempted by ERISA

Under ERISA § 514, a state-law claims conflicts with ERISA and is expressly preempted if it "relates to" an employee benefit plan governed by ERISA. 29 U.S.C. § 1144(a). This action is undoubtedly related to employee benefit claims, and all of TeamHealth Plaintiffs' causes of action are preempted by ERISA.

Plaintiffs' claims are conflict preempted because they seek to compel thousands of different ERISA-governed plans administered by Defendants to pay them their unilaterally set charges without reference to the specific benefit rates established by the terms of each governing health plan—and without any of the plans ever having agreed to pay anything other than the plan benefit rates. For instance, if the governing plan adopted an out-of-network program that limited the member's benefit for out-of-network ER service to 200% of Medicare, any judgment finding that Nevada common law imposes an obligation on

Defendants to pay the TeamHealth Plaintiffs their full billed charges, substantially above that out-of-network benefit, necessarily conflicts with the terms of the ERISA plan. D5499 (plan document instructing to use OCM exclusively); 11/10/2021 Tr. 126:4–131:4 (Mr. Haben testified that testimony discussing the plan document contained in D5499 required the OCM program to price out-of-network claims); 11/15/2021 Tr. 136:22-140:12 (Ms. Paradise testified that the usual and customary language in P146, a certificate of coverage for a fully insured plan, did "not suggest . . . that the physician reasonable and customary program established by FAIR Health would be used to reimburse an[] out-of-network emergency service"); *id.* 137:25-138:7 (Ms. Paradise testified that plan document must be reviewed to determine what out-of-network program applies); 11/16/2021 Tr. 142:24-143:6 (Ms. Hare testified that plan documents dictate out-of-network reimbursement); 11/16/2021 Tr. 148:12-18 (Ms. Hare testified that HPN's & SHL's claims processing system is designed to reimburse claims based on plan documents and not full billed charges). But ERISA requires the Defendants to "specify the basis on which payments are made to and from [their plans]" and to administer their plans "in accordance with the documents and instruments governing the plan[s]." 29 U.S.C. § 1102(b)(4); 29 U.S.C. § 1104(a)(1)(D). Any verdict that awards remedies in excess of what Defendants owed under the governing plans would be contrary to ERISA.

ERISA preempts any state law that would, as Plaintiffs request, rewrite the terms of the governing health plans to require payment for out-of-network

ER services at amounts higher than permitted by the plans. Indeed, it is well established that ERISA preempts implied-in-fact contract claims such as the TeamHealth Plaintiffs. *Aetna Life Ins. Co. v. Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000) ("We have held that ERISA preempts common law theories of breach of contract implied in fact…"); *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1356 (9th Cir. 1984) (breach of implied-in-fact contract claim was conflict preempted), *abrogated on other grounds in Dytrt v. Mountain States Tel. & Tel. Co.*, 921 F.2d 7889, 7894 n.4 (9th Cir. 1990); *Parlanti v. MGM Mirage*, 2:05-CV-1259-ECR-RJJ, 2006 WL 8442532, at *6 (D. Nev. Feb. 15, 2006) (breach of contract claim conflict preempted).

*** * * ***

Dated this 17th day of November, 2021.

[signatures and certificate of service intentionally omitted]

APPENDIX J

DISTRICT COURT
CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA	Case Non.: A-19-792978-B Dept. No.: 27 **DEFENDANTS' MOTION TO DISMISS PLAINTIFFS' FIRST AMENDED COMPLAINT** Hearing Date: June 5, 2020 Hearing Time: 1:00 PM

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.

* * * *

II. NEARLY ALL OF PLAINTIFFS' CLAIMS RELATE TO EMPLOYER SPONSORED ERISA PLANS AND ARE THUS SUBJECT TO PREEMPTION

When considering a motion to dismiss, the general rule is that a court is limited to reviewing the allegations in the Complaint and should not consider outside evidence. However, there is an exception to this rule where the defendant raises a defense of preemption. In that circumstance, the court may consider evidence outside the complaint showing that the claims relate to employee benefit plans governed by ERISA.[3] The purpose of this exception to the general rule is to prevent plaintiffs, like Plaintiffs here, from attempting to thwart congressional intent that ERISA provide the exclusive remedy for these types of claims through artful pleading.

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[3] *Densmore v. Mission Linen Supply*, 164 F. Supp. 3d 118, 1188, n.2 (E.D. Cal. 2016)

Plaintiffs' Complaint fails to identify any of the specific claims at issue, including failing to identify who was treated, on what date, and pursuant to which health plan. Instead, all the Complaint identifies is the general time frame during which Plaintiffs allegedly provided medical services to Defendants' members and submitted claims/requests for processing and adjudication to Defendants. *See* Compl. at ¶¶ 25-26. Despite this, Defendants have determined that nearly all of the at-issue claims relate to ERISA-governed employee benefit plans and are thus conflict preempted.

During the time frames alleged in the Complaint, Plaintiffs 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 Plaintiffs submitted to UHIC, UHS and UMR, based on the known information, all but one of the claims were made against ERISA-governed plans.[4] For the claims made against Oxford and SHO, all of the claims were made against ERISA governed plans.[5] For the claims made against SHL, approximately 72% of the claims were made against ERISA-governed plans.[6] For the claims made against HPN, approximately 84% of the claims were made against

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[4] **Exhibit 1** at ¶ 7 (UHIC, UHS and UMR Declaration).

[5] **Exhibit 2** at ¶ 7 (Oxford Declaration); **Exhibit 3** at ¶ 7 (SHO Declaration).

[6] **Exhibit 4** at ¶ 7 (SHL and HPN Declaration).

ERISA-governed plans.[7] In sum, over 90% of Plaintiffs' claims in the relevant period were for services provided to members of ERISA-governed plans.

Furthermore, for all of the claims that Plaintiffs are asserting in this litigation, Plaintiffs represented that they received assignments of benefits from their patients that, if valid, would allow Plaintiffs to sue under ERISA by standing in the shoes of each patient and asserting claims for benefits seeking additional reimbursement under the terms of the plans.[8] As discussed in more detail below, these assignments of benefits are critical because they render Plaintiffs the type of party, under the *Davila* test discussed in Section IV, that can assert a claim under ERISA § 502(a)(1)(B), ERISA's civil enforcement statute, causing Plaintiffs' state law claims to be completely preempted.

III. LEGAL STANDARD FOR CONFLICT PREEMPTION UNDER ERISA

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[7] *Id.* at ¶ 8.

[8] *See* **Exhibit 1** at ¶ 7 (UHIC, UHS and UMR Declaration), **Exhibit 4** at ¶¶ 7-8 (SHL and HPN Declaration); **Exhibit 2** at ¶ 7 (Oxford Declaration); **Exhibit 3** at ¶ 7 (SHO Declaration); *See also* **Exhibit 5** (sample claims forms to UMR during the 2017-2019 time period showing Box 27 "Accept Assignment" checked "YES"); **Exhibit 6** (sample claim forms to SHO during the same time period). Defendants have reviewed claim forms and related data for the claims that were made to the other entities in this lawsuit and confirmed that Plaintiffs 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.

A. The ERISA Preemption Clause, Saving Clause and Deemer Clause

The Employee Retirement Income Security Act ("ERISA") is a federal legislative scheme that "comprehensively regulates" employee benefit plans. 29 U.S.C. § 1001(b); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44 (1987). ERISA comprehensively regulates, among other things, employee benefit plans that, "through the purchase of insurance or otherwise . . . [provide] medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, [or] death." 29 U.S.C. § 1002(1).

To ensure that plans and plan administrators would be subject to a uniform body of benefit laws, Congress capped off ERISA with three provisions relating to the preemptive effect of the federal legislation, which are set forth below:

1.) "Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws[9] insofar as they may now or hereafter **relate to** any employee benefit plan . . .". 29

[9] Under ERISA, the term "state law" is defined as "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State." 29 U.S.C. § 1144(c)(1). Thus, ERISA preempts not only state statutes but also the common law of each state.

U.S.C. § 1144(a) (pre-emption clause) (emphasis added).[10]

2.) "Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A) (saving clause).

3.) Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." 29 U.S.C. § 1144(b)(2)(B) (deemer clause).

The U.S. Supreme Court summarized how the above clauses work together as follows: "If a state law 'relate[s] to . . . employee benefit plan[s],' it is preempted. [29 U.S.C § 1144(a)] The saving clause excepts from the pre-emption clause laws that 'regulat[e] insurance.' [29 U.S.C § 1144(b)(2)A)]. The deemer clause makes clear that a state law that 'purport[s] to regulate insurance' cannot deem an employee benefit plan to be an insurance company. [29 U.S.C. § 1144(b)(2)(B)]." *Pilot Life Ins. Co.*, 481 U.S. at 45.

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[10] In cases discussing conflict preemption, this section is also commonly referred to as § 514(a) of ERISA.

B. ERISA's "Relates to" Preemption Clause is Broad and Preempts any State Law Claim that Requires a Plan to Deviate from Plan Terms. Plaintiffs' Claims Conflict with the Plan Documents and Would Require the Court to Essentially Rewrite Them.

The Ninth Circuit has repeatedly stated that ERISA's preemption clause is "one of the broadest preemption clauses ever enacted by Congress." *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1439 (9th Cir. 1990); s*ee also Egelhoff v. Egelhoff*, 532 U.S. 141, 146 (2001) (calling the ERISA preemption clause "clearly expansive.").[11] "[A] state law 'relate[s] to' a benefit plan in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Pilot Life Ins. Co.*, 481 U.S. at 47. "[T]o determine whether a state law has the forbidden connection, we look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of

[11] Plaintiffs may argue in their response that the federal court has already rejected these preemption arguments when it granted Plaintiffs' motion to remand. Such an argument would be misplaced. Although the federal court found that complete preemption did not apply when it remanded this case, the defense of conflict preemption under § 514(a) of ERISA (aka 29 U.S.C. § 1144(a)) is broader than complete preemption and thus even more likely to apply to Plaintiffs' state law claims. *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1492 (7th Cir. 1996) ("the defense of 'conflict preemption' is much broader because § 514 [of ERISA] is much broader than § 502(a).").

the state law on ERISA plans." *Egelhoff*, 532 U.S. at 147.

ERISA commands that a plan shall "specify the basis on which payments are made to and from the plan," 29 U.S.C. § 1102(b)(4), and that the fiduciary shall administer the plan "in accordance with the documents and instruments governing the plan," 29 U.S.C. § 1104(a)(1)(D) (emphasis added). Thus, any state law claim that would run counter to these ERISA requirements by, for example, requiring a plan administrator to make payments that are different than the payments required to be paid pursuant to the plan documents, is preempted. *Egelhoff*, 532 U.S. at 147.

Here, that is exactly what Plaintiffs' state law claims attempt to do. Plaintiffs are out-of-network medical providers that allege they provided treatment to thousands of patients who were members of health plans administered/issued by Defendants. Compl. at ¶ 64. Plaintiffs further allege that the Defendants failed to adequately reimburse Plaintiffs for these services and they seek a judgment requiring the Defendants to "reimburse the Health Care Providers at the usual and customary rate. . . or alternatively for the reasonable value of the services provided." *Id.* at ¶¶ 21, 62, 69, and subparagraphs E and F of Plaintiffs' Request for Relief. However, each health plan at issue already provides for particular coverage and reimbursement for types of services rendered to plan members for services received from out-of-network providers like Plaintiffs. Thus, the remedy Plaintiffs seek via their state law claims is nothing less than a complete rewriting of the health plans at issue. Plaintiffs

are essentially asking this Court to insert the terms "usual and customary rate" and "reasonable value" into each of the controlling health plans implicated by the at-issue claims, regardless of the plans' terms. As explained more fully below, courts have repeatedly found that ERISA does not permit a plaintiff to use a state law claim to rewrite and/or avoid a plan's payment terms. In sum, Plaintiffs' state law claims unquestionably "relate to" ERISA-governed health plans issued and/or administered by Defendants and are thus conflict preempted by ERISA.

C. Plaintiffs' State Law Claims Do Not Fall Within ERISA's Saving Clause

Once it is determined that a state law claim "relates to" a benefit plan, which all of Plaintiffs' claims do, the next question is whether the state laws at issue "regulate insurance." If they do, they are exempted from ERISA preemption under the ERISA saving clause. 29 U.S.C. § 1144(b)(2)(A).

The U.S. Supreme Court has held that two criteria should be considered in determining whether a state law falls within ERISA's saving clause. First, a court should consider whether, as a matter of "common sense," the state law is one that "regulates insurance." *Pilot Life Ins. Co.*, 481 U.S. at 48-49. Second, a court should use the McCarran-Ferguson[12] test to determine whether the state law (1) is limited to the insurance industry, (2) has the effect of transferring or

[12] The McCarran-Ferguson Act generally permits states to regulate the "business of insurance." 15 U.S.C. § 1012(a). In determining what constitutes the "business of insurance," courts have come up with the three part McCarran-Ferguson test.

spreading a policyholder's risk, and (3) involves an integral part of the relationship between the insurer and the insured. *Id.* The Nevada Supreme Court has adopted the U.S. Supreme Court's framework for assessing whether the ERISA saving clause applies and held that all three elements of the McCarran-Ferguson test must be met for the ERISA saving clause to apply. *Villescas v. CNA Ins. Companies*, 109 Nev. 1075, 1082, 864 P.2d 288, 293 (1993).[13]

Here, none of Plaintiffs' state law claims fall within the ERISA saving clause. As to Plaintiffs' common law claims for (1) Breach of Implied-in-Fact Contract, (2) Tortious Breach of the Implied Covenant of Good Faith and Fair Dealing, and (3) Unjust Enrichment, none of these claims can be said to regulate insurance or to be "limited to the insurance industry." Rather, such claims are applicable to a wide variety of non-insurance related commercial disputes. *See e.g., Pilot Life Ins. Co*., 481 U.S. at 48–49 (1987) (holding that a claim for tortious breach of contract and the Mississippi law of bad faith did not "regulate insurance" and was thus preempted because "[a]ny breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages.").

With respect to Plaintiffs' statutory claims for (1) Violation of NRS 686A.020 and 686A.310 (Nevada Unfair Trade Practices Act), (2) Violation of Nevada

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[13] Although the Nevada Supreme Court did not expressly reference Pilot Life's "Common Sense Test," other Nevada courts applying Nevada law have applied both the Common Sense Test and the McCarran-Ferguson Test. *See Brandner v. UNUM Life Ins. Co. of Am*., 152 F. Supp. 2d 1219, 1226 (D. Nev. 2001)

Prompt Pay Statutes, (3) Violation of Consumer Fraud and Deceptive Trade Practices Acts and (4) Declaratory Judgment, all of these claims fail the McCarran-Ferguson test. While the Nevada Unfair Trade Practices Act is specifically aimed at insurance companies, the Nevada Supreme Court has found that the law does not have the effect of spreading a policyholder's risk and thus does not fall within ERISA's saving clause. *Villescas*, 109 Nev. at 1083, 864 P.2d at 293.

The Nevada Prompt Pay Act does not fall under the saving clause for the same reason. "Riskspreading . . . is the pooling or averaging of policyholder's risks." *Id.* at 1082, 864 P.2d at 293; *see also* BLACK'S LAW DICTIONARY (11th ed. 2019) (defining "Risk" in the insurance context as "[t]he chance or degree of probability of loss to the subject matter of an insurance policy."). The Prompt Pay Act simply subjects an insurer to fines by the Nevada Insurance Commissioner if the insurer does not process/pay claims within a specified time frame. NRS 683A.0879(8). This does nothing to pool or average a policyholder's risks.

Finally, Nevada's Deceptive Trade Practices Act and Uniform Declaratory Judgments Act are laws of general applicability and not limited to the insurance industry. *See* NRS 598.0915 (stating that any "person" with a "business or occupation" can be liable under the Act); NRS 30.040 (allowing a declaratory judgment claim to be brought for any "deed, written contract or other writings constituting a contract."). Thus, these claims also do not fall under the ERISA saving clause and, as a result, are conflict preempted.

D. In the Alternative, ERISA's Deemer Clause also Bars Plaintiffs' State Law Claims

Even if this Court were to find that some of Plaintiffs' claims fall within ERISA's saving clause, *which they do not*, the claims would still be preempted by ERISA's "deemer clause." 29 U.S.C. § 1144(b)(2)(B). This clause bars enforcement of any state insurance law against self-funded ERISA plans by mandating that these plans be "deemed" to not be insurance companies for purposes of state insurance laws and regulations. As with ERISA's "relates to" preemption clause, the U.S. Supreme Court has construed the "deemer clause" broadly, stating:

> We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause. By forbidding States to deem employee benefit plans 'to be an insurance company or other insurer . . . or to be engaged in the business of insurance,' the deemer clause relieves plans from state laws 'purporting to regulate insurance.' As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation 'relate[s] to' the plans . . . State laws that directly regulate insurance are 'saved' but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws.

FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990). Here, the only state laws at issue that even purport to regulate insurance are Plaintiffs' claims for violation of (1) the Nevada Unfair Trade Practices Act and (2) the Nevada Prompt Pay Statutes. However, even assuming, *arguendo*, that these laws would otherwise fall within ERISA's saving clause, the deemer clause prohibits them being enforced against any ERISA plans that are self-funded, which must be deemed not to be in the business of insurance. In sum, ERISA conflict preemption presents an insurmountable barrier to Plaintiffs' state law claims.

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Dated this 26th day of May, 2020.

[signatures and certificate of service intentionally omitted]