No. _____

IN THE

# Supreme Court of the United States

UNITEDHEALTHCARE INSURANCE COMPANY; UNITED HEALTHCARE SERVICES, INC.; UMR, INC.; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; AND HEALTH PLAN OF NEVADA, INC.,

*Petitioners*,

v.

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; AND CRUM STEFANKO AND JONES, LTD.,

*Respondents*.

**On Petition for a Writ of Certiorari to the Supreme Court of the State of Nevada**

## PETITION FOR A WRIT OF CERTIORARI


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## QUESTION PRESENTED

Section 514(a) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1144(a), expressly preempts state laws that "relate to" employee benefit plans.

Petitioners provide administrative services to employee health benefit plans. Their duties include paying "out-of-network" medical providers—on the plans' behalf—the amounts allowed by the plans for medical services provided to plan members. In this case, petitioners paid the full amounts authorized by plan terms, but they were sued by providers asserting an unjust enrichment claim alleging that Nevada law required petitioners to pay the providers *more* than the plan terms allowed. Three federal appellate decisions have held that materially identical claims were preempted by ERISA § 514 because they depend on the administrator's duties *under the plan* to pay for out-of-network care and thus necessarily "relate to" the plan. In direct conflict with those decisions, the Nevada Supreme Court affirmed petitioners' unjust enrichment liability, relying on a line of this Court's precedents holding that § 514 does not apply to generally applicable laws that only incidentally increase plan costs.

The question presented is:

Whether ERISA § 514 preempts a claim asserting that the administrator of an ERISA-governed health plan was required by state law to reimburse out-of-network providers at a rate higher than allowed by the plan's terms for out-of-network services.

## PARTIES TO THE PROCEEDING

Petitioners are UnitedHealthcare Insurance Co.; United HealthCare Services, Inc.; UMR, Inc.; Sierra Health and Life Insurance Co., Inc.; and Health Plan of Nevada, Inc., appellants below.

Respondents are Fremont Emergency Services (Mandavia), Ltd.; Team Physicians of Nevada-Mandavia, P.C.; and Crum Stefanko and Jones, Ltd, respondents below. The Eighth Judicial District Court of the State of Nevada and the Hon. Nancy L. Allf were respondents to mandamus proceedings consolidated with the appeal from the judgment.

## RELATED PROCEEDINGS

- *UnitedHealthcare Ins. Co. et al. v. Fremont Emergency Servs. (Mandavia), Ltd. et al.*, Nevada Supreme Court No. 85525 (judgment entered June 12, 2025).
- *UnitedHealthcare Ins. Co. et al. v. Eighth Jud. Dist. Ct.*, Nevada Supreme Court No. 85656 (mandamus denied June 12, 2025).
- *UnitedHealthcare Ins. Co. et al. v. Fremont Emergency Servs. (Mandavia), Ltd. et al.*, Nevada Supreme Court No. 84558 (appeal dismissed Sept. 29, 2022).
- *Fremont Emergency Servs. (Mandavia), Ltd. et al. v. UnitedHealthcare Ins. Co. et al.*, Eighth Judicial District Court of the State of Nevada, Clark County, No. A-19-792978-B (judgment entered March 9, 2022).
- *UnitedHealthcare Ins. Co. et al. v. Eighth Jud.*

*Dist. Ct.*, Nevada Supreme Court No. 83629 (mandamus denied October 25, 2021).

- *UnitedHealthcare Ins. Co. et al. v. Eighth Jud. Dist. Ct.*, Nevada Supreme Court No. 81680 (mandamus denied July 1, 2021).
- *Fremont Emergency Servs. (Mandavia), Ltd. et al. v. UnitedHealth Grp., Inc. et al.*, U.S. District Court for the District of Nevada No. 2:19-CV-832 (motion to remand granted Feb. 20, 2020).

**RULE 29.6 DISCLOSURE**

Petitioner UnitedHealthcare Insurance Co. is a wholly owned subsidiary of UHIC Holdings, Inc., which in turn is a wholly owned subsidiary of United HealthCare Services, Inc.

Petitioner United HealthCare Services, Inc. is a wholly owned subsidiary of UnitedHealth Group Inc.

Petitioner UMR, Inc. is a wholly owned subsidiary of United HealthCare Services, Inc.

Petitioners Sierra Health and Life Insurance Co., Inc. and Health Plan of Nevada, Inc. are wholly owned subsidiaries of Sierra Health Services, Inc., which is a wholly owned subsidiary of UnitedHealthcare, Inc., which in turn is a wholly owned subsidiary of United HealthCare Services, Inc.

UnitedHealth Group Inc. is a publicly held corporation and does not have a parent corporation. No publicly held corporation owns 10 percent or more of UnitedHealth Group Inc.'s stock.

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## PETITION FOR A WRIT OF CERTIORARI

Petitioners UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Sierra Health and Life Insurance Company, Inc.; and Health Plan of Nevada, Inc. (hereinafter "United"), respectfully petition for a writ of certiorari to review the judgment of the Supreme Court of Nevada in this case.

## OPINIONS BELOW

The Nevada Supreme Court's decision is reported at 570 P.3d 107 (Nev. 2025), and is reprinted in the Appendix to the Petition ("Pet. App.") at 1a-40a. The Nevada Supreme Court's prior decision denying United's mandamus petition is an unpublished disposition available at 489 P.3d 915 and is reprinted in the Pet. App. at 92a-97a.

The district court's order denying United's motion to dismiss is unpublished, available at 2020 WL 10353883, and is reprinted in the Pet. App. at 98a-157a. The district court's orders denying United's motion for judgment as a matter of law and its renewed motion for judgment as a matter of law are unpublished and are reprinted in the Pet. App. at 74a-91a and 41a-70a, respectively.

## JURISDICTION

The Nevada Supreme Court issued its decision on June 12, 2025. Pet. App. 1a. On August 1, 2025, Justice Kagan extended the time within which to file a petition for certiorari to and including October 10, 2025. No. 25A129. This Court's jurisdiction is invoked under 28 U.S.C. § 1257(a).

## RELEVANT STATUTORY PROVISIONS

Section 514 of ERISA provides, in relevant part, that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).

## INTRODUCTION

This case raises an important issue of federal preemption under ERISA § 514. United administers and insures employee health benefit plans nationwide. Such plans generally promise members that the plans will pay for their medical care in two different categories. The "network" category involves care received from providers that have contractually agreed with the plan's administrator to accept reimbursement at specified rates. When a member receives care from a network provider, the administrator is contractually obligated to pay the provider the network rate on behalf of the plan, generally relieving the member of any payment responsibility beyond a co-pay or other form of member contribution.

The second category involves "out-of-network" care received from providers who have not entered into a network contract with the plan's administrator to provide services at specified rates to plan members. In this category, the plan authorizes the administrator to reimburse the *member* for out-of-network services at a particular rate, but neither the plan nor its administrator has any legal relationship with or obligation to the provider. The administrator's duty to pay for the member's out-of-network care instead arises solely from its obligation to the

plan and its members, and it is limited by the plan's terms.

Respondents are for-profit, private-equity-backed medical groups affiliated with TeamHealth Holdings, Inc. (collectively, "TeamHealth"). TeamHealth was previously party to network contracts with United, but TeamHealth chose to terminate those contracts and become an out-of-network provider. It then brought suit in Nevada state court and elsewhere against United, seeking to expand United's duties as plan administrator by requiring it to pay more for plan members' out-of-network care than authorized by the plans' own terms. The suit is one of dozens of lawsuits initiated across the country by providers against United and other entities seeking to impose new state-law duties on them in their capacities as administrators and insurers of ERISA-governed health benefit plans.

Such claims, properly understood, fall within the heartland of ERISA § 514's express preemption provision. Section 514 preempts any state laws—including common-law claims—that "relate to" an employee benefit plan. That provision applies to claims "premised on" such plans, *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990), which occurs when "the existence of ERISA plans is essential to the [claim]'s operation," *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 320 (2016) (quotation omitted); *see infra* at 21 (detailing § 514 preemption standards). That standard unambiguously encompasses the kind of claim for which United was held liable here. That claim is necessarily premised on United's duty *to the plans* to pay, *on the plans' be-*

*half*, for care provided *to plan members*, and it seeks to alter that duty by requiring United to pay more for such care than the plan itself authorizes.

Courts have nevertheless sharply divided over preemption of such claims. Every federal appellate court to have considered the issue—including the Second, Third, and Fifth Circuits—has correctly recognized that § 514 preempts such causes of action because they are predicated on the existence of an ERISA plan and would effectively rewrite the plan's out-of-network payment provisions if successful. Many district courts agree. By contrast, the Nevada Supreme Court in this case held that § 514 does not apply to such claims, and several trial courts have rejected preemption in materially identical circumstances.

The conflict and confusion among courts on this important issue warrants this Court's review. The Nevada Supreme Court's decision and others like it directly contravene one of ERISA's core purposes, i.e., to encourage employers to offer benefit plans in part through the promise of predictability afforded by uniform national regulation. They also disregard the equally fundamental rule that ERISA leaves to employers substantive decisions about what plan benefits to provide, including what rate of reimbursement to promise plan members for medical care they receive. *See Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003); *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). Decisions misapplying this Court's § 514 preemption precedents are encouraging the continuing proliferation of lawsuits that seek to alter plan benefits and impose costly

burdens on plans and plan administrators, resurrecting the very patchwork of state-by-state regulation of benefit plan terms that ERISA was enacted to prevent. This case presents a rare, clean vehicle for addressing the issue: a final judgment with a full factual record, which makes clear both why United was held liable and why that liability is preempted by ERISA § 514.

Certiorari should be granted.

## STATEMENT OF THE CASE

Team Health Holdings, Inc., is one of the largest for-profit physician staffing companies in the country, providing emergency department staffing and claim billing services in Nevada and elsewhere. 43App.10747-48.[1] The company—with the help of its private-equity backing, *see* 40App.9879-80—has in recent years launched what one executive described as its litigation "playbook," 148App.36431: a series of lawsuits across the country seeking to use courts to impose rates TeamHealth could not obtain through contract negotiations for the provision of emergency medical services to members of ERISA-governed health benefit plans.[2]

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[1] References to "App." refer to the Appellant's Appendix filed by United in the Nevada Supreme Court. "TH.App" refers to the Respondent's Appendix filed by TeamHealth in the Nevada Supreme Court.

[2] TeamHealth and similarly situated companies have filed dozens of such lawsuits against various plan administrators and insurers. *See, e.g.*, *Emergency Servs. of Okla., P.C. v. Aetna Health Inc.*, No. 5:17-cv-600 (W.D. Okla. May 30, 2017), ECF No. 1-2; *ACS Primary Care Physicians Sw., P.A. v. Molina*

In April 2019, after terminating its Nevada contracts with United, TeamHealth initiated suit against United in Nevada state court. Its suit targeted United because TeamHealth providers provided care to members of ERISA-governed employee health benefit plans administered or insured by United. Most of the plans at issue are "self-funded" or "self-insured," meaning that the employer funds the plan, which pays all benefit claims directly. For self-funded plans, United provides services only as a third-party claim administrator, including authorizing and making payments on behalf of the plan directly out of plan funds—not United funds. 21App.5248-49, 22App.5251. A minority of the plans are "insured" plans, meaning that the plan obtains insurance policies to pay benefit claims. For the insured plans at issue in this case, United issued the

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*Healthcare Inc.,* No. 2017-777084 (Harris Cnty. Dist. Ct., Tx. Nov. 16, 2017); *Se. Emergency Physicians LLC v. Ark. Health & Wellness Health Plan Inc.*, No. 4:17-cv-00492 (E.D. Ark. Aug. 2, 2017), ECF No. 1; *Emergency Prof. Servs, Inc. v. Aetna Health, Inc.*, No. 1:19-cv-01224 (N.D. Ohio May 29, 2019), ECF No. 1; *Atl. ER Physicians Team Pediatric Assocs., PA v. UnitedHealth Grp., Inc.*, No. 1:20-cv-20083 (D.N.J. Dec. 21, 2020), ECF No. 2; *Fla. Emergency Physicians Kang & Assocs., M.D., Inc. v. United Healthcare of Fla., Inc.*, No. 0:20-cv-60757 (S.D. Fla. June 9, 2020), ECF No. 27; *Emergency Grp. of Ariz. Pro. Corp. v. United Healthcare Inc.*, No. 2:19-cv-04687 (D. Ariz. Aug. 9, 2019), ECF No. 18; *Gulf-to-Bay Anesthesiology Assocs., LLC v. United Healthcare of Fla., Inc.*, No. 8:20-cv-02964 (M.D. Fla. Dec. 11, 2020), ECF No. 1-2; *Emergency Care Servs. of Pa., P.C. v. UnitedHealth Grp., Inc.*, No. 1:19-cv-01195 (M.D. Pa. July 11, 2019), ECF No. 1; *Gulf-to-Bay Anesthesiology Assocs., LLC v. United Healthcare of Fla., Inc.*, No. 2023-CA-016780 (Fla. 13th Judicial Cir., Hillsborough Cnty. Nov. 21, 2023).

insurance policy, authorizes payments, and pays claims through the insurance policy, albeit on the plan's behalf. For convenience, the balance of this petition refers to United as the administrator of the health plans at issue.

In either role, any duty on United's part to make any payments at all to TeamHealth derives entirely from United's duties to the plan and its members pursuant to the plan's specific terms. The relationship necessarily depends on the plan because the TeamHealth providers do not have distinct "network" contracts with United, which would otherwise govern their relationship and fix a specified reimbursement rate for TeamHealth's services. Absent such network contracts, TeamHealth can seek reimbursement from United only because United is required by the plan to make payments on members' behalf, at a rate specified by the plan, for medical services they receive from out-of-network providers. *See, e.g.*, 76App.18914 (plan provision requiring United to reimburse out-of-network claims at 125% of Medicare rate).

TeamHealth's suit against United asserted a variety of state-law causes of action—including unjust enrichment—challenging the manner in which United carried out duties prescribed by ERISA-governed health benefit plans. 1App.1-17. Specifically, TeamHealth objected to United's decisions concerning plan reimbursements for out-of-network emergency healthcare TeamHealth's providers rendered to plan members. TeamHealth disclaimed any contention that the ERISA plan terms required—or even permitted—United to pay TeamHealth more

than United actually paid. Instead, TeamHealth alleged that United breached a distinct duty under *state* law to reimburse TeamHealth *more* for out-of-network care received by plan members than permitted by the plans themselves. As relevant here, TeamHealth asserted that United unjustly enriched itself under state law by causing TeamHealth to be underpaid in exchange for a benefit TeamHealth allegedly conferred on United—namely, the discharge of United's obligations to plan members. Nev. S. Ct. Answering Br. 69-75.

TeamHealth ultimately challenged payments it received for 11,563 emergency medicine claims, for which it unilaterally billed a total of $13.34 million. 42App.10329, 10391. As is common, TeamHealth's full billed charges substantially exceeded the reimbursements promised to members by the plans' terms. *See, e.g.*, *Higgs v. Costa Crociere S.p.A. Co.*, 969 F.3d 1295, 1315 (11th Cir. 2020) (providers "bill arbitrarily large amounts with the knowledge and expectation that no one will ever be required to pay so high a figure"); Uwe E. Reinhardt, *The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy*, 25 Health Aff. 57, 59 (2006) (hospital bills "add up to large totals that do not bear any systematic relationship to the amounts third-party payers actually pay them for the listed services"). Pursuant to the plans' rate specifications, United agreed to pay a total of $2.84 million for the out-of-network services plan members received from TeamHealth providers. 42App.10329. TeamHealth's claims demanded that United instead pay the full amount of TeamHealth's billed charges as the "reasonable value" under *state*

law for the care provided. 21App.5186.

Given the inextricable link between TeamHealth's claims and United's reimbursement obligations to plan members, United moved to dismiss, arguing, *inter alia*, that § 514(a) of ERISA expressly preempted TeamHealth's claims because they "relate to" the plans United administered. Pet. App. 178a-190a. The district court denied the motion, asserting that "the relationship between the parties—i.e. provider/insurer—is not a relationship that is intended to be governed by Section 514(a)" and deeming the claims non-preempted because they "neither seek recovery under an ERISA plan, require examination of an ERISA plan, nor implicate any discernible goal of ERISA." Pet. App. 125a.

United sought review of that ruling through a petition for a writ of mandamus, which the Nevada Supreme Court denied in an unpublished opinion, ruling that the "extraordinary" remedy of mandamus was not warranted. Pet. App. 94a.

TeamHealth subsequently filed the operative Second Amended Complaint, 21App.5179-5195, and the case proceeded to a jury trial in 2021. Based on the fully developed record, United again raised the issue of express preemption in a motion for judgment as a matter of law filed at the close of TeamHealth's case-in-chief, Pet. App. 174a-177a, which the district court denied, Pet. App. 91a.

The jury found United liable for unjust enrichment and breach of an implied-in-fact contract, among other claims. The jury rejected TeamHealth's claims for its full billed charges, but found that

TeamHealth had been underpaid as a matter of state law and determined that United owed TeamHealth $2.65 million more than the amount United paid pursuant to the plans' own terms. Pet App. 43a. Following the entry of judgment on March 9, 2022, Pet. App. 71a-73a, United raised its preemption argument once more in a renewed motion for judgment as a matter of law, Pet. App. 170a-173a. The court denied that motion in October 2022, declining to "revisit" its prior ruling on preemption and concluding that this Court's opinion in *Rutledge v. Pharmaceutical Care Management Association*, 592 U.S. 80 (2020), foreclosed a finding of § 514 preemption. Pet. App. 68a-69a.

United timely appealed, raising various objections to the judgment, including the contention that TeamHealth's claims were expressly preempted under § 514. Pet. App. 158a-169a. The Nevada Supreme Court rejected most of TeamHealth's claims as a matter of state law, including its implied-in-fact contract claim, which failed because TeamHealth had not proved the existence of any distinct contract obligating United to reimburse TeamHealth for services rendered to plan members. Pet. App. 13a-18a, 39a. The court affirmed only the unjust enrichment claim, rejecting United's arguments under state law and ERISA § 514. Pet. App. 10a-12a, 18a-21a.

On the § 514 argument relevant here, the court reasoned that § 514—which it incorrectly described as a "conflict preemption" provision—did not apply because TeamHealth's lawsuit was "based on costs alone" and thus did "not impact plan administration." Pet. App. 11a. The court cited *New York State*

*Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995)—the main precedent applied in *Rutledge*—to conclude that the claims were not preempted because "the sole issue in this case is the rate of reimbursement for emergency services." Pet. App. 11a-12a.

## REASONS FOR GRANTING THE PETITION

Appellate courts have sharply divided over ERISA § 514 preemption of state-law claims like those asserted by TeamHealth. That conflict reflects broader confusion among courts regarding the scope of the rule applied by this Court in *Travelers* and *Rutledge* that § 514 does not preempt generally applicable state laws with only incidental effects on plan costs. This Court's review is urgently needed to resolve this confusion and address the burgeoning misunderstanding of the *Rutledge*/*Travelers* rule—a misunderstanding that is undermining ERISA's important uniformity and efficiency objectives. The issue is cleanly presented in this case, offering this Court an ideal opportunity for much-needed course correction.

### I. COURTS ARE DIVIDED OVER WHETHER ERISA § 514 PREEMPTS STATE-LAW CLAIMS SEEKING TO FORCE HEALTH PLAN ADMINISTRATORS TO PAY MORE FOR OUT-OF-NETWORK CARE THAN THE PLANS ALLOW

ERISA was enacted "to provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). "To this end," Congress established in ERISA § 514 an

"expansive pre-emption provision[]" that is "intended to ensure that employee benefit plan regulation would be 'exclusively a federal concern.'" *Id.* (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)).

An essential aspect of what § 514 guards against is varying state regulation of substantive plan benefits. Under ERISA, "private parties, not the Government, control the level of benefits." *Alessi*, 451 U.S. at 511. ERISA thus grants employers "large leeway to design" benefit plans "as they see fit." *Nord*, 538 U.S. at 833. To protect employers from interference by state law in determining plan benefit levels, § 514 expressly and broadly preempts any state law that "relate[s] to" employee benefit plans governed by ERISA. 29 U.S.C. § 1144(a). That preemptive effect extends not only to state regulations but also to state common-law claims that seek to override or supplement the terms of a plan. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48, 57 (1987).

Although enforcing the boundaries of § 514 is critical to achieving ERISA's core objectives, courts have divided as to the application of § 514 in cases like this one. Addressing essentially identical common-law unjust enrichment claims by out-of-network medical providers seeking higher rates of reimbursement from a health plan's insurer or third-party administrator, the Third and Fifth Circuits have held such claims preempted by § 514. *See Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co.*, 967 F.3d 218, 239-41 (3d Cir. 2020); *Access Mediquip L.L.C. v. UnitedHealthcare Ins. Co.*, 662 F.3d 376, 387-87 (5th

Cir. 2011), *adhered to on reh'g en banc*, 698 F.3d 229 (5th Cir. 2012). The Second Circuit held the same in an unpublished summary order. *See Park Ave. Podiatric Care, P.L.L.C. v. Cigna Health & Life Ins. Co.*, 2024 WL 2813721, at *2 (2d Cir. June 3, 2024). In direct conflict with those decisions, the Nevada Supreme Court held in this case that such unjust enrichment claims are not preempted by § 514.

### A. Multiple Decisions Of Federal Appellate Courts And Other Courts Have Held That ERISA § 514 Preempts Unjust Enrichment And Similar State-Law Claims

In *Plastic Surgery*, the Third Circuit addressed ERISA § 514's preemptive effect on several types of state-law claims asserted by an out-of-network healthcare provider against a plan administrator. The court first considered the provider's breach of contract and promissory estoppel claims, which arose from an alleged agreement governing the provision of services. Those claims did not relate to ERISA plans within the meaning of § 514, the court held, because they arose from an alleged "separate agreement" between the administrator and the providers, and thus did not implicate "the terms of the plan." 967 F.3d at 231. A direct, voluntary contractual relationship between the administrator and the provider is a "relationship ERISA did not intend to govern," and because the claims sought damages "based on the specific agreement reached by the parties," they did "not impermissibly interfere with plan administration." *Id.* at 236-37.

But as to the provider's unjust enrichment claims—which were legally and factually identical to

the claim asserted here—the court reached the "opposite conclusion." *Id.* at 239. To establish an unjust enrichment claim, the court explained, the provider had to show that the administrator "received a benefit" from the provider, the retention of which without compensation would be unjust. *Id.* at 240 (quotation omitted). The "benefit" asserted by the provider was "the discharge of the obligation" the administrator owed to the plan beneficiaries. *Id.* And the obligation discharged was "none other than the insurer's duty to its insured *under the terms of the ERISA plan*" to make payments on plan members' behalf for out-of-network services they receive. *Id.* at 241. In other words, there was "simply [] *no* cause of action" for unjust enrichment "if there [was] no plan." *Id.* at 240 (quotations omitted). Because the unjust enrichment claims thus were necessarily "premised on … the existence of an ERISA plan," they were "squarely preempted." *Id.* at 240, 242 (quoting *Ingersoll-Rand*, 498 U.S. at 140; alterations omitted).

The Fifth Circuit reached the same result on essentially the same facts in *Access Mediquip*. The out-of-network provider there asserted state-law misrepresentation, unjust enrichment, and quantum meruit claims against a health plan administrator, seeking to compel the administrator to pay reimbursements at rates higher than allowed by the plan. Much like the Third Circuit in *Plastic Surgery*, the Fifth Circuit distinguished between preempted and non-preempted claims. According to the Fifth Circuit, the misrepresentation claims were not preempted because they invoked state law that "d[id]

not purport to regulate what benefits [the insurer] 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." 662 F.3d at 385. By contrast, the provider's unjust enrichment and quantum meruit claims against the administrator depended entirely on the plan members' rights to coverage *under the plans* for the out-of-network services they received from the provider. As the court explained, the provider could "recover under these claims only to the extent that the patients' ERISA plans confer on their participants and beneficiaries a right to coverage for the services provided." *Id.* at 386.

The Second Circuit recently reached the same conclusion in its unpublished decision in *Park Avenue*, which—like *Plastic Surgery* and *Access Mediquip*—addressed a provider's state common-law claims against an ERISA plan administrator, seeking to recover additional reimbursement for out-of-network services provided to a plan member. 2024 WL 2813721, at *2. The court recognized that *any* duty on the administrator's part to pay for "covered services" for the plan member was necessarily "based on [its] obligations as claims administrator for [the patient's] plan." *Id.* In other words, absent the administrator's duties *under the plan* to reimburse the provider *on behalf of the plan*, the provider would have no basis for recovering from the administrator. Because the "existence of a [] plan" thus was "a critical factor in establishing liability," the claims were preempted under § 514. *Id.*

In addition to the foregoing federal appellate de-

cisions, multiple district court decisions have held that § 514 preempts unjust enrichment and other state-law claims seeking to compel administrators and insurers of ERISA-governed plan to pay providers more for out-of-network services provided to plan members than allowed by the members' own plans. *See, e.g.*, *Rowe Plastic Surgery of N.J., L.L.C. v. Aetna Life Ins. Co.*, 2025 WL 1907005, at *4, *6 (E.D.N.Y. July 10, 2025); *Nathaniel L. Tindel, M.D., LLC v. Excellus Blue Cross Blue Shield*, 2023 WL 3318489, at *7 (N.D.N.Y. May 9, 2023); *AMISUB (SFH), Inc. v. Cigna Health & Life Ins. Co.*, 681 F. Supp. 3d 842, 855-57 (W.D. Tenn. 2023), *aff'd*, 142 F.4th 403 (6th Cir. 2025). Like the federal appellate decisions, these decisions recognize that § 514 applies to unjust enrichment claims because "the nature of the benefit allegedly conferred on [the insurer] is premised on the existence of the Plan." *Nathaniel L. Tindel*, 2023 WL 3318489, at *7 (quotation omitted).

The same dynamic extends beyond unjust enrichment claims—numerous other federal and state appellate decisions have adopted similar reasoning to find similar state laws and claims preempted by ERISA. *See, e.g.*, *HCA Health Servs. of Tenn., Inc. v. Bluecross Blueshield of Tenn., Inc.*, 2016 WL 3357180, at *7 (Tenn. Ct. App. June 9, 2016) (provider's implied-in-law contract claim against insurer was preempted by ERISA because the provider "premise[d] its state law cause of action," including the requisite showing of a "benefit" conferred on the insurer, on "the relationship established by the insurance contract, governed by ERISA, between [the

insurer] and the patient" (quotation omitted)); *Port Med. Wellness, Inc. v. Conn. Gen. Life Ins. Co.*, 24 Cal. App. 5th 153, 181 (Cal. Ct. App. 2018) (provider's quantum meruit claim seeking to recover for value of services rendered to plan members preempted because it amounted to a "state law claim[] creating an alternative enforcement mechanism to secure benefits under the terms of ERISA-covered plans"); *Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co.*, 103 F.4th 597, 602 (9th Cir. 2024) (provider's state-law contract and quasi-contract claims against plan administrator for reimbursement for medical services provided to members were "in reality a challenge to the administration of ERISA plan benefits" (quotation and alteration omitted)); *Am.'s Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1331 (11th Cir. 2014) (Georgia prompt payment law preempted because it would "compel certain action (prompt benefit determinations and payments) by plans and their administrators").

### B. The Nevada Supreme Court And Other Courts Reject Preemption Of Unjust Enrichment And Similar State-Law Claims

The rule adopted by the Nevada Supreme Court below is in direct and irreconcilable conflict with the foregoing decisions. In urging the Nevada Supreme court to reject preemption, TeamHealth relied heavily on this Court's decisions in *Rutledge* and *Travelers*, *see* Nev. S. Ct. Answering Br. 117-18, 120-25, which hold that generally applicable state laws do not implicate § 514 merely because they have the incidental effect of increasing plan costs. The Nevada Supreme Court agreed that the *Rut-*

*ledge*/*Travelers* principle applied here, construing TeamHealth's unjust enrichment claim as bearing only on the "costs" of services and therefore not preempted because a "suit based on costs alone does not impact plan administration." Pet. App. 11a (citing *Travelers*, 514 U.S. at 659-60).

The same view has been adopted in several recent district court decisions rejecting § 514 preemption of substantially identical claims. In *Emergency Physician Services of New York v. UnitedHealth Group, Inc.*, 749 F. Supp. 3d 456 (S.D.N.Y. 2024), for example, the district court relied on *Rutledge* and *Travelers* to conclude that analogous state-law claims asserted by another TeamHealth affiliate provider were not preempted, *id.* at 470. According to the *Emergency Physician* court, the unjust enrichment cause of action does not relate to an underlying ERISA plan because the claim in the abstract "applies evenhandedly to both ERISA and non-ERISA plans," and deploying the claim to force the administrator to pay more than allowed under the plan terms merely has the effect of increasing costs that the insurer might opt to pass along to consumers. *Id.* The court rejected the Third Circuit's contrary ruling in *Plastic Surgery*, deeming the case "unpersuasive" because it "predat[ed] *Rutledge*." *Id.* at 470 n.7.

Other district court decisions have likewise held that applying § 514 to unjust enrichment claims like those at issue here "misses the central holding of *Rutledge*, which is that a state law doesn't 'relate to' an ERISA plan if it merely 'establishes a floor for the cost of the benefits that plans choose to provide.'"

*Vanguard Plastic Surgery, PLLC v. UnitedHealthcare Ins. Co.*, 658 F. Supp. 3d 1250, 1259 (S.D. Fla. 2023) (quoting *Rutledge*, 592 U.S. at 90). These decisions reason that such claims somehow "operate independently of the existence of any ERISA plans," *Fla. Emergency Physicians Kang & Assocs., M.D., Inc., v. United Healthcare of Fla., Inc.*, 526 F. Supp. 3d 1282, 1298 (S.D. Fla. 2021)—even though the administrator's alleged state-law payment duty would not exist but for the plan. Ignoring that critical fact, these decisions instead treat unjust enrichment claims as governed by the *Rutledge*/*Travelers* principle that laws "which increase the costs plans incur … do[] not necessarily have an impermissible connection with an ERISA plan." *Id.* at 1299; *see Emergency Servs. of Okla., PC v. Aetna Health, Inc.*, 556 F. Supp. 3d 1259, 1263-65 (W.D. Okla. 2021) (same, citing *Rutledge* and *Travelers* in concluding that "the plans are not the factual basis for [the provider's] claims" because they "are not seeking payment under the plans and have not asserted their claims based upon any terms of any ERISA plan"); *Cigna Healthcare of Tenn. Inc. v. Baptist Mem'l Health Care Corp.*, 2024 WL 5161956, at *5 (W.D. Tenn. Dec. 18, 2024) (affirming arbitral panel's application of *Rutledge* to determine that ERISA "did not preempt [provider's] quantum meruit claim because quantum meruit is nothing more than a cost regulation—representing a cost of providing an out-of-network benefit—which does not 'relate to' or create an impermissible connection with ERISA plans" (quotation omitted)).[3]

[3] The arbitral panel had expressly rejected the Third Cir-

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As the foregoing discussion shows, appellate courts and federal district courts are directly split over the question whether ERISA § 514 expressly preempts the unjust enrichment claims at issue in this case. The plethora of decisions on the issue shows that it is recurring, important, and unresolved. This Court should intervene now and settle the question. The only alternative is growing confusion among courts and litigants, which needlessly increases plan costs for employers and employees alike.

## II. THE NEVADA SUPREME COURT'S DECISION CONFLICTS WITH THIS COURT'S ERISA § 514 PRECEDENTS

The Nevada Supreme Court's decision conflicts with foundational principles of § 514 preemption recognized and applied in many decisions of this Court. And contrary to the decisions of the Nevada Supreme Court and the district courts cited above, the distinct principle recognized in *Travelers* and applied in *Rutledge* does not compel a different result in cases like this one.

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cuit's analysis in *Plastic Surgery* as "not consistent with *Rutledge*." Index of Court Filings, *Baptist Mem'l Healthcare Corp. v. CIGNA Health Care of Tenn.*, No. 2:23-cv-02550 (W.D. Tenn. 2023), ECF No. 1-2 at 167.

### A. The Unjust Enrichment Liability Imposed On United Arises From, And Seeks To Alter, United's Duties To The Plans And Their Members

This Court's precedents have long construed § 514's open-ended "relate to" standard as preempting state laws and claims that either make "reference to" ERISA plans or bear a "connection with" ERISA plans. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). Under those precedents, a claim makes "reference to" an ERISA-governed plan when, *inter alia*, it is "premised on … the existence of a[n ERISA] plan." *Ingersoll-Rand*, 498 U.S. at 140. Phrased otherwise, a claim makes reference to a plan when the plan is "essential to the law's operation." *Gobeille*, 577 U.S. at 320 (quotations omitted); *see Rutledge*, 592 U.S. at 88; *Cal. Div. of Lab. Standards Enf't v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997). This Court's precedents likewise have established that a claim bears a "connection with" an ERISA plan when, *inter alia*, it seeks to "govern[] a central matter of plan administration" by, for example, requiring "payment of specific benefits" contrary to plan terms. *Rutledge*, 592 U.S. at 87 (quoting *Gobeille*, 577 U.S. at 320). The Nevada Supreme Court's decision affirming United's unjust enrichment liability cannot be reconciled with those § 514 precedents.

1. As the Third Circuit explained in *Plastic Surgery*, an unjust enrichment claim by an out-of-network provider seeking to compel the administrator of a health plan to make increased payments on behalf of the plan relies on the existence of an

ERISA plan as a "critical factor in establishing liability," *Ingersoll-Rand*, 498 U.S. at 139-40, because such liability depends on the duty the administrator owes to the plan and its members *under the plan terms*, *Plastic Surgery*, 967 F.3d at 239-41; *supra* at 13-14. As the Nevada Supreme Court acknowledged, an unjust enrichment claim arises when "one party performs another's contractual duty if the balance of equities favors restitution." Pet. App. 19a-20a (citing Restatement (Third) of Restitution & Unjust Enrichment § 22 cmt. g (Am. L. Inst. 2011)). And liability for unjust enrichment was proper here, the court reasoned, because "United had a contractual duty to its insureds to pay reasonable rates for out-of-network emergency care," and TeamHealth discharged that duty, to United's benefit, when TeamHealth "did not bill United insureds for the balance between what United paid and what TeamHealth billed." Pet. App. 20a.

The problem from the perspective of § 514 is obvious: United's duty "to its insureds to pay reasonable rates for out-of-network emergency care" was a duty arising solely under the terms of the ERISA-governed health plans—no unjust enrichment claim could exist absent that duty. And by its terms, the claim asserted that United was subject to an inconsistent duty that required United to pay on members' behalf more than the plan allowed for care received from out-of-network providers. The Nevada Supreme Court's decision affirming unjust enrichment liability in this context conflicts directly with this Court's decisions in *Gobeille* and other cases holding that § 514 preempts a state law when an

ERISA-governed plan is "essential to the law's operation," *Gobeille*, 577 U.S. at 320 (quotations omitted); *see supra* at 21 (citing cases).

2. The claims also bear a "connection with" ERISA claims because they "govern[] a central matter of plan administration" by requiring "payment of specific benefits" contrary to plan terms. *Rutledge*, 592 U.S. at 87 (quoting *Gobeille*, 577 U.S. at 320). Claim adjudication and payment—the determination of benefits owed under a plan—represent the core function of "plan administration." *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 147-48 (2001). Like the plans here, health plans generally promise their members that they will pay for out-of-network emergency services, but rarely if ever at 100% of the provider's billed charges. Instead, plans typically promise members they will reimburse for covered out-of-network services at specified rates, which plans may set in different ways. For example, a plan may fix a specific rate, such as a percentage of the applicable Medicare rate. *See, e.g.*, 76App.18914 (plan provision requiring United to reimburse out-of-network claims at a rate of 125% of the Medicare rate). Or a plan may prescribe a rate structure based on multiple factors, such as the plan's assessment of the "reasonable and customary" rate. *See, e.g.*, 6TH.App.884. Determining what amount to pay for a given claim under the plan terms is a matter of the plan's discretion, which is subject to review in federal court under ERISA's exclusive benefit enforcement scheme, ERISA § 502(a)(1)(B), 28 U.S.C. § 1132(a)(1)(B); *see Davila*, 542 U.S. at 217 (ERISA § 502(a) establishes "an exclusive federal remedy" for

adverse benefit determinations). An unjust enrichment claim in this context seeks to override the plan's payment terms by allowing a *state* court to determine what reimbursement rate is required under *state* law, which may—and usually does, as in this case—require the administrator to pay for out-of-network services at rates higher than the plan-specified rate.[4]

In short, the plain objective and effect of an unjust enrichment claim is to "force" the plans "to adopt a certain scheme of substantive coverage," *Gobeille*, 577 U.S. at 320 (quoting *Travelers*, 514 U.S. at 668), and to disable "employers from structuring their [health] benefit plans" as they see fit, *Shaw*, 463 U.S. at 97. Under this Court's precedents, § 514 prohibits states from imposing liability on that basis. The Nevada Supreme Court's decision is irreconcilable with those precedents.

### B. Unjust Enrichment Liability Cannot Escape § 514 Preemption Under The *Rutledge*/*Travelers* Rule

In arguing below that its claims did not "relate to" ERISA plans within the meaning of § 514, TeamHealth relied chiefly on this Court's decisions in *Travelers* and *Rutledge*. In *Travelers*, this Court rejected preemption of a New York law that imposed

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[4] The proper approach for a provider seeking increased reimbursement from a plan administrator for care provided to a plan member is to obtain an assignment of the member's benefit claim and then pursue that claim through the plan's administrative structure and ERISA's exclusive federal enforcement scheme.

surcharges on hospital billing rates for patients covered by particular insurers. 514 U.S. at 668. The law did not directly apply to plans or the administrators, but it had the effect of exerting "indirect economic influence" on plans because the surcharges increased the underlying costs of the hospital services covered by the plans. *Id.* at 659. The Court held that such indirect economic effects did not establish an "impermissible connection between the New York law and ERISA plans" because the law "did not 'bind plan administrators to any particular choice.'" *Rutledge*, 592 U.S. at 87 (quoting *Travelers*, 514 U.S. at 659). For example, if a plan before the law's enactment promised to pay, say, $1000 for a given hospital service, the plan could still promise to pay only $1000 after the law's enactment. Nothing about the law required the plan or its administrator to alter the type or value of the benefits provided.

In *Rutledge*, this Court applied the same principle to reject § 514 preemption of an Arkansas statute that fixed minimum prices pharmacy benefit mangers ("PBMs") must pay to pharmacies for prescription drugs. 592 U.S. at 83-85. The statute was challenged under § 514 because many plans contracted with PBMs to provide prescription drug benefits, and the statute effectively increased the PBMs' costs. This Court applied *Travelers* to reject that argument, upholding the law because it simply "establishe[d] a floor for the cost of the benefits that plans choose to provide," which affected plan economics, but did not "require plans to provide any particular benefit to any particular beneficiary in any particular way." *Id.* at 90. Again, if a plan promised mem-

bers it would pay $100 for a particular drug, the plan could still promise to pay only $100 after the law's enactment. The Arkansas law in *Rutledge* thus was simply a "cost regulation" bearing neither "an impermissible connection with or reference to ERISA." *Id.* at 91-92.

The Nevada Supreme Court agreed with TeamHealth's invocation of that principle, citing *Travelers* to reject preemption on the ground that "the sole issue in this case is the rate of reimbursement for emergency services." Pet. App. 12a. That reasoning defeats itself. The fact that TeamHealth's unjust enrichment claim challenged the "rate of reimbursement for emergency services" is the reason *for* preemption: the "rate of reimbursement" is already *prescribed by the plan*, while an unjust enrichment claim would require the plan's administrator to pay a *different* "rate of reimbursement" under state law on behalf of the plan and its members. The Nevada Supreme Court's own analysis thus confirms preemption under § 514.

Like other courts citing the *Rutledge/Travelers* rule in this context, what the Nevada Supreme Court failed to understand is that unjust enrichment claims are not generally applicable cost regulations like the laws at issue in *Rutledge* and *Travelers*. As just shown, the laws in those cases had the effect of increasing plans' *underlying costs*, but they did not require the plans and administrators to *alter plan benefits* to reflect those costs. In both cases, the laws "did not 'bind plan administrators to any particular choice.'" *Rutledge*, 592 U.S. at 87 (quoting *Travelers*, 514 U.S. at 659).

The unjust enrichment claim asserted here and in other similar cases is entirely different. It is asserted directly against a plan administrator, challenging payments it makes on behalf of the plan, pursuant to duties prescribed by the plan. And it explicitly seeks to bind the plan administrator to a particular choice, i.e., it must pay certain out-of-network providers *not* the amount prescribed by the plan, but whatever amount a jury decides is the "reasonable" rate under state law. An unjust enrichment claim thus explicitly forces the administrator, acting on the plan's behalf, to make a different choice than the choice dictated by the plan for reimbursing plan members. Courts relying on *Rutledge* and *Travelers* to reject § 514 preemption in this context have failed to recognize the critical distinction between unjust enrichment claims and the generally applicable cost regulations at issue in those cases.

### C. Unjust Enrichment Liability In This Context Subjects Plans And Their Administrators To An Impossible Dilemma

The Nevada Supreme Court's preemption ruling contravenes not only the formal standards of § 514 preemption, but also simple common sense.

Allowing unjust enrichment liability in this context creates an intractable dilemma for administrators of employee health plans. On the one hand, plan documents require them to reimburse out-of-network services at a specific rate or pursuant to a specific methodology. But on the other hand, if they adhere to the plan terms, they will be subject to state-law unjust enrichment liability for failing to pay whatever greater amount is demanded by pro-

viders or authorized by juries. It is impossible for plan administrators to reconcile these conflicting legal requirements.

This practical reality underscores the importance of enforcing § 514's formal standards, which exist in part to "minimiz[e] the administrative and financial burden of complying with conflicting directives." *Rutledge*, 592 U.S. at 86 (quoting *Ingersoll-Rand*, 498 U.S. at 142). Conflicting directives arising from differing state laws are problematic enough, but here the conflict is even more acute—even for a single plan within a single state, the very act of complying with plan reimbursement requirements is what will subject the administrator to state-law liability. That dilemma directly contradicts "ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002).

## III. THE QUESTION PRESENTED IS IMPORTANT AND RECURRING

The question presented is extremely important. As described above, *see supra* at 5 & n.2, this case is not an isolated dispute. To the contrary, it is one of many similar suits filed across the country seeking increased payments for services provided to members of employee health benefit plans. And as also described above, *see supra* at 11-20, courts have divided over whether and when such suits should proceed—a division driven in part by confusion over the limits of this Court's decision in *Rutledge*. That growing uncertainty is allowing for the improper weaponization of state common law to impose costly new burdens on plans and their administrators, con-

travening ERISA's objective of encouraging employers to establish health plans through the promise of a predictable and uniform federal regulatory regime. *See Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (recognizing that unpredictable "costs," including "litigation expenses," could "discourage employers from offering welfare benefit plans in the first place").

The Nevada Supreme Court's erroneous decision exacerbates the problem by creating a roadmap for state courts adjudicating such suits to evade the preemptive effect of ERISA while imposing specific state-law benefit payment obligations on ERISA-governed benefit plans. In so doing, it will undoubtedly encourage the proliferation of such suits. The inevitable result—indeed, the explicit objective—will be to increase the costs of providing out-of-network benefits. Employer costs will increase, or more costs will be shifted onto employees, or benefits will be reduced—most likely, some combination of all three. Meanwhile, the pervasive uncertainty as to the amounts that will ultimately be owed will stymie the efforts of both self-funded plan sponsors and plan insurers to budget for expected medical costs. These problems are amplified by the recent rapid rise in private-equity ownership in the healthcare sector, which has been associated with a significant increase in costs to patients and plan sponsors. *See* Alexander Borsa et al., *Evaluating Trends In Private Equity Ownership And Impacts On Health Outcomes, Costs, And Quality: Systematic Review*, BMJ (July 19, 2023), https://www.bmj.com/content/382/bmj-2023-075244. To be clear, increased costs alone

are not the basis for § 514 preemption here, but they are certainly a good reason for this Court to clarify and confirm the § 514 rules that properly govern cases like this one.

## IV. THIS CASE IS AN IDEAL VEHICLE TO RESOLVE THE QUESTION PRESENTED

This case is the best possible vehicle to resolve the split among appellate courts. TeamHealth's suit proceeded through trial, judgment, and appeal to the highest state court in Nevada. At every turn, the question of the application of ERISA § 514 to preempt the unjust enrichment claims was carefully preserved, fully ventilated by the parties, and directly addressed by the courts. *See supra* at 9-11. The issue thus comes before this Court from a true final judgment within its jurisdiction and with the benefit of a factual record that is not speculative or liberally construed based on the pleadings, but instead fixed by the trial record.

That posture not only best facilitates this Court's review, but it is relatively unusual for this issue. Although the § 514 preemption issue is extremely important for the reasons already discussed, the issue typically does not survive all the way through to a final judgment against the plan administrator with fully exhausted appeals. Preemption is generally addressed at the pleading stage, and when claims are allowed to proceed over a § 514 preemption objection, there is obviously no final decision to appeal immediately. Indeed, there often is no appealable final order on preemption at all, because defendants either prevail or settle. And even where claims are dismissed at the pleading stage on preemption

grounds, courts often find other claims non-preempted, again effectively precluding an appeal of the preemption issue because defendants either prevail or settle. This case thus presents a unique opportunity for this Court to address the issue—an opportunity it may not have again soon.

## CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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