IN THE SUPREME COURT OF THE STATE OF NEVADA

UNITED HEALTHCARE 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 professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; and CRUM, STEFANKO AND JONES, LTD., d/b/a RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,

Respondents.

No 84558

DOCKETING STATEMENT
CIVIL APPEALS

GENERAL INFORMATION

All appellants not in proper person must complete this docketing statement. NRAP 14(a). The purpose of the docketing statement is to assist the Supreme Court in screening jurisdiction, classifying cases for en banc, panel, or expedited treatment, compiling statistical information and identifying parties and their counsel.

WARNING

This statement must be completed fully, accurately and on time. NRAP 14(c). The Supreme Court may impose sanctions on counsel or appellant if it appears that the information provided is incomplete or inaccurate. *Id*. Failure to fill out the statement completely or to file it in a timely manner constitutes grounds for the imposition of sanctions, including a fine and/or dismissal of the appeal.

A complete list of the documents that must be attached appears as Question 26 on this docketing statement. Failure to attach all required documents will result in the delay of your appeal and may result in the imposition of sanctions.

This court has noted that when attorneys do not take seriously their obligations under NRAP 14 to complete the docketing statement properly and conscientiously, they waste the valuable judicial resources of this court, making the imposition of sanctions appropriate. *See* KDI Sylvan Pools v. Workman, 107 Nev. 340, 344, 810 P.2d 1217, 1220 (1991). Please use tab dividers to separate any attached documents.

1. Judicial District County Eighth Department 27

County Clark Judge Nancy Allf

District Ct. Case No. A-19-792978-B

2. Attorney filing this docketing statement:

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Client(s) United Healthcare Insurance Company ("UHIC"), United Health Care Services Inc. ("UHS", which does business as UnitedHealthcare or "UHC" and through UHIC), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Company ("SHL"), and Health Plan of Nevada, Inc.

If this is a joint statement by multiple appellants, add the names and addresses of other counsel and the names of their clients on an additional sheet accompanied by a certification that they concur in the filing of this statement.

3. Attorney(s) representing respondents(s):

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(List additional counsel on separate sheet if necessary)

4. Nature of disposition below (check all that apply):

- ☐ Judgment after bench trial
- ☒ Judgment after jury verdict
- ☐ Summary judgment
- ☐ Default judgment
- ☐ Grant/Denial of NRCP 60(b) relief
- ☐ Grant/Denial of injunction
- ☐ Grant/Denial of declaratory relief
- ☐ Review of agency determination
- ☐ Dismissal:
  - ☐ Lack of jurisdiction
  - ☐ Failure to state a claim
  - ☐ Failure to prosecute
  - ☐ Other (specify)
- ☐ Divorce Decree:
  - ☐ Original
  - ☐ Modification
- ☐ Other disposition (specify):

5. Does this appeal raise issues concerning any of the following? No.

☐ Child Custody

☐ Venue

☐ Termination of parental rights

6. Pending and prior proceedings in this court. List the case name and docket number of all appeals or original proceedings presently or previously pending before this court which are related to this appeal:

UnitedHealth Grp., Inc. v. District Court, Case No. 81680
United Healthcare Ins. Co. v. District Court, Case No. 83629

7. Pending and prior proceedings in other courts. List the case name, number and court of all pending and prior proceedings in other courts which are related to this appeal (e.g., bankruptcy, consolidated or bifurcated proceedings) and their dates of disposition:

None

8. Nature of the action. Briefly describe the nature of the action and the result below:

This action stems from a disagreement on reimbursement rates for emergency medical services. Following a jury trial, the district court entered judgment in favor of the plaintiffs in the amount of $63,429,873.96, plus interest, attorneys' fees, if any, and costs.

9. Issues on appeal. State specifically all issues in this appeal (attach separate sheets as necessary):

1. Whether the Unfair Claims Practices Act applies to plaintiffs' claims as non-insureds against defendants (including non-insurer defendants) for amounts that not only failed to establish a "reasonably clear" liability, but that the jury rejected in awarding substantially lower amounts.

2. Whether, in the circumstances of this case, punitive damages are available under a quasi-contract theory of unjust enrichment or under the Unfair Claims Practices Act absent a special relationship.

3. Whether plaintiffs established an implied-in-fact contract when the parties negotiated but failed to reach an agreement and no meeting of the minds or exchange of promises occurred.

4. Whether a private right of action exists under the Prompt Pay Act, and if so, whether a plaintiff may pursue such a claim without exhausting administrative remedies.

5. Whether the district improperly precluded discovery and excluded critical evidence relevant to the parties' claims and defenses at trial, including

a. evidence of improper coding and claims submissions in a case where the excessiveness of plaintiffs' charges was an issue;

b. the arm's-length market rates for plaintiffs' services or what plaintiffs accepted from other payors, in a case where plaintiffs claimed defendants' rates were unreasonably low;

c. evidence of plaintiffs' costs to provide the services for which they were seeking reimbursement;

d. evidence of how plaintiffs set their billed charges;

e. evidence of how reimbursed funds were allocated—including that doctors received no share of plaintiffs' corporate profits—in a case where plaintiffs claimed that defendants' alleged underpayment hurt doctors and the provision of emergency services in Nevada; and

f. evidence of plaintiffs' "balance billing" policies, when plaintiffs were allowed to represent to the jury that they do not "balance bill" patients

6. Whether the district court erred in excluding evidence that plaintiffs had initially claimed a "special relationship" with defendants, but then dropped such claims.

7. Whether the district court erred in including evidence regarding references to defendants' conduct after the relevant time period for discovery and evidence.

8. Whether the jury was improperly influenced by plaintiffs' counsels' rampant injection of personal opinions as to the justness of their clients' cause, the credibility of witnesses, and the culpability of defendants.

9. Whether the jury's verdict was excessive, appearing to have been given under the influence of passion or prejudice.

10. Whether the district court erred in holding defendants liable for engaging in First Amendment protected activity that should have been precluded by the *Noerr-Pennington* doctrine and on the basis of documents that were admitted without proper foundation.

11. Whether the district court erred in permitting plaintiffs to change their punitive damages theory.

12. Whether the jury was impaneled using an irregular peremptory challenge process that deprived defendants of their statutory rights.

13. Whether the district court improperly admitted evidence during the liability and punitive damages phases of trial.

14. Whether the district abused its discretion in the improper manner and purposes for which deposition testimony was presented to the jury.

15. Whether the district court erred in permitting expert damages testimony of David Leathers based on opinions contained in an untimely expert report.

16. Whether the district court abused its discretion in failing to instruct the jury on theories defendants were entitled to, including, but not limited to,

a. Failure of condition precedent

b. Unfair Claims Practices Act definition of insurer

c. Failure to exhaust administrative remedies under the Prompt Pay Act

17. Whether the district court erred in instructing the jury on rebuttable presumption for spoliation.

18. Whether, absent a claim for bad faith, the punitive damages award should have been capped under NRS 41.005.

19. Whether, regardless of the statutory cap, the punitive damages awards—ranging from a 5:1 ratio to a 14,210:1 ratio for conduct causing solely economic harm to a large corporation—was constitutionally excessive.

20. Whether plaintiffs' claims are preempted by ERISA.

(Post-judgment motions remain pending in the district court. This list and articulation of issues may change as a result of the district court's resolution of those motions.)

10. Pending proceedings in this court raising the same or similar issues. If you are aware of any proceedings presently pending before this court which raises the same or similar issues raised in this appeal, list the case name and docket numbers and identify the same or similar issue raised:

None.

11. Constitutional issues. If this appeal challenges the constitutionality of a statute, and the state, any state agency, or any officer or employee thereof is not a party to this appeal, have you notified the clerk of this court and the attorney general in accordance with NRAP 44 and NRS 30.130?

☒ N/A

☐ Yes

☐ No

If not, explain:

12. Other issues. Does this appeal involve any of the following issues?

☐ Reversal of well-settled Nevada precedent (identify the case(s))

☒ An issue arising under the United States and/or Nevada Constitutions

☒ A substantial issue of first impression

☒ An issue of public policy

☒ An issue where en banc consideration is necessary to maintain uniformity of this court's decisions

☐ A ballot question

The cumulative weight of the errors that occurred throughout the litigation is overwhelming. It is necessary in this instance for en banc consideration to maintain uniformity of the Court's decisions.

This case also involves the important question of whether actions protected by the First Amendment are the proper object of liability and punitive damages.

This case also involves the constitutional limits on punitive damages awards and the interpretation of Nevada's statutory cap in NRS 41.005.

13. Assignment to the Court of Appeals or Retention in the Supreme Court. Briefly set forth whether the matter is presumptively retained by the Supreme Court or assigned to the Court of Appeals under NRAP 17, and cite the subparagraph(s) of the Rule under which the matter falls. If appellant believes that the Supreme Court should retain the case despite its presumptive assignment to the Court of Appeals, identify the specific issue(s) or circumstance(s) that warrant retaining the case, and include an explanation of their importance or significance:

This matter is presumptively retained by the Supreme Court under NRAP 17(a)(9).

14. Trial. If this action proceeded to trial, how many days did the trial last?

22

Was it a bench or jury trial? Jury

15. Judicial Disqualification. Do you intend to file a motion to disqualify or have a justice recuse him/herself from participation in this appeal? If so, which Justice?

No.

TIMELINESS OF NOTICE OF APPEAL

16. Date of entry of written judgment or order appealed from 3/9/22 (Exhibit A)

If no written judgment or order was filed in the district court, explain the basis for seeking appellate review:

17. Date written notice of entry of judgment or order was served 3/9/22 (Exhibit A)

Was service by:

☐ Delivery

☒ Mail/electronic/fax

18. If the time for filing the notice of appeal was tolled by a post-judgment motion (NRCP 50(b), 52(b), or 59)

(a) Specify the type of motion, the date and method of service of the motion, and the date of filing.

☒ NRCP 50(b) Date of filing 4/6/22 (Exhibit B)

☐ NRCP 52(b) Date of filing _____

☒ NRCP 59 Date of filing 4/6/22 (Exhibit C); 4/6/22 (Exhibit D)

NOTE: Motions made pursuant to NRCP 60 or motions for rehearing or reconsideration may toll the time for filing a notice of appeal. ***See*** **AA Primo Builders v. Washington, 126 Nev. __, 245 P.3d 1190 (2010).**

(b) Date of entry of written order resolving tolling motion

N/A. The parties' motions remain pending. The appeal is premature because tolling post-judgment motions remain pending. To avoid waiver, and because the judgment would otherwise be final but for those motions, defendants filed the notice of appeal in an abundance of caution. Pursuant to NRAP 4(a)(6), the notice of appeal from the final judgment will be deemed timely upon entry of the district court's orders resolving the pending tolling motions.

(c) Date written notice of entry of order resolving tolling motion was served

The motions remain pending.

Was service by: N/A

☐ Delivery

☐ Mail/Electronic/Fax

19. Date notice of appeal filed 4/6/22 (Exhibit E)

If more than one party has appealed from the judgment or order, list the date each notice of appeal was filed and identify by name the party filing the notice of appeal:

N/A

20. Specify statute or rule governing the time limit for filing the notice of appeal, *e.g.*, NRAP 4(a) or other

The time limit for filing the notice of appeal from a final judgment is governed by NRAP 4(a)(1).

SUBSTANTIVE APPEALABILITY

21. Specify the statute or other authority granting this court jurisdiction to review the judgment or order appealed from:

(a)

☒ NRAP 3A(b)(1) (see below)	☐ NRS 38.205
☐ NRAP 3A(b)(2)	☐ NRS 233B.150
☐ NRAP 3A(b)(3)	☐ NRS 703.376
☐ Other (specify)	

(b) Explain how each authority provides a basis for appeal from the judgment or order:

This appeal is from a final judgment pursuant to NRAP 3A(b)(1). Once decisions on the pending tolling motions are entered, the Court undoubtedly will have jurisdiction under NRAP 3A(b)(1) and NRAP 4(a)(6).

22. List all parties involved in the action or consolidated actions in the district court:

(a) Parties:

Fremont Emergency Services (Mandavia), Ltd.
Team Physicians of Nevada-Mandavia, P.C.
Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine
United Healthcare Insurance Company ("UHIC")
United Health Care Services Inc. ("UHS", which does business as UnitedHealthcare or "UHC" and through UHIC)
UMR, Inc. ("UMR")
Sierra Health and Life Insurance Company ("SHL")
Health Plan of Nevada, Inc.

(b) If all parties in the district court are not parties to this appeal, explain in detail why those parties are not involved in this appeal, e.g., formally dismissed, not served, or other:

N/A

23. Give a brief description (3 to 5 words) of each party's separate claims, counterclaims, cross-claims, or third-party claims and the date of formal disposition of each claim.

Plaintiffs filed their "Second Amended Complaint" for breach of implied-in-fact contract, unjust enrichment, violation of NRS 686A.020 and 686A.310, and violations of Nevada prompt pay statutes and regulations on October 7, 2021 (Exhibit F).

The claims were resolved by the March 9, 2022, "Judgment" (Exhibit A).

24. Did the judgment or order appealed from adjudicate ALL the claims alleged below and the rights and liabilities of ALL the parties to the action or consolidated actions below?

☐ Yes

☒ No

25. If you answered "No" to question 24, complete the following:

(a) Specify the claims remaining pending below:

See answers to Questions 16 and 21(b) above.

(b) Specify the parties remaining below:

(c) Did the district court certify the judgment or order appealed from as a final judgment pursuant to NRCP 54(b)?

☐ Yes

☒ No

(d) Did the district court make an express determination, pursuant to NRCP 54(b), that there is no just reason for delay and an express direction for the entry of judgment?

☐ Yes

☒ No

26. If you answered "No" to any part of question 25, explain the basis for seeking appellate review (e.g., order is independently appealable under NRAP 3A(b)):

This is an appeal from a judgment upon jury verdict which purports to be a final "judgment" pursuant to NRAP 3A(b)(1). Given that designation and that appellate deadlines are jurisdictional, appellants filed this appeal out of an abundance of caution, which practice is contemplated in NRAP 4(a)(6). Pursuant to NRAP 4(a)(6), moreover, the notice of appeal from the final judgment will be deemed timely upon entry of the district court's orders resolving the pending tolling motions.

27. Attach file-stamped copies of the following documents:

- The latest-filed complaint, counterclaims, cross-claims, and third-party claims
- Any tolling motion(s) and order(s) resolving tolling motion(s)
- Orders of NRCP 41(a) dismissals formally resolving each claim, counterclaims, cross-claims and/or third-party claims asserted in the action or consolidated action below, even if not at issue on appeal
- Any other order challenged on appeal
- Notices of entry for each attached order

VERIFICATION

I declare under penalty of perjury that I have read this docketing statement, that the information provided in this docketing statement is true and complete to the best of my knowledge, information and belief, and that I have attached all required documents to this docketing statement.

United Healthcare Insurance Company ("UHIC"), United Health Care Services Inc. ("UHS", which does business as UnitedHealthcare or "UHC" and through UHIC), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Company ("SHL"), and Health Plan of Nevada, Inc.
Name of appellants

May 19, 2022
Date

Clark County, Nevada
State and county where signed

Abraham G. Smith
Name of counsel of record

/s/ Abraham G. Smith
Signature of counsel of record

CERTIFICATE OF SERVICE

I hereby certify that this "Docketing Statement" was filed electronically with the Nevada Supreme Court on the 19th day of May, 2022. Electronic service of the foregoing "Docketing Statement" shall be made in accordance with the Master Service List as follows:

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I further certify that I served a copy of this document by mailing a true and correct copy thereof, postage prepaid, at Las Vegas, Nevada, addressed as follows:

LANSFORD W. LEVITT
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Dated this 19th day of May, 2022.

/s/ Cynthia Kelley
An Employee of Lewis Roca Rothgerber Christie LLP

EXHIBIT A TO DOCKETING STATEMENT

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DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation, Defendants	Case No.: A-19-792978-B Dept. No.: XXVII **NOTICE OF ENTRY OF JUDGMENT**

Please take notice than a Judgement was entered on March 9, 2022, a copy of which is attached hereto.

DATED this 9th day of March, 2022.

McDONALD CARANO LLP

By: */s/ Kristen T. Gallagher*

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 9th day of March, 2022, I caused a true and correct copy of the foregoing **NOTICE OF ENTRY OF JUDGMENT** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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

JUDG

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation, Defendants.	Case No.: A-19-792978-B Dept. No.: XXVII **JUDGMENT**

This action came on for trial before the Court and a jury, the Honorable Nancy L. Allf, District Court 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.

Dated this 9th day of March, 2022

Nancy L Allf

TW

519 56D 37C6 D5AF
Nancy Allf
District Court Judge

CERTIFICATE OF SERVICE

I certify that on this 4th day of March, 2022, I caused a true and correct copy of the foregoing to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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/s/
Kevin Leyendecker

CSERV

DISTRICT COURT
CLARK COUNTY, NEVADA

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

AUTOMATED CERTIFICATE OF SERVICE

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

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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,

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

HEARING REQUESTED

DEFENDANTS' RENEWED MOTION FOR JUDGMENT AS A MATTER OF LAW

LEWIS ROCA

vs.

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

Defendants.

TABLE OF CONTENTS

Page

TABLE OF CONTENTS
(continued)

TABLE OF AUTHORITIES

Page

CASES

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

STATUTES

TABLE OF AUTHORITIES
(continued)

I. INTRODUCTION

Defendants United Healthcare Insurance Company ("UHIC"), United Health Care Services Inc. ("UHS", which does business as UnitedHealthcare or "UHC" and through UHIC), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Company ("SHL"), and Health Plan of Nevada, Inc. ("HPN") (collectively, "Defendants"), bring this Renewed Motion for Judgment as a Matter of Law ("Motion").

TeamHealth Plaintiffs[1] did not present any relevant evidence related to several of the Defendants, and no evidence related to key elements of nearly every cause of action in their Second Amended Complaint ("SAC"). The jury's verdict also forecloses TeamHealth Plaintiffs' unjust enrichment claims. This Court should direct a verdict on all of TeamHealth Plaintiffs' claims, which fail as a matter of law:

- TeamHealth Plaintiffs presented no evidence on the conduct of SHL, HPN, or UMR. Without such proof, all claims against these Defendants fail as a matter of law.
- All Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' claim under the Unfair Claims Practices Act. Because they are not insureds, TeamHealth Plaintiffs lack standing to bring this claim against Defendants. And two Defendants (UHS and UMR) are not insurers at all, so this statute does not apply to them. In addition, TeamHealth Plaintiffs failed to present evidence on key elements of this cause of action: (1) whether Defendants' liability was "reasonably clear"; (2) whether Defendants failed to effectuate a prompt, equitable, and fair settlement; (3) whether officers or directors knowingly permitted the violations; and (4) whether TeamHealth Plaintiffs were actually harmed by Defendants' claims process.

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[1] The "TeamHealth Plaintiffs" collectively refers to the three Plaintiffs that initiated this action, each of which is owned by and affiliated with TeamHealth Holdings, Inc.: Fremont Emergency Services (Mandavia), Ltd. ("Fremont"), Team Physicians of Nevada-Mandavia, P.C. ("TPN"), and Crum, Stefanko and Jones, Ltd., d/b/a Ruby Crest Emergency Medicine ("Ruby Crest").

- TeamHealth Plaintiffs have not presented any evidence that could support punitive damages. The only cause of action for which TeamHealth Plaintiffs appropriately sought punitive damages is their claim under the Unfair Claims Practices Act.[2] Because only insurers can be liable under that Act, punitive damages cannot be awarded against non-insurer Defendants UHS and UMR. Punitive damages also cannot be awarded against any Defendant because TeamHealth Plaintiffs' claim under the Act sounds in contract, not tort. And even if punitive damages could be awarded on this claim, TeamHealth Plaintiffs have presented no evidence that Defendants acted with malice, fraud, or oppression.
- To the extent the Court disagrees that Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' cause of action for breach of implied-in-fact contract, Defendants must necessarily be entitled to judgment as a matter of law on TeamHealth Plaintiffs' unjust enrichment claims. That is, because these claims are mutually exclusive, unjust enrichment claims cannot stand when a valid contract exists.
- All Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' cause of action for breach of an implied-in-fact contract because TeamHealth Plaintiffs failed to present any evidence the jury could consider on basic questions of contract formation: (1) whether the parties intended to contract, (2) whether promises were exchanged, and (3) whether the terms of the contract were reasonably clear.
- All Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' Prompt Pay Act claim. Only insureds have standing to bring a suit under that Act, and TeamHealth Plaintiffs are not the Defendants' insureds. In addition,

[2] Even assuming that TeamHealth Plaintiffs properly asserted that they were seeking punitive damages when they raised this position for the first time halfway through trial, a position inconsistent with both the SAC and the Joint Pretrial Memorandum ("JPTO"), TeamHealth Plaintiffs are not entitled to punitive damages based on these claims because TeamHealth Plaintiffs' unjust enrichment claims fail as a matter of law.

TeamHealth Plaintiffs failed to exhaust available administrative remedies under the Insurance Code, rendering their claims nonjusticiable as a matter of Nevada law. Finally, the jury found that TeamHealth Plaintiffs were not entitled to their full billed charges, which necessarily means the At-Issue claims were not "fully payable" as required under the Act.

- All of TeamHealth Plaintiffs' causes of action are subject to conflict preemption under ERISA § 514, and Defendants are therefore entitled to judgment as a matter of law on every cause of action.

For the reasons discussed in this Motion, this Court should grant Defendants judgment as a matter of law.

II. LEGAL ARGUMENT

"If the court does not grant a motion for judgment as a matter of law made under Rule 50(a),[3] the court is considered to have submitted the action to the jury subject to the court's later deciding the legal questions raised by the motion." NRCP 50(b). "No later than 28 days after service of written notice of entry of judgment . . . the movant may file a renewed motion for judgment as a matter of law and may include an alternative or joint request for a new trial under Rule 59." *Id.* "In ruling on the renewed motion, the court may: (1) allow judgment on the verdict, if the jury returned a verdict; (2) order a new trial; or (3) direct the entry of judgment as a matter of law." *Id.* To bring a renewed motion for judgment as a matter of law under Rule 50(b), the moving party must have made a companion Rule 50(a) motion earlier in the trial. NRCP 50(b). *See, e.g.*, *Zhang v. Barnes*, 132 Nev. 1049, 382 P.3d 878 (2016); *City of Reno v. Bedian*, 131 Nev. 1264 (Nev. App. 2015). "The standards for granting a motion for judgment notwithstanding the verdict are the same as those for granting a directed verdict." *Sheeketski v. Bartoli*, 86 Nev. 704, 475 P.2d 675, 706 (1970).

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[3] Defendants moved twice for judgment as a matter of law under Rule 50(a) during trial: in writing on November 17, 2021 after TeamHealth Plaintiffs' rested, and orally on December 6, 2021, after the jury returned its verdict on liability, but before the punitive damages phase. *See* Defs. Mot. for Judgment as a Matter of Law; 12/6/2021 Tr. 50:17-56:18.

This Court may enter judgment as a matter of law "when 'the evidence is so overwhelming for one party that any other verdict would be contrary to the law.'" *Grosjean v. Imperial Palace, Inc.*, 125 Nev. 349, 362, 212 P.3d 1068, 1077 (2009) (quoting *M.C. Multi-Family Dev., L.L.C. v. Crestdale Assocs., Ltd.*, 124 Nev. 901, 910, 193 P.3d 536, 542 (2008)). Such a determination requires the establishment of clear, uncontradicted, self-consistent, and unimpeached evidence. *Sheeketski*, 475 P.2d at 677. In considering a motion for judgment as a matter of law, the court must view the evidence and all inferences from the evidence in a light most favorable to the party against whom the motion is directed; it must not weigh the evidence or evaluate the credibility of the witnesses. *State Univ. & Cmty. Coll. Sys. v. Sutton*, 120 Nev. 972, 986, 103 P.3d 8, 18 (2004); *Banks v. Sunrise Hosp.*, 120 Nev. 822, 839, 102 P.3d 52, 64 (2004); *Connell*, 97 Nev. at 438, 634 P.2d at 674. "[A] nonmoving party can defeat a motion for judgment as a matter of law if it presents sufficient evidence such that the jury could grant relief to that party." *D&D Tire v. Ouellette*, 131 Nev. 462, 466, 353 P.3d 32, 35 (2015).

Defendants are entitled to judgment as a matter of law on all of TeamHealth Plaintiffs' remaining claims.[4] Judgment should be entered in favor of SHL, HPN, and UMR for all claims, for the simple reason that TeamHealth Plaintiffs failed to present any evidence related to these Defendants on key elements of their causes of action. All Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' claim under the Unfair Claims Practices Act; not only because TeamHealth Plaintiffs lack standing under that Act, but also because they have presented no evidence on key elements of that claim. Because TeamHealth Plaintiffs properly sought punitive damages only under that cause of action, their claim for punitive damages must also fail. Every Defendant is entitled to judgment as a matter of law on TeamHealth Plaintiffs' claim for breach of implied-in-fact contract because TeamHealth Plaintiffs presented no evidence showing the basic elements of contract formation. To the extent the Court disagrees that Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' implied-in-fact contract claims,

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[4] In fact, because all of TeamHealth Plaintiffs' causes of action are preempted by ERISA, *see infra* Section F, Defendants are entitled to judgment as a matter of law on all claims.

all Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' unjust enrichment claims because the jury found that there was an implied-in-fact contract between TeamHealth Plaintiffs and Defendants. And even if TeamHealth Plaintiffs properly sought punitive damages under their unjust enrichment claims (they did not), because those claims must be dismissed as a matter of law, TeamHealth Plaintiffs' punitive damages claims fail under this theory, as well. Every Defendant is also entitled to judgment on TeamHealth Plaintiffs' claim under the Prompt Pay Act, because TeamHealth Plaintiffs do not have a private right of action under that Act, because they failed to exhaust available administrative remedies, and because the jury found that TeamHealth Plaintiffs were entitled to only a portion of their full billed charges.

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

At the heart of TeamHealth Plaintiffs' case is their contentions regarding certain of UnitedHealthcare's (e.g., Defendants UHS and UHIC's) out-of-network programs—particularly, the development and implementation of the outlier cost management program. And yet, TeamHealth Plaintiffs introduced ***no evidence*** to establish any claim against SHL, HPN, or UMR, all of whom reimburse ***independently*** of the UnitedHealthcare out-of-network programs at issue in this case. No testimony came in regarding the history of any relationship or amount of pre-disputed claim reimbursements between SHL, HPN, or UMR on the one hand, and any of the TeamHealth Plaintiffs on the other. There is no evidence about any interactions or course of dealing between TeamHealth Plaintiffs and SHL, HPN, or UMR. While TeamHealth Plaintiffs did present some evidence concerning SHL, HPN, and UMR's different out-of-network reimbursement methodologies or programs, that evidence did not support their "one size fits all" approach to trying this case against different defendants with different reimbursement methodologies. As an initial matter, SHL and HPN's claims director actually testified that these two Nevada entities ***do not*** use "cost reduction or savings programs" and ***do not*** use MultiPlan – the thirty-party vendor featured prominently in TeamHealth Plaintiffs' case against UHS and UHIC. 11/16/2021 Tr. 158:14-18 (Ms. Hare testified that SHL and HPN do not use "cost reduction or savings programs"); *id.* 177:13-16 (same). And while TeamHealth Plaintiffs did establish that

UMR earns a fee for certain out-of-network programs that do not pay claims at billed charges (*see, e.g.*, 11/15/2021 Tr. 188:22–189:7 (testifying that UMR has "programs that a client can elect to offer, and one of the ways that we charge for those programs is a percentage of savings")) and that UMR uses third-party vendors including (but not limited to) MultiPlan (*see id.* 211:8–11), the testimony clearly establishes that UMR developed these programs independently of UnitedHealthcare and in fact implemented programs using Data iSight ***independent of and before*** UnitedHealthcare. *See* 11/10/2021 Tr. 142:25-143:12; DX4569. Thus, the evidence regarding UMR merely establishes that UMR had "similar" programs with similar fee structures. *Id*. 194:20–205:2 (eliciting testimony from Mr. Ziemer about claims being paid based on UMR's out-of-network programs and UMR's fees); *id*. 221:10–224:16 (questioning based on how summary plan documents administered by UMR determine At-Issue Claim reimbursement). This is plainly insufficient. Nor have TeamHealth Plaintiffs introduced a single document that evidences a contract manifested by conduct. *See, e.g.*, P159 (UMR's administrative services agreement with a client); 11/15/2021 Tr. 197:21–203:23 (questioning related to P159 and how it relates to claims reimbursement). Without specific evidence apart from the list of claims itself (which purports to show the amounts billed and amounts allowed, and little else, *see* P473), TeamHealth Plaintiffs have not proved their causes of action against these Defendants—mostly glaringly as to SHL and HPN. This complete failure of proof makes any verdict against these Defendants contrary to law.

TeamHealth Plaintiffs' causes of action require proof of something more than a disparity between their billed charges and the amounts they received in reimbursement. Without evidence of a course of dealing between TeamHealth Plaintiffs, on the one hand, and SHL, HPN, and UMR on the other, there are no facts from which jurors could infer an implied-in-fact contract. *Smith v. Recrion Corp.*, 91 Nev. 666, 668, 541 P.2d 663, 664 (1975) (terms of an implied-in-fact contract are "manifested by conduct"). Without specific evidence about the individual claims submitted to these Defendants, their liability could not be "reasonably clear" for the purposes of TeamHealth Plaintiffs' Unfair Claims Practices Act claim. NRS 686A.310(e) (unlawful for insurer to "fail[] to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear"). And without evidence about these Defendants' conduct in retaining a

benefit, there cannot be sufficient proof that they were unjustly enriched by paying TeamHealth Plaintiffs what they did on the claims that were submitted to them. Judgment should be entered in favor of UMR, SHL, and HPN on all causes of action.

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

TeamHealth Plaintiffs bring a cause of action against all Defendants under the Unfair Claims Practices Act. That Act confers standing only on an ***insured*** as against its ***insurer***. TeamHealth Plaintiffs are not insureds, and several of the Defendants are not insurers. Even if they were, TeamHealth Plaintiffs have failed to offer evidence on several of the elements of this cause of action. Defendants are entitled to judgment as a matter of law.

1. TeamHealth Plaintiffs Lack Standing to Assert a Cause of Action Under the Unfair Claims Practices Act

Under the text of the Unfair Claims Practices Act, under the many decisions of the Nevada Supreme Court and other cases, and under the guidance of the Nevada Insurance Commissioner, no private right of action exists in favor of TeamHealth Plaintiffs against any Defendant.

The text of the Unfair Claims Practices Act is conclusive on this subject. The private right of action, added by the Nevada Legislature in 1987, is created by the following language:

> 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.

NRS 686A.310(2) (emphasis added); *see also* 1987 St. of Nev., Ch. 470 p. 1067 A.B. 811. The Nevada Legislature in 1989 considered language to "expressly provide for action by a third party claimant for violation of the unfair claims settlement practices act by insurance companies," but no such enactment has ever been added. *Crystal Bay Gen. Imp. Dist. v. Aetna Cas. & Sur. Co*., 713 F. Supp. 1371, 1377 (D. Nev. 1989). There is, therefore, no text supporting a cause of action in favor of a third-party claimant against any defendant.

TeamHealth Plaintiffs, as service providers, are mere third party beneficiaries to an insurance contract, and have no right to file claims for breach under the Unfair Claims Practices

Act. The seminal case on this subject, *Tweet v. Webster*, 614 F. Supp. 1190 (D. Nev. 1985), held that the Act did not create a private cause of action. In that case, Chief Judge Reed extensively canvassed the text and history of the Act, similar enactments in California and elsewhere, the model code upon which these acts are based, and legislative history, and concluded that no private right of action existed under the Act. "Where Nevada's insurance code has *no* language relating to other liability of insurers," other than those expressly provided, "none can be read in." *Id.* at 1194. "[W]here a legislature writes an insurance code with specific penalties and remedies for violation thereof, the code is as the legislature intended." *Id.*[5]

Case after case since *Tweet* and since the 1987 enactment of a private right of action has consistently refused to find an extra-textual right of action in favor of third-party claimants or medical providers. *See, e.g.*, *Crystal Bay*, 713 F.Supp. at 1376 (while right of action for insured, there was "no reason to disagree with [the court's] conclusion that the Act created no private right of action in favor of third party claimants against the insurer."); *Burley v. Nat'l Union Fire Ins. Co. of Pittsburgh PA*, No. 315CV00272HDMWGC, 2016 WL 4467892, at *2 (D. Nev. Aug. 22, 2016) ("It is well established that third party claimants have no private cause of action under NRS 686A.310."); *Talbot v. Sentinel Ins. Co*., No. 2:11-CV-01766-MMD, 2012 WL 3995562, at *4 (D. Nev. Sept. 10, 2012) ("The law in Nevada is clear: third-party claimants may not bring claims against insurers or their insured under NRS § 686A.310."); *Weast v. Travelers Cas. & Sur. Co*., 7 F. Supp. 2d 1129, 1132 (D. Nev. 1998) ("[T]he [Nevada Unfair Practices] Act created no private right of action in favor of third party claimants against the insurer."); *Hunt v. State Farm Mut. Auto. Ins. Co*., 655 F. Supp. 284, 287 (D. Nev. 1987) ("Nevada does not recognize a right of action on the part of a third-party claimant against an insurance company for bad-faith refusal to settle.").

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[5] As noted above, the Nevada Legislature enacted a new provision of the Unfair Claims Practices Act two years after *Tweet*, that provided for a private right of action where "an insurer is liable to its insured." 1987 St. of Nev., Ch. 470 p. 1067 A.B. 811. As also noted, the Nevada Legislature considered and rejected a private right of action in favor of third-party claimants like TeamHealth Plaintiffs. *Crystal Bay*, 713 F. Supp. at 1377.

The Nevada Supreme Court has also held that that individuals in far closer privity than TeamHealth Plaintiffs to the underlying insurance contract lacked standing to sue. *See United First Ins. Co. v. McClelland*, 105 Nev. 504, 780 P.2d 193 (1989) (where dependent of person whose benefits were denied sued, dependent not considered insured under policy for purposes of standing); *Gunny v. Allstate Insurance Co.*, 108 Nev. 344, 346, 830 P.2d 1335, 1336 (1992) (where son injured in boat operated by father, son did not have standing to sue under NRS 686A.310 for claim under father's insurance policy).

Cases since *Gunny* have consistently applied its holding to permit only an insured with an insurance contract with the insurer to pursue claims under the Act. *See, e.g.*, *Fulbrook v. Allstate Ins. Co.*, Nos. 61567, 62199, 2015 WL 439598, at *4 (Nev. Jan. 30, 2015) ("This statute, however, does not provide a private right of action to third-party claimants."); *Wilson v. Bristol W. Ins. Grp.*, No. 209-CV-00006-KJD-GWF, 2009 WL 3105602, at *2 (D. Nev. Sept. 21, 2009) ("No private right of action as a third-party claimant is created under NRS 686A.310."). [6]

It may be, as some federal district courts have suggested, that where the insured assigns its benefits to a third-party claimant such as a medical provider, that third-party claimant may step into the shoes of insured. But that is irrelevant to this case. "Without an assignment, voluntary or forced," TeamHealth Plaintiffs "still lacked standing to proceed directly against" Defendants for liability under the Act.[7] *Bell v. Am. Fam. Mut. Ins. Co.*, 127 Nev. 1118, 373 P.3d 895 (2011); *see*

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[6] In *Bergerud v. Progressive Casualty Insurance*, 453 F. Supp. 2d 1241 (2006), the court permitted a claim under the Act to survive a motion to dismiss where the plaintiff "is an insured, had a contractual relationship with [the insurer-defendant], and is a first-party claimant." *Id.* at 1250. The court also noted in *dicta* that "Nevada does not exclude non-contracting parties from asserting a private right of action for violation of the … Act. Instead, only third-party claimants and parties without a contractual relationship with an insurer cannot assert a claim under the … Act." *Id.* This *dicta*, however, was unrelated to the case and inconsistent with *Gunny*, insofar as it confuses *Gunny*'s holding on the common-law bad faith claim with the holding on the Unfair Claims Practices Act claim.

[7] Defendants have always contended—and continue to contend—that the Plaintiffs in fact received assignments of benefits from all of Defendants' plan members and by virtue of those assignments, stand in the shoes of Defendants' plan members which must result in all of Plaintiffs' claims being subject to preemption under ERISA. However, Plaintiffs have disclaimed any reliance on these assignments and the Court has repeatedly rejected Defendants' argument. Therefore, Plaintiffs are estopped from now changing course and accepting the benefit of receiving an assignment

also Hetly v. Am. Equity Ins. Co., No. 208CV00522PMPLRL, 2008 WL 11389200, at *3 (D. Nev. Nov. 14, 2008) ("However, generally, a valid assignment confers a right of standing upon the assignee to sue in place of the assignor."); *cf. Wilson*, 2009 WL 3105602, at *2 (finding no assignment of benefits to support common-law bad faith claim). For instance, in *Hicks v. Dairyland Insurance Co.*, No. 2:08-CV-1687-BES-PAL, 2009 WL 10693627 (D. Nev. Apr. 27, 2009), the Court held that a third-party claimant lacked standing under the Act where he was not an insured and lacked an assignment of benefits from the insured. *Id.* at *3. TeamHealth Plaintiffs have not only not proven such an assignment, they have disclaimed reliance on such an assignment. SAC at 2 n.5.[8]

Although TeamHealth Plaintiffs seek relief only under 686A.310(1)(e), *see* SAC ¶ 92–93; JPTO at 5 (citing SAC ¶¶ 90–97), other prongs under the heading of NRS 686A.310 refer to practices directed generally at "claimants." But TeamHealth Plaintiffs are not "claimants." The implementing regulations for the Unfair Claims Practices Act contemplate only two valid categories of claimants. A first-party claimant is defined as one "asserting a right to payment under an insurance contract or policy arising out of the occurrence of the contingency or loss covered by the contract or policy." Nev. Admin. Code 686A.625. A first-party claimant "does not include a person who provides service to an injured party." *Id.* A third-party claimant is "one asserting a claim against any person, corporation, association, partnership or other legal entity insured under an insurance contract or policy." *Id.* 686A.650. Likewise, a third-party claimant "does not include a person who provides service to an injured party." *Id.*[9] TeamHealth Plaintiffs

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(potential standing as a third party claimant) while avoiding the consequences of such an assignment (ERISA preemption).

[8] If Plaintiffs chose to rely on assignments to manufacture standing for their Unfair Insurance Practice Act claim, then the claim would be preempted by ERISA. *See DB Healthcare, LLC v. Blue Cross Blue Shield of Ariz., Inc*., 852 F.3d 868, 873 (9th Cir. 2017) (valid assignment of benefits confers standing to bring claim under ERISA); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004) ("[I]f an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely pre-empted by ERISA § 502(a)(1)(B).").

[9] The only contract contemplated by these definitions would be the "insurance policy or contract" which is defined as an "insurance policy, plan or written agreement for or affecting insurance by

do not qualify as first-party or third-party claimants under the Act. Indeed, TeamHealth Plaintiffs are categorically and specifically excepted from the definition of claimant.

In short, the consistent law, as developed by the Nevada Legislature, the Nevada Supreme Court, the Nevada federal district courts, and the Nevada Commission of Insurance excludes service providers such as TeamHealth Plaintiffs from having a private right of action under the Act. This Court should follow the copious and undisputed authority- and grant Defendants judgment as a matter of law.

2. Several Defendants Are Not Insurers and Cannot Be Held Liable Under the Unfair Claims Practices Act

Notwithstanding TeamHealth Plaintiffs' unequivocal lack of standing to pursue a claim under the Unfair Claims Practice Act, the plain text of the Unfair Claims Practices Act, the consistent and unanimous case law, and the implementing regulations apply the Act to insurers only. The text provides only that "an insurer is liable to its insured." NRS 686A.310(2). The title of NRS 686A.310 makes clear that it provides for the ***liability of [an] insurer*** for damages" (emphasis added). Nevada law defines an "insurer" as "every person engaged as principal and as indemnitor, surety or contractor in the business of entering into contracts of insurance." NRS 679A.100. The Nevada Supreme Court in *Albert H. Wohlers & Co. v. Bartgis* held that a plan administrator is ***not*** an insurer for the purposes of NRS 686A.310 because they are not in the business of entering into insurance contracts. 114 Nev. 1249, 1264, 969 P.2d 949, 960 (1998).

Claims under the Unfair Claims Practices Act against UHS and UMR fail because those two Defendants are not insurers as to all claims, and UHIC is not an insurer with respect to some claims. 11/2/2021 Tr. 164:21–25 (Mr. Haben testified that some Defendants perform third party administrator services for ASO clients); 11/3/2021 Tr. 86:19–87:2 (Mr. Haben testified that defendants performing third-party administrator services pay claims based on the directives of the

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whatever name called and includes all clauses, riders or endorsements offered by any person or entity engaged in the business of insurance in this State." Nev. Admin. Code 686A.627. This definition cannot encompass the unwritten implied-in-fact contract the jury found existed in this case.

self-insured client because defendants only "administer the funds"); 11/8/2021 Tr. 152:23–153:1 (Mr. Haben testified that UMR is a third-party administrator); 11/9/2021 Tr. 130:19–131:10 (Mr. Haben testified that "UMR is the third-party administrator" and "UnitedHealthcare itself is a third-party administrator . . . [f]or self-employed groups"); 11/10/2021 Tr. 21:11–22 (Mr. Haben testified that third-party administrators "do[] not incur the medical cost risk"); *id.* 24:10–17 (Mr. Haben testified that UHIC is a third-party administrator and an insurer); *id*. 29:16–19 (Mr. Haben testified that an administrative services agreement is between "the employer group, with the third-party administrator to perform services on their behalf"); *id*. 29:20–30:10 (Mr. Haben testified that certificates of coverage are only associated with fully insured plans and summary plan documents and administrative services agreements are associated with a self-insured plan); 11/15/2021 Tr. 183:19-23 (Mr. Ziemer testified that UMR "is a third-party administrator, so what that means is that our clients are employer groups, and they wish to self-fund their benefit plan."); *id.* 184:21-185:4 (Mr. Ziemer testified that UMR is a third-party administrator and that "the employer is actually the one that pays the claims. . . . So what UMR does is we administer the benefits [] that that employer group provides to us."). These Defendants act as plan administrators for employer self-funded plans. As an administrator of an employer self-funded plans, UHS and UMR are not insurers. The employers are insurers and UHS, UMR, and UHIC provide administration services. In *Albert H. Wohlers*, an insured argued that the plan administrator was liable because an administrator fits within the statutory definition of a "person," but the Nevada Supreme Court held that "when considering unfair claims practices" the Act "proscribes unfair practices in settling claims by an insurer, which [a plan administrator] is not." 114 Nev. at 1265.

Because UHS and UMR are plan administrators and not insurers with respect to all the At-Issue Claims, the Court should direct a verdict in favor of UHS and UMR with respect to all claims under the Unfair Claims Practices Act. Because UHIC is a plan administrator with respect to 119 At-Issue Claims, the Court should direct a verdict in favor of UHIC with respect to those claims. In total, Defendants are entitled to a judgment as a matter of law on TeamHealth Plaintiffs' cause of action under the Unfair Claims Practices Act with respect to 4,636 of the At-Issue Claims because they were submitted to self-funded plans.

3. TeamHealth Plaintiffs Have Presented No Evidence That Any Defendant's Liability Was "Reasonably Clear" Prior to Trial

The Unfair Claims Practices Act delineates and proscribes many unfair practices, but TeamHealth Plaintiffs' complaint and Joint Pretrial Memorandum restrict their claim to the practice described in NRS 686A.310(1)(e): "Failing to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear." *See* SAC ¶ 92; JPTO at 5 (citing SAC ¶¶ 90–97). "This statute concerns the manner in which an insurer handles an ***insured's*** claim." *Patel v. Am. Nat'l Prop. & Cas. Co.*, 367 F. Supp. 3d 1186, 1193 (D. Nev. 2019) (emphasis added).

To prevail on this claim, TeamHealth Plaintiffs must prove that Defendants failed to fairly settle payment of an insurance claim after the Defendants' liability was reasonably clear. *Yusko v. Horace Mann Servs. Corp.*, No. 2:11–cv–00278–RLH–GWF, 2012 WL 458471, at *4 (D. Nev. Feb. 10, 2012) (granting summary judgment where plaintiff had not presented any evidence that an officer, director, or department head was aware of the conduct in question); *Tweet*, 614 F. Supp. at 1194 ("Furthermore, in the present case, plaintiffs do not present probative evidence supporting their allegation that their claim against CSAA had become 'reasonably clear.'").

Here, there is no probative evidence that Defendants' liability for the At-Issue Claims had become "reasonably clear" prior to trial. In most cases, the "reasonably clear" requirement is established by the fact the insurer had concluded internally that a particular claim should be paid but did not pay the claim. But the evidence at trial ***confirmed*** that Defendants in fact paid each of the At-Issue Claims. *See* 11/16/2021 Tr. 226:23-227:10 (Mr. Leathers testified that Defendants' data for the At-Issue Claims includes reimbursement amounts); *id.* 233:12-22 (Mr. Leathers testified that he analyzed claims that were allegedly underpaid as opposed to not paid). Defendants paid those claims based on methodologies designed to arrive at a reasonable reimbursement amount. And while the record is clear that Plaintiffs would like to have received a higher reimbursement, where the specific amount owed in dispute as to any one claim is not reasonably clear to the insurer, that is sufficient to defeat this claim. *See, e.g.*, *Clifford v. Geico Cas. Co.*, 428 F. Supp. 3d 317, 325 (D. Nev. 2019). In general, this claim is satisfied where the insurer waited

an "inordinate amount of time" to provide information about a particular claim. *See, e.g.*, *Fries v. State Farm Mut. Auto. Ins. Co.*, No. 3:08CV00559LRH-VPC, 2010 WL 653757, at *4 (D. Nev. Feb. 22, 2010); *Turk v. TIG Ins. Co.*, 616 F. Supp. 2d 1044, 1052 (D. Nev. 2009). But there is no evidence that any Defendant waited an inordinate amount of time before communicating about a claim. In fact, there is no evidence in the record about *any* Defendant's handling of *any* particular one of the At-Issue Claims.

Liability never became reasonably clear until the jury returned its verdict, which assessed liability for an amount *neither* party presented as the reasonable value of the charges. Disagreement between experts on the amounts of damages alone is enough to grant judgment to defendants because "liability has not become reasonably clear." *Lubritz v. AIG Claims, Inc.*, No. 217CV02310APGNJK, 2018 WL 7360623, at *7 (D. Nev. Dec. 18, 2018). Courts regularly hold that where there are genuine issues of material fact regarding the existence or scope of liability of an insurer, liability has perforce not become reasonably clear. *Big-D Constr. Corp. v. Take It for Granite Too*, 917 F. Supp. 2d 1096, 1118 (D. Nev. 2013).

Here, TeamHealth Plaintiffs' own expert Mr. Leathers offered two alternative theories of the amount of damages TeamHealth Plaintiffs suffered. *Compare* 11/17/2021 Tr. 16:15-16:24 (measuring damages based on full billed charges) *with id.* 286:25-287:8 (measuring damages based on average amount Defendants paid other out-of-network providers). And Defendants expert Mr. Deal offered yet another calculation. 11/18/21 Tr. 206:24-209:20 (measuring damages by comparing to out-of-network providers in same geographic region as each TeamHealth Plaintiff). And the jury's verdict further demonstrates that *no* Defendant's liability was reasonably clear because the jury *rejected* the amount TeamHealth Plaintiffs billed for each of the At-Issue claims, instead determining that a reasonable value was far less than what TeamHealth Plaintiffs requested. 11/29/21 Special Verdict Form. *See* 12/6/2022 Tr. 51:10-13. And the jury clearly disagreed with both experts, instead awarding $2.65 million in liability—an amount neither party offered as a proposed amount of damages. *Id*.

The Unfair Claims Practices Act does not prohibit good faith disagreements over the valuation of claims in the course of settling those claims. The Act targets delays in settlement

where liability, not coverage, has become reasonably clear. Because the parties' experts disagreed about the amount damages TeamHealth Plaintiffs suffered, liability never became reasonably clear until the jury rendered its verdict. And the jury's award of an amount significantly lower than TeamHealth Plaintiffs' billed charges necessarily means that there was no sum certain that was reasonably clear before trial. Based on the statutory text and the case law, liability for these At-Issue Claims is by definition not reasonably clear.

4. TeamHealth Plaintiffs Have Presented No Evidence that Defendants Failed to Effectuate a Prompt, Equitable, and Fair Settlement

TeamHealth Plaintiffs contend that Defendants failed to "effectuate a prompt, equitable, and fair settlement" because they did not negotiate with TeamHealth Plaintiffs on each of the At-Issue Claims. That is not what the Act requires. TeamHealth Plaintiffs presented no evidence that, ***where an individual claim was appealed and negotiated***, Defendants were unreasonable in negotiating a fair settlement. Indeed, they presented no evidence at trial that the parties negotiated reimbursement rates ***at all***. TeamHealth Plaintiffs offered no evidence that they communicated with Defendants and sought to negotiate a higher reimbursement on the disputed claims, and that Defendants rejected their reasonable demands for additional payment.

Without such evidence, TeamHealth Plaintiffs failed to prove that Defendants violated the Unfair Claims Practices Act as a matter of law. *See, e.g.*, *Harter v. Gov't Emps. Ins. Co.*, No. 2:19-CV-1330 JCM (EJY), 2020 WL 4586982, at *4 (D. Nev. June 11, 2020) (granting summary judgment where evidence showed defendant "negotiated in good faith"); *Matarazzo v. GEICO Cas. Co.*, No. 219CV529JCMVCF, 2020 WL 1517556, at *4 (D. Nev. Mar. 30, 2020) (granting summary judgment where insurer "promptly responded to plaintiff's requests and communications" and "had a basis for disputing plaintiff's demands for the full policy limit"); *Amini v. CSAA Gen. Ins. Co.*, No. 2:15–cv–0402–JAD–GWF, 2016 WL 6573949, at *6 (D. Nev. Nov. 4, 2016) (granting summary judgment where insurer "reasonably and promptly responded to claim communications and engaged in settlement negotiations").

5. TeamHealth Plaintiffs Have Presented No Evidence That an Officer, Director, or Department Head of Defendants Knowingly Permitted the Alleged Violations

For there to be liability under NRS 686.310, TeamHealth Plaintiffs must prove that an "officer, director, or department head of the insurer has knowingly permitted such an act or has had prior knowledge thereof." NRS 686A.270. Without evidence that an officer, director, or department head permitted the unfair insurance practices, TeamHealth Plaintiffs' claim fails as a matter of law. *Hackler v. State Farm Mut. Auto. Ins. Co.*, 210 F. Supp. 3d 1250, 1255 (D. Nev. 2016) (finding "Claims Teams Managers" did not qualify under the statutory requirements of NRS § 686A.270); *see also Yusko*, 2012 WL 458471, at *4 (granting summary judgment where plaintiff had not presented any evidence that an officer, director, or department head was aware of the conduct in question).

To be sure, TeamHealth Plaintiffs have presented testimony from officers of some of the Defendants. TeamHealth Plaintiffs questioned John Haben on the stand on five separate court days. 11/10/2021 Tr. 13:5-7 (Mr. Haben was the "Vice President of the out of network programs"). At no time did TeamHealth Plaintiffs ask Mr. Haben about his *prior* knowledge of any one of the At-Issue Claims. 11/2/2021 Tr. 123:13–128:22 (questioning based on *hypothetical* payment of $254 for treatment of a gun-shot victim); 11/9/2021 Tr. 27:18–40:12 (questioning of Mr. Haben related to one At-Issue Claim based on purported plan documents P444 (EOB), P120 (SPD), P290 (COC) elicited testimony based on documents, not prior knowledge); *id.* 40:15–45:10 (questioning related to Ruby Crest's purported appeal of the At-Issue Claim depicted in P444 (related testimony at 11/9/2021 Tr. 27:18–40:12) made clear that Mr. Haben had no knowledge of the claim appeal exhibit, P470, including Plaintiffs' counsel's assertion that Defendants would not engage with them during the appeal); *id.* 101:11–107:16 (questioning based on a MultiPlan document, P413, related to how Data iSight works made clear that Mr. Haben lacks knowledge of whether every At-Issue Claim priced by Data iSight amounted to 250–350% of Medicare); *id.* 126:16–129:20 (questioning related to the P444 At-Issue Claim and why the Data iSight pricing came out to 250% of Medicare but refusing to elicit Mr. Haben's understanding of that claim); 11/10/2021 Tr. 175:6–176:6 (questioning Mr. Haben based on *hypothetical*, but not At-Issue, claim); *id.* 176:7–181:12

(Mr. Haben read the billed charge and allowed amount from document regarding one At-Issue Claim but providing no testimony about his prior knowledge of the claim); *id.* 208:17–214:13 (Mr. Haben testified that P290 and P470 may not relate to the At-Issue Claim contained in P444). TeamHealth Plaintiffs did not elicit any testimony from Daniel Rosenthal regarding any particular At-Issue Claim. Joint Submission of Dep. Clips for Trial Record as Played on Nov. 12, 2021 10:05-06, 21:11-15 (Mr. Rosenthal testified that he was the former President of UnitedHealth Networks and the current CEO of Commercial Business for UnitedHealth Group's West Region). Rebecca Paradise, Vice President of Out-of-Network Payment Strategy, was questioned on a small number of At-Issue Claims, but she did not have prior knowledge of any of them. *See* 11/15/2021 Tr. 51:10-12; *id.* 7:22–8:4 (Ms. Paradise testified that claims in general may be paid at a higher amount than what would be remitted by MultiPlan based on direction of client); *id.* 10:4–12:12 (Ms. Paradise testified about an email regarding the experience of a United employee regarding an unknown claim priced by MultiPlan); *id.* 17:7–19:8 (questioning related to P444 that did not elicit Ms. Paradise's prior knowledge of the claim); *id.* 20:2–9 (Ms. Paradise testified that it would "untenable" for her to determine whether every claim using Data iSight was priced at 250% of Medicare); *id.* 117:5–15 (Ms. Paradise testified that she is "unaware of a specific situation" in which Defendants paid "ER claims at usual and customary"); *id.* 123:21–124:3 (Ms. Paradise testified that she does "not review[] any claim. I didn't review any of the thousands of claims that are at—at issue in this case."). Similarly, Scott Ziemer, UMR's Vice President of Customer Solutions, was questioned on a small number of claims, but he did not have any prior knowledge of them. 11/15/2021 Tr. 244:8-11; *id.* 194:20–205:2 (failing to elicit testimony from Mr. Ziemer about his prior knowledge of the specific At-Issue Claims despite showing him a demonstrative based on P473 because Plaintiffs focused on Defendants' fees); *id.* 211:8–11 (Mr. Ziemer testified that "to [his] knowledge we have not told MultiPlan or Data iSight" how to reimburse claims because "[w]e rely on their tool. They use publicly available information. They have their own algorithm to determine their reasonable amount."); *id.* 221:10–224:16 (questioning Mr. Ziemer on how a summary plan document relates to At-Issue Claims, but failing to elicit any testimony

regarding his prior knowledge of those claims); *id.* 236:11–12 ("I am not a plan document person.").

Not a single officer, director, or department head has been presented for SHL or HPN. Leslie Hare, the sole SHL and HPN witness, testified explicitly that she is not a department head. 11/16/2021 Tr. 199:11-15 (testifying that she reports to another person and does not consider herself a department head). Ms. Hare also testified that she did not have any prior knowledge regarding the At-Issue Claims. 11/16/2021 Tr. 135:6-18 (testifying that she is generally aware that the At-Issue Claims were submitted by TeamHealth Plaintiffs, but nothing else); *id.* 142:24-143:6 (failing to elicit testimony regarding the specific At-Issue Claims, but instead eliciting testimony that out-of-network claims in general get reimbursed pursuant to plan documents).

In sum, TeamHealth Plaintiffs presented no evidence that demonstrates that any officer, director, or department head permitted the unfair insurance practices that TeamHealth Plaintiffs allege.

6. TeamHealth Plaintiffs Have Presented No Evidence of Damages from Defendants' Claims Process as Opposed to the Underlying At-Issue Claims

TeamHealth Plaintiffs have no claim under the Unfair Claims Practices Act unless they prove they suffered a harm that is distinct from the underlying At-Issue Claims. *See Safety Mut. Cas. Corp. v. Clark Cty. Nev.*, No. 2:10-CV-00426-PMP, 2012 WL 1432411, at *2 (D. Nev. Apr. 25, 2012) ("Clark County does not identify any evidence raising a genuine issue of material fact that it suffered any damages from these two alleged claims handling failures apart from the denial of coverage itself."); *Sanders v. Church Mut. Ins. Co.*, No. 2:12-CV-01392-LRH, 2013 WL 663022, at *3 (D. Nev. Feb. 21, 2013) (damages under Unfair Claims Practices Act must be "costs which are separate and apart from damage caused by the underlying accident"); *Yusko*, 2012 WL 458471, at *4 ("Here, Yusko has not presented evidence of any damages resulting from Horace Mann's conduct. The only damages for which the Court has evidence are a result of the underlying accident, not the claims process or any conduct by Horace Mann."). That is, to have a valid claim under the Unfair Insurance Practice Act, TeamHealth Plaintiffs must have been separately harmed

by the ***claims process itself***, and not just through the performance of emergency medicine services that went uncompensated or undercompensated.

To the extent TeamHealth Plaintiffs presented any evidence at all that they were harmed by Defendants' conduct, that harm is limited to the plain fact that they received less than their full billed charges in Defendants' adjudication of the At-Issue Claims. They do not allege, and they have not proved, a harm that is distinct from the underpayments themselves. 11/16/2021 Tr. 65:7-10 (Leif Murphy, TeamHealth's CEO, testified that billed charges should be awarded because "[w]e perform the service"); *id.* 86:20-23 (TeamHealth "entitled to billed charge"); 11/22/2021 Tr. 75:21-76:2 (Mr. Bristow, TeamHealth Plaintiffs' corporate representative, testified that Defendants required to pay full billed charges even though they increased year over year); *id.* 85:19-22 (testimony from Mr. Bristow that "Plaintiffs' theory that they were entitled to full billed charges for the services that they billed for United members on an out-of-network basis was limited by a determination of whether those charges were or were not reasonable."). There is no evidence that TeamHealth Plaintiffs suffered "costs which are separate and apart from damage caused by the underlying accident." *Sanders*, 2013 WL 663022, at *3. For that reason, Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' claims under the Unfair Claims Practices Act.[10]

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[10] Consequential damages are not permitted under the Unfair Claims Practices Act, at all. *See also Van Dyke v. St. Paul Fire & Marine Ins. Co.*, 448 N.E.2d 357, 362 (Mass. 1983) (affirming summary judgment for insurer because "any omission by [the insurer] to comply with [Massachusetts' UCPA] did not cause any injury to or adversely affect the plaintiffs"); *Michelman v. Lincoln Nat. Life Ins. Co.*, 685 F.3d 887, 901 (9th Cir. 2012) (rejecting liability under Washington statute where no damages arose from the nominal statutory violation); *Provident Am. Ins. Co. v. Castaneda*, 988 S.W.2d 189, 199 (Tex. 1998) (damages under Texas statute must be "separate and apart from those that would have resulted from a wrongful denial of the claim").

But even assuming the Unfair Claims Practices Act allowed consequential damages, such damages would be available only with a showing of insurer's bad-faith intent. *U.S. Fidelity & Guar. Co. v. Peterson*, 91 Nev. 617, 619-20, 540 P.2d 1070, 1071 (1975) (adopting "the rule that allows recovery of consequential damages where there has been a showing of bad faith by the insurer"); *Blue Cross & Blue Shield of Ky., Inc. v. Whitaker*, 687 S.W.2d 557, 559 (Ky. Ct. App. 1985) ("Absent some proof that [the insurer] acted intentionally, willfully or in reckless disregard of its insured's rights, we cannot uphold a verdict allowing consequential or punitive damages."). Such a limitation is necessary to prevent parties who cannot make out a bad faith claim, as TeamHealth Plaintiffs concededly cannot here, from recovering all of the damages of such a claim without evidence of the insurer's culpable mental state.

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

Based on the evidence submitted at trial, Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' claim for punitive damages under the Unfair Claims Practices Act.[11] Punitive damages are available only to punish or deter "conduct that is outrageous, because of the defendant's evil motive or his reckless indifference to the rights of others." Restatement (Second) of Torts § 908(2); *see Coughlin v. Hilton Hotels Corp.*, 879 F. Supp. 1047, 1050 (D. Nev. 1995) (citing *Turnbow v. Dep't of Human Res.*, 109 Nev. 493, 853 P.2d 97, 99 (1993)) ("[P]unitive

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[11] TeamHealth Plaintiffs did not seek punitive damages in connection with any other cause of action. JPTO at 5–6; *see also* SAC ¶¶ 80–89 (no allegation of entitlement to punitive damages in Second Claim for Relief for unjust enrichment). Because in the Joint Pretrial Memorandum TeamHealth Plaintiffs did not request punitive damages in connection with the unjust enrichment cause of action, they have waived the right to seek those damages on that cause of action. "As a general proposition a pretrial order does control the subsequent course of the trial and supersedes the pleadings." *Walters v. Nev. Title Guar. Co.*, 81 Nev. 231, 234, 401 P.2d 251, 253 (1965); *see also* EDCR 2.67(b)(2) (pretrial memorandum must present "a list of all claims for relief … with each category of damage requested"). Even assuming TeamHealth Plaintiffs actually sought punitive damages on their unjust enrichment claim, because Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' unjust enrichment claims, TeamHealth Plaintiffs are not entitled to punitive damages on this theory, either.

Furthermore, as previously argued, unjust enrichment is a species of "quasi-contract." *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 380–81, 283 P.3d 250, 257 (2012))and therefore not a predicate tort for punitive damages. Accordingly, Nevada trial courts consistently find that punitive damages are not available for unjust enrichment claims. *E.g.*, *Gonor v. Dale*, 2015 WL 13772882, at *2 (Dist. Ct. Nev. July 16, 2015) ("To the extent that any claims for punitive damages against the Dale defendants (i.e. unjust enrichment detrimental reliance and quantum meruit) sound in contract, not in tort, such claim for punitive damages against the Date defendants is DENIED."); *Raider v. Archon Corp.*, 2015 WL 13446907, at *2 n.1 (Dist. Ct. Nev. June 19, 2015); *Hartman v. Silver Saddle Acquisition Corp.*, 2013 WL 11274332, at *3 (Dist. Ct. Nev. Jan. 28, 2013). Other jurisdictions are also in accord. *See Priority Healthcare Corp. v. Chaudhuri*, 2008 WL 4459041 *5 (M.D. Fla. 2008) ("Because unjust enrichment is not intended to be punitive, I find that punitive damages are not available under this theory"); *Moench v. Notzon*, 2008 WL 668612 *5 n.3 (Tex. Ct. App. 2008) (noting that "exemplary damages are not available for unjust enrichment"); *U.S. East Telecommunications, Inc. v. U.S. West Information Sys., Inc.*, 1991 WL 64461 *4 (S.D.N.Y. 1991) ("Neither are punitive damages available on an unjust enrichment cause of action."); *Edible Arrangements Int'l, Inc. v. Chinsammy*, 446 F. App'x 332, 334 (2d Cir. 2011) (punitive damages not allowed because a "claim of unjust enrichment is a quasi-contract claim for which the right to recovery is 'essentially equitable.'"); *Guobadia v. Irowa*, 103 F. Supp. 3d 325, 342 (E.D.N.Y. 2015) (no punitive damages for "unjust enrichment and other quasi-contract claims"); *Seagram v. David's Towing & Recovery, Inc.*, 62 F. Supp. 3d 467, 478 (E.D. Va. 2014) (same); *Conner v. Decker*, 941 N.W.2d 355 (Iowa Ct. App. 2019) (same); *Am. Safety Ins. Serv., Inc. v. Griggs*, 959 So. 2d 322, 332 (Fla. App. 2007) ("Unjust enrichment awards are not punitive, and allowing plaintiffs a recovery worth more than the benefit conferred would result in an unwarranted windfall."); *Dewey v. Am. Stair Glide Corp.*, 557 S.W.2d 643, 650 (Mo. App. 1977) ("Dewey's theory of recovery of actual damages is based on the contract theory of unjust enrichment. It is beyond question that punitive damages do not lie for a breach of contract. Thus, Dewey is not entitled to punitive damages.").

damages are not designed to compensate the victim of a tortious act but rather to punish and deter oppressive, fraudulent or malicious conduct."); *State Farm Mut. Auto Ins. Co. v. Campbell*, 538 U.S. 408, 419 (2003) (factors that indicate outrageous conduct: "the harm caused was physical as opposed to economic; the tortious conduct evinced an indifference to or a reckless disregard of the health or safety of others; the target of the conduct had financial vulnerability; the conduct involved repeated actions or was an isolated incident; and the harm was the result of intentional malice, trickery, or deceit, or mere accident").

In analyzing whether conduct is outrageous or reprehensible in a way that permits an award of punitive damages, economic harms are considered less reprehensible as threats to the "health or safety of others." *Bains LLC v. Acro Prods. Co.*, 405 F.3d 764, 775 (9th Cir. 2005); *see also Calloway v. Reno*, 116 Nev. 250, 993 P.2d 1259, 1267 (2000) ("Purely economic loss is generally defined as 'the loss of the benefit of the user's bargain … including … pecuniary damage for inadequate value, … or consequent loss of profits."). Also, "socially valuable task[s]" or "conduct that might have some legitimate purpose" is considered less reprehensible than conduct that is discriminatory. *Bains LLC*, 405 F.3d at 775.

The only harm for which TeamHealth Plaintiffs presented evidence is that they received less payment than they demanded as reimbursement for certain out-of-network emergency medicine services. There is no evidence that these "underpayments" threatened anyone's health or physical safety; to the contrary, the only harm appears to be purely economic, in that TeamHealth Plaintiffs' parent company and investors received less of a windfall than they might have anticipated. Moreover, the Defendants' motive in paying less than TeamHealth Plaintiffs' full billed charges was not "evil" or fraudulent—the only testimony on this subject consistently affirmed that Defendants intended to control skyrocketing healthcare costs for their clients and members. On the evidence presented, TeamHealth Plaintiffs cannot be awarded punitive damages on their Unfair Claims Practices Act claim as a matter of law.

1. Punitive Damages Cannot Be Applied Against UHS or UMR Because They Are Not Insurers

The only cause of action for which TeamHealth Plaintiffs contend the jury can award punitive damages is their claim under the Unfair Claims Practices Act. *See* JPTO at 5–6. As explained above, this Act applies only to insurers and not to administrators of self-funded health benefits plans. For that reason, punitive damages cannot be awarded against UHS or UMR, who are not insurers and cannot be liable under the Act.

2. Punitive Damages Cannot Be Awarded on a Cause of Action that Sounds in Contract

TeamHealth Plaintiffs cannot obtain punitive damages against ***any*** Defendant because their cause of action under the Unfair Claims Practices Act sounds in contract, not in tort. NRS 42.005 permits punitive damages only "in an action for breach of an obligation not arising from contract," and the Nevada Supreme Court has ruled that punitive damages cannot be awarded under NRS 42.005 where an action "sounds in contract, and not in tort." *Rd. Highway Builders, LLC v. N. Nev. Rebar, Inc.*, 284 P.3d 377, 384 (Nev. 2012); *see also Sprouse v. Wentz*, 105 Nev. 597, 602, 781 P.2d 1136, 1140 (1989) ("[P]unitive damages must be based on an underlying cause of action ***not based on a contract theory***." (emphasis added)). This prohibition applies not just to breach of contract claims, but broadly to any cause of action that "arises from" or "sounds in" contract. *Frank Briscoe Co. v. Clark County*, 643 F. Supp. 93, 100 (D. Nev. 1986) (breach of warranty claim cannot support an award of punitive damages); *e.g.*, *Desert Salon Servs., Inc. v. KPSS, Inc.*, No. 2:12–CV–1886 JCM (CWH), 2013 WL 497599, at *5 (D. Nev. Feb. 6, 2013) (contract-based causes of action for intentional interference with contractual relations, intentional interference with prospective economic advantage, and breach of the implied covenant of good faith and fair dealing cannot support an award of punitive damages); *Franklin v. Russell Rd. Food & Beverage, LLC*, No. 14A709372, 2015 WL 13612028, at *13 (Nev. Dist. Ct. June 25, 2015) (claims alleging failure to pay Plaintiffs Nevada's minimum wage do not "sound in tort, and in fact, are based on a contract theory").

It is undisputed that TeamHealth Plaintiffs' Unfair Claims Practices Act sounds in contract: they have ***conceded*** that their claim sounds in contract, and this Court ***agreed***. *See* Ps' Opp. to

Mot. to Dismiss at 25–26 (May 29, 2020); Order Denying Mot. to Dismiss FAC ¶ 68. For that reason alone, punitive damages cannot be awarded as a matter of law.[12] NRS 42.005.

Because TeamHealth Plaintiffs' Unfair Claims Practices Act claim sounds in contract, and because that claim is the ***only*** predicate for punitive damages in this case, TeamHealth Plaintiffs as a matter of law cannot recover punitive damages.[13]

Moreover, the ordinary way that a insurer in Nevada may be held liable for punitive damages in Nevada is through a tortious breach of the implied covenant of good faith and fair dealing in the insurance contract with its insured. *See, e.g.*, *Great Am. Ins. Co. v. Gen. Builders,*

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[12] Were this cause of action to sound in tort rather than contract as this Court has held, then TeamHealth Plaintiffs would have no standing to bring a cause of action under the Unfair Claims Practices Act. The Nevada Supreme Court has held on multiple occasions that NRS 686A.310 does not create a private right of action in favor of third-party claimants—as opposed to insureds—like TeamHealth Plaintiffs. *See, e.g.*, *Fulbrook*, 2015 WL 439598, at *4 ("This statute, however, does not provide a private right of action to third-party claimants."); *Gunny*, 108 Nev. at 346) ("[W]e conclude that [plaintiff] has no private right of action as a third-party claimant under NRS 686A.310."); *see also* Mot. to Dismiss FAC at 23–24. TeamHealth Plaintiffs are judicially estopped from now arguing that this claim sounds in tort after convincing this Court that the claim was based on contract.

[13] Nor is TeamHealth Plaintiffs' Unfair Claims Practices Claim akin to a breach of the covenant of good faith and fair dealing between a insurer and an insured. Not only did TeamHealth Plaintiffs expressly abandon such a claim, 11/22/2021 Tr. 310:20-22 ("We're not pursuing bad faith as a basis for punitive damages."), but such a breach—even if proved—would amount only to *contractual* bad faith, not the kind of *tortious* bad faith necessary to sustain a claim for punitive damages. That is, in fact, why punitive damages against insurers are generally only available in claims by their insureds with whom they have, rather than an arm's length relationship, a special relationship of trust. *See, e.g.*, *Great Am. Ins. Co. v. Gen. Builders, Inc.*, 113 Nev. 346, 354–56, 934 P.2d 257, 263 (1997). In *Great American Insurance Co.*, the Nevada Supreme Court explained that the breach in that situation is considered tortious because of the "inherently unequal bargaining positions" in the insurer-insured relationship, which is one of the "special relationships" creating duties akin to those of a fiduciary. *Id.* Absent that special relationship of trust and reliance, and where both parties are "experienced commercial entities represented . . . by professional and experienced agents," there is no tort liability to support a claim for punitive damages. *Id.* (vacating punitive damages award). Critically, the insurer's special relationship is specifically with its *insured*, not others to whom the insurer may owe contractual or other duties. *See Ins. Co. of the W. v. Gibson Tile Co., Inc.*, 122 Nev. 455, 462, 134 P.3d 698, 702 (2006). In *Insurance Co. of the West*, the Supreme Court held that an insurer acting as surety had no special relationship with its principal, so the insurer's breach was purely contractual, not tortious: "[t]herefore, as a matter of law, there was no basis for the jury's award of punitive damages." *Id.* at 464, 133 P.3d at 703.

Here, neither the Unfair Practices Act Claim nor the unjust enrichment claim is based on anything other than an arm's-length relationship between sophisticated parties. The fiduciary-like special relationship of trust applicable to the insurer-insured relationship is absent, and so is any tort that can sustain a claim for punitive damages.

Inc., 113 Nev. 346, 354–56, 934 P.2d 257, 263 (1997). In *Great American Insurance Co.*, the Nevada Supreme Court explained that the breach in that situation is considered tortious because of the "inherently unequal bargaining positions" in the insurer-insured relationship, which is one of the "special relationships" creating duties akin to those of a fiduciary. *Id.* Absent that special relationship of trust and reliance, and where both parties are "experienced commercial entities represented . . . by professional and experienced agents," there is no tort liability to support a claim for punitive damages. *Id.* (vacating punitive damages award). Critically, the insurer's special relationship is specifically with its *insured*, not others to whom the insurer may owe contractual or other duties. *See Ins. Co. of the W. v. Gibson Tile Co., Inc.*, 122 Nev. 455, 462, 134 P.3d 698, 702 (2006). In *Insurance Co. of the West*, the Supreme Court held that an insurer acting as surety had no special relationship with its principal, so the insurer's breach was purely contractual, not tortious: "[t]herefore, as a matter of law, there was no basis for the jury's award of punitive damages." *Id.* at 464, 133 P.3d at 703.

3. TeamHealth Plaintiffs Have Presented No Evidence of Oppression, Fraud, or Malice

NRS 42.005 requires "clear and convincing evidence" of "oppression, fraud or malice." NRS 42.005(1); *see also United Fire Ins. Co. v. McClelland*, 105 Nev. 504, 512, 780 P.2d 193, 198 (1989) (to obtain punitive damages, plaintiff must show evidence of "oppression, fraud, or malice"). Far from "clear and convincing" evidence, TeamHealth Plaintiffs have presented ***no*** evidence of fraud, oppression, or malice, that would permit a reasonable jury to award punitive damages under NRS 42.005.

a. No Evidence of Fraud

To prove fraud, TeamHealth Plaintiffs must prove (1) a false representation, (2) Defendants' knowledge or belief that the representation is false, (3) Defendants' intention to induce TeamHealth Plaintiffs' reliance on that representation, (4) TeamHealth Plaintiffs' justifiable reliance on the representation, and (5) damages. *Nev. State Educ. Ass'n v. Clark Cty. Educ. Ass'n*, 482 P.3d 665, 675 (2021).

TeamHealth Plaintiffs presented no evidence of any of these elements at trial, and therefore punitive damages cannot be awarded based on fraud. At most, TeamHealth Plaintiffs presented evidence that Defendants made some representations about FAIRHealth and Data iSight. *See* P363 (United Website Showing Fair Health Used as Benchmark); 11/3/2021 Tr. 27:24–37:4; 11/10/2021 Tr. 92:14–100:3, 104:6–109:23; 11/12/2021 Tr. 79:20–82:19, 85:6–88:6 (Mr. Haben's testimony that this P363 did not reveal any misrepresentations); P488 (United Healthcare Member Rights & Responsibilities Page). There is no evidence showing these representations were false, no evidence that TeamHealth Plaintiffs justifiably relied on these representations, and no evidence that these representations caused them to be harmed in any way. Indeed, TeamHealth Plaintiffs repeatedly argued to the jury that they had no choice but to treat Defendants' members by virtue of their legal obligations under EMTALA. *See, e.g.*, 11/2/2021 Tr. 30:7-31:10, 35:8-36:1 (opening argument discussing ER doctors' legal obligations under EMTALA); 11/15/2021 Tr. 154:14-21 (Dr. Scherr testifying to the same); 11/23/2021 Tr. 81:19-82:2 (Dr. Scherr disagreeing with Defendants' expert that ER providers are willing sellers because of EMTALA). Thus, representations about reimbursement criteria plainly could not have induced TeamHealth Plaintiffs to treat Defendants' members – by their own admission they had no such discretion.

The jury has discretion to award punitive damages only if it finds by clear and convincing evidence that the defendant was guilty of malice, fraud, or oppression in the conduct that provides the basis for liability. NRS 42.002. That is, to award punitive damages, the jury must find that Defendants acted fraudulently ***in their failure to negotiate*** equitable, fair, and prompt settlements in violation of the Unfair Claims Practices Act. The websites that TeamHealth Plaintiffs have offered into evidence have no connection with any failure to negotiate claims; those websites were published long before the dates of service on the At-Issue Claims. TeamHealth Plaintiffs therefore have not offered any evidence of fraud that could support an award of punitive damages.

b. No Evidence of Oppression or Malice

Oppression or malice requires that the defendant "knows of the probable harmful consequences of a wrongful act and willfully and deliberately fails to act to avoid those consequences." *Kinder Morgan Energy Partners, L.P. v. Claytor*, 130 Nev. 1205, *published at*

Nos. 60131, 60667, 2014 WL 7187204, at *4 (Nev. Dec. 16, 2014). To prove oppression or malice, TeamHealth Plaintiffs must prove "despicable conduct" that shows "a conscious disregard of the rights or safety of others." *Id.*; *see also Ainsworth v. Combined Ins. Co. of Am.*, 104 Nev. 587, 590, 763 P.2d 673, 675 (1988) (oppression is "a conscious disregard for the rights of others which constitute[s] an act of subjecting plaintiffs to cruel and unjust hardship"). Such "conscious disregard of the rights or safety of others" cannot, as a matter of law, include underpayments to TeamHealth Plaintiffs or their corporate parents, or a "strategy to terminate … contracts" with TeamHealth practice groups. *See* Ps' Resp. to Ds' Trial Br. re: Out-of-State Harms at 4. Such economic harms are not "reprehensible" in a way that could justify an award of punitive damages. *See Bains LLC*, 405 F.3d at 775.

TeamHealth Plaintiffs submitted no evidence that could support a finding of malice, fraud, or oppression. Indeed, there is no malice or oppression as a matter of law because Defendants ***paid*** the insurance claims at issue. *See Pioneer Chlor Alkali Co. v. Nat'l Union Fire Ins. Co.*, 863 F. Supp. 1237, 1250–51 (D. Nev. 1994) (acknowledging "difficulty constructing a factual situation where an insurer who violated [NRS 686A.310] could have done so with an oppressive or malicious intent yet not denied, or refused to pay, the claim"). Defendants cannot have had the "evil" state of mind required to prove malice or oppression—the only evidence concerning the states of mind of Defendants' executives shows that they were concerned about controlling costs for their clients and members, and this evidence concerns Defendants' out-of-network programs generally rather than the settlement of any particular At-Issue Claim. *See* 11/10/2021 Tr. 45:10–47:24 (Mr. Haben testified that Defendants' out-of-network programs are in place to help control costs and that they "continuously look at our out-of-network programs to make sure we're paying a fair and reasonable rate, and we're addressing costs."); 11/10/2021 Tr. 136:13–137:1 (Mr. Haben testified that Defendants reached out to Multiplan for help in controlling costs because "[c]lients were demanding better controls on medical costs, and they were looking for better solutions."); 11/11/2021 Tr. 23:21–24:4 (Mr. Haben testified that market intelligence revealed that Defendants were "behind our competitors" who were "doing a better job" to control client healthcare spend"); 11/15/2021 Tr. 199:14–23 (Mr. Ziemer testified that UMR has "a variety of programs under our

cost reduction and savings programs that are designed to help our clients control costs."); 11/12/2021 Tr. 215:22–23 (Ms. Paradise testified that "I'm focused on driving savings for the clients. I don't have accountability for any revenue related to the programs").

TeamHealth Plaintiffs both have failed to present evidence on a ***harm*** that could support punitive damages, and have failed to present evidence that Defendants had a state of mind that could support punitive damages.

Indeed, as discussed above, the very uncertainty of TeamHealth Plaintiffs' underlying claim that they have been underpaid precludes punitive damages. "In most instances, unless the insured would be entitled to a directed verdict on the underlying insurance claim, an arguable reason to deny the claim exists, precluding the imposition of punitive damages." 14A STEVEN PLITT ET AL., COUCH ON INSURANCE § 207:73 (3d ed. June 2021 update). As TeamHealth Plaintiffs cannot show such a clear entitlement to their billed charges, punitive damages are categorically improper.

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

TeamHealth Plaintiffs claim that Defendants breached an implied-in-fact contract under which they had agreed to pay TeamHealth Plaintiffs their full billed charges for all out-of-network services indefinitely into the future. None of the evidence presented at trial even begins to prove the existence of such a contract. "[A]n implied-in-fact contract exists where the conduct of the parties demonstrates that they (1) intended to contract; (2) exchanged bargained-for promises; and (3) the terms of the bargain are sufficiently clear." *Magnum Opes Constr. v. Sanpete Steel Corp.*, 129 Nev. 1135 (2013) (citing *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 379, 283 P.3d 250, 256 (2012)).[14] "The terms of an express contract are stated in words while those of

[14] Defendants cite *Magnum Opes* for its persuasive value, and its application of *Certified Fire*, not as precedent. NRAP 36(c)(3). Defendants note that this case has been cited by the Nevada Federal District Court as binding authority in this action. *See Fremont Emergency Servs. (Mandavia), Ltd. v. UnitedHealth Grp., Inc.*, 446 F. Supp. 3d 700, 705 (D. Nev. 2020).

an implied contract are manifested by conduct." *Smith*, 91 Nev. at 668, 541 P.2d at 664 (citing *Youngman v. Nev. Irrigation Dist.*, 70 Cal. 2d 240, 74 Cal. Rptr. 398, 449 P.2d 462 (1969)).

The evidence that TeamHealth Plaintiffs presented at trial shows that Defendants did ***not*** agree to pay them their full billed charges, and that Defendants in fact almost ***never*** paid their full billed charges. *See* 11/16/2021 Tr. 63:9-17 (Mr. Murphy testified that TeamHealth does "agree[] to discount to discount billed charges" to "get paid"); *id*. 65:17-22 (Mr. Murphy testified that reimbursement at less than billed charges was acceptable at time of claim submission); 11/17/21 Tr. 167:19-168:7 (Mr. Leathers, TeamHealth Plaintiffs' expert, testified that, prior to the period in dispute, Defendants paid TeamHealth Plaintiffs' full billed charges infrequently); 11/22/2021 Tr. 14-17 (Mr. Bristow testified that, prior to the period in dispute, Defendants paid TeamHealth Plaintiffs their full billed charges around 7% of the time). There is no evidence that Defendants intended to contract with TeamHealth Plaintiffs, no evidence that they promised to reimburse TeamHealth Plaintiffs at their full billed charges, and no evidence that Defendants agreed to any of the material terms of such of a contract. In fact, testimony from TeamHealth Plaintiffs' own former contract negotiator at trial explicitly contradicts TeamHealth Plaintiffs' contention that there was an implied-in-fact contract. 11/23/2021 Tr. 34:19-23 (Ms. Harris testifying that, once Fremont's contract with Sierra Health Plan of Nevada terminated, there was "no contract whatsoever between Sierra and Fremont."). Under these facts, judgment should be entered in Defendants' favor as a matter of law.

1. An Implied-in-Fact Contract Requires All Elements of Contract Formation

At the outset, an implied-in-fact contract has no different elements than an express written or oral contract, except that the elements are manifested by conduct and not words. "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." *Cashill v. Second Jud. Dist. Ct. of State ex rel. Cty. of Washoe*, 128 Nev. 887, 381 P.3d 600 (2012). Thus, TeamHealth Plaintiffs must show that the parties: "(1) intended to contract; (2) exchanged

bargained-for promises; and (3) the terms of the bargain are sufficiently clear." *Magnum Opes*, 129 Nev. 1135, No. 60016, 2013 WL 7158997 (Table), at *3.[15]

2. No Intent to Contract

TeamHealth Plaintiffs presented no evidence at trial that shows that any Defendants ever intended to enter into a contract with TeamHealth Plaintiffs—or any evidence that TeamHealth Plaintiffs intended to enter into a contract with Defendants. Without this evidence, their implied-in-fact contract cause of action fails as a matter of law. "To find a contract implied-in-fact, the fact-finder must conclude that the parties intended to contract." *Certified Fire*, 128 Nev. at 379–80, 283 P.3d at 256; *see also Smith*, 91 Nev. at 669, 541 P.2d at 665 (citing *Horacek v. Smith*, 33 Cal. 2d 186, 199 P.2d 929 (1948)) ("In order to prevail on the theory of a contract implied in fact, the court would necessarily have to determine that both parties intended to contract, and that promises were exchanged.").

There is no evidence on record on which a jury could conclude the parties intended to contract.[16] The bare fact that TeamHealth Plaintiffs provided services to Defendants' insureds does not evidence an intent to contract. In *Steele v. EMC Mortg. Corp.*, 129 Nev. 1154 (2013), *published at* 2013 WL 5423081, the Nevada Supreme Court affirmed summary judgment on a contract claim where the plaintiff did not present evidence that she entered into a contract with the defendant, but relied only on the defendant's acquiescence to the plaintiffs' supposed performance. *Id*. at *1 ("Although appellant presented evidence that EMC Mortgage accepted loan payments from appellant and communicated with appellant regarding the loan's status, this conduct alone does not manifest the parties' intent to bind appellant to the terms of the loan so as to give rise to an implied contract between EMC Mortgage and appellant.").[17] Similarly here, TeamHealth

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[15] *See supra* note 12.

[16] In fact, TeamHealth Plaintiffs successfully moved *in limine* to exclude evidence that categorically disproves the parties' intention to contract. *See* Mot. for New Trial at n.1 and Discovery Errors Sections I.B.1, I.C.1 (discussing excluded evidence regarding failed negotiations for network contract between TeamHealth Plaintiff Fremont and Defendants).

[17] Cited for persuasive value, not as precedent. NRAP 36(c)(3).

Plaintiffs rely solely on the facts that they performed out-of-network emergency medicine services, and that Defendants reimbursed them for those services on behalf of their plan members. 11/16/2021 Tr. 65:7-10 (Mr. Murphy testified that billed charges should be awarded because "[w]e perform the service"); 11/15/2021 Tr. 154:14-21 (Dr. Scherr only testified that they have to treat patients by operation of law); 11/10/2021 Tr. 25:24-28:5 (Mr. Haben testified that the allowed amount payable to providers "is defined by the benefit plan" and is not the billed charges); *id.* 33:22-34:2 (Mr. Haben testified that the allowed amount for out-of-network claims is paid based on what is "[d]efined in the benefit plan"); 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). That is not enough to show contract formation.

Testimony from TeamHealth Plaintiffs' own employees underscores that there was no intent to contract between the parties. 11/22/2021 Tr. 95:1-6 (Mr. Bristow, TeamHealth Plaintiffs' corporate representative, explained that TeamHealth Plaintiffs submitted claims from TeamHealth Plaintiff Fremont under the Tax Identification Number of TeamHealth Plaintiff Ruby Crest because "we [] want also [to] have access to that health plan contract with a group that's not contracted."); *id.* 99:18-22 (Mr. Bristow emailed his colleague suggesting to "sub-TIN all of the Fremont sites under the other Nevada entity that is not contracted, but is getting better reimbursement at Team Physicians of Mandavia); *id.* 106:21-107:3 (Mr. Bristow was informed that Ruby Crest was non-participating with Defendants, so there was no contract between the parties); 11/23/2021 Tr. 34:19-23 (Ms. Harris testifying that, once Fremont's contract with Sierra Health Plan of Nevada terminated, there was "no contract whatsoever between Sierra and Fremont.").

If anything, Defendants' prior conduct establishes that there was ***no agreement*** to pay the TeamHealth Plaintiffs' full billed charges. TeamHealth Plaintiffs submitted evidence detailing Defendants' payments for the thousands of At-Issue Claims, which shows that Defendants rarely paid TeamHealth Plaintiffs' full billed charges. P473. "[T]he fact of agreement may be implied from a course of conduct in accordance with its existence," but the course of conduct here implies exactly the opposite of what TeamHealth Plaintiffs contend. 17A C.J.S. Contracts § 375, at 425

(1963). This is not a case in which a contract is implied because the parties "repeatedly adhered to" the terms of a contract "in their previous course of dealing." *Reno Club v. Young Inv. Co.*, 64 Nev. 312, 334, 182 P.2d 1011, 1021 (1947). Defendants' course of conduct repeatedly repudiates any notion that Defendants agreed to pay TeamHealth Plaintiffs their full billed charges on each reimbursement claim for out-of-network emergency medicine services.

There is no evidence that shows Defendants communicated by word and deed that that they intended to contract with TeamHealth Plaintiffs at any specific reimbursement rate for the disputed emergency medicine services, much less the TeamHealth Plaintiffs' full billed charges. In fact, TeamHealth Plaintiffs successfully moved to exclude any such evidence of contract negotiations. *See* 10/20/21 Tr. at 17:21–24. Regardless, that Defendants may have been willing to contract with TeamHealth Plaintiffs, had they been willing to agree to different terms, does not evidence that Defendants did agree to any particular contractual terms. *See* 11/16/2021 Tr. 63:9-17 (Mr. Murphy testified that TeamHealth does "agree[] to discount to discount billed charges" to "get paid"); *id.* 65:17-22 (Mr. Murphy testified that a certain reimbursement less than billed based on a wrap arrangement was acceptable at time of claim submission). "With respect to contract formation, preliminary negotiations do not constitute a binding contract unless the parties have agreed to all material terms." *May v. Anderson*, 121 Nev. 668, 672, 119 P.3d 1254, 1257 (2005). There is no evidence of such an agreement here.

3. No Promises Exchanged

Another essential element of contract formation is that "promises were exchanged" through the parties' conduct. *Smith*, 91 Nev. at 669, 541 P.2d at 665 (citing *Horacek v. Smith*, 33 Cal. 2d 186, 199 P.2d 929 (1948)); *see also Certified Fire*, 128 Nev. at 379–80, 283 P.3d at 256 ("To find a contract implied-in-fact, the fact-finder must conclude that … promises were exchanged."); *Magnum Opes Constr. v. Sanpete Steel Corp.*, 129 Nev. 1135 (2013) (citing *Certified Fire*, 283 P.3d at 256) ("Turning to the parties' substantive arguments, an implied-in-fact contract exists where the conduct of the parties demonstrates that they … exchanged bargained-for promises.").[18]

[18] *See supra* note 12.

TeamHealth Plaintiffs presented no evidence at trial that shows the Defendants exchanged promises with TeamHealth Plaintiffs concerning the rate of payment for out-of-network emergency medicine services. 11/16/2021 Tr. 65:7-10 (Mr. Murphy testified that billed charges should be awarded because "[w]e perform the service"); 11/15/2021 Tr. 154:14-21 (Dr. Scherr only testified that they have to treat patients by operation of law); 11/10/2021 Tr. 25:24-28:5 (Mr. Haben testified that the allowed amount payable to providers "is defined by the benefit plan" and is not the billed charges); *id.* 33:22-34:2 (Mr. Haben testified that the allowed amount for out-of-network claims is paid based on what is "[d]efined in the benefit plan"). As discussed above, evidence of the parties' contract negotiations was excluded from evidence. TeamHealth Plaintiffs have not proved that Defendants exchanged promises.

4. No Meeting of the Minds on Material Terms

TeamHealth Plaintiffs also did not present any evidence at trial from which a jury could infer the terms of an implied-in-fact contract. "A valid contract cannot exist when material terms are lacking or are insufficiently certain and definite" for a court "to ascertain what is required of the respective parties" and to "compel compliance" if necessary. *Grisham v. Grisham*, 128 Nev. 679, 685, 289 P.3d 230, 235 (2012); *see also May*, 121 Nev. at 672, 119 P.3d at 1257 ("A valid contract cannot exist when material terms are lacking or are insufficiently certain and definite."). Here, there are at least two material terms that TeamHealth Plaintiffs did not established through evidence: price and contract term.

Price in particular is a material term to any contract for Defendants to pay TeamHealth Plaintiffs a specific rate for their services. Courts commonly find there to be no contract formation where the parties have not agreed to a price. *E.g.*, *Certified Fire*, 128 Nev. at 380, 283 P.3d at 256 ("There are simply too many gaps to fill in the asserted contract for quantum meruit to take hold. Precision never agreed to a contract for only design-related work, ***the parties never agreed to a price for that work***, and they disputed the time of performance." (emphasis added)); *Matter of Est. of Kern*, 107 Nev. 988, 991, 823 P.2d 275, 276–77 (1991) ("In the case at bar, several essential elements of a valid contract are missing. … [M]aterial terms such as subject matter, ***price***, payment terms, quantity, and quality are either altogether lacking or insufficiently certain and definite to

support specific performance." (emphasis added)). TeamHealth Plaintiffs did not present a shred of evidence that Defendants affirmatively agreed to pay them at the full billed charges or in any other amount. Indeed, within the span of this litigation they have changed their own view of what Defendants supposedly agreed to pay for out-of-network services. *See United Healthcare Ins. Co. v. Eighth Jud. Dist. Ct. in & for Cty. of Clark*, 489 P.3d 915 (Nev. 2021) (noting that "[t]he 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.").

Nor have Plaintiffs submitted any evidence of the duration or term of the implied-in-fact contract. To the contrary, TeamHealth Plaintiffs objected to Defendants questioning witnesses on this topic. *See* 11/10/2021 Tr. 168:22-169:4. TeamHealth Plaintiffs' position appears to be that the duration is indefinite—that Defendants somehow agreed to pay them at their full rates forever into the future. Yet TeamHealth Plaintiffs cannot point to a single piece of evidence that indicates anyone acting as an agent of the Defendants, by their actions, agreed to a specific term for this contract to persist in perpetuity. To the contrary, Defendants' witnesses have denied having agreed to any such term. 11/10/2021 Tr. 168:16–21 (testifying that the only contracts that Defendants enter into "need[] to be in writing on contractual paper that was drafted by our attorneys and approved and used and available through a database"); Joint Submission of Dep. Clips for Trial Record as Played on Nov. 12, 2021 39:21–41:23. In the context of an agreement to pay Plaintiffs' full billed charges, where payors and providers typically agree to far lower rates as part of network agreements that last only a few years, the contract duration is a material term of the contract. Without a meeting of the minds on that term, there can be no implied contract. *See Kern*, 107 Nev. at 991.

Based on the evidence at trial, any verdict finding that Defendants formed an implied-in-fact contract with TeamHealth Plaintiffs to pay their full billed charges for out-of-network emergency medicine services would be contrary law, and Defendants are entitled to judgment as a matter of law.

E. If the Court Disagrees that Defendants are Entitled to Judgment as a Matter of Law on TeamHealth Plaintiffs' Implied-in-Fact Contract Claims, Then TeamHealth Plaintiffs are Not Entitled to Judgment as a Matter of Law on their Unjust Enrichment Claims

As a matter of law, where, as here, a jury finds there is an enforceable contract between parties, the remedy of unjust enrichment is barred. The purpose of the remedy of unjust enrichment is to compensate a party that confers a benefit with reasonable expectation of payment and without an express agreement memorializing that expectation. Richard A. Lord, Williston on Contracts § 68:1, at 24 (4th ed. 2003). As comment e. to the Restatement (Third) of Restitution and Unjust Enrichment § 49 notes, the remedy of quantum meruit is "regarded in modern law" as an instance of "unjust enrichment rather than contract." This is well-established established in Nevada. *See, e.g.*, *Richey v. Axon Enters., Inc.*, 437 F. Supp. 3d 835, 849 (D. Nev. 2020) ("As a quasi-contract claim, unjust enrichment is unavailable when there is an enforceable contract between the parties."); *Leasepartners Corp. v. Robert L. Brooks Tr. Dated Nov. 12, 1975*, 113 Nev. 747, 756 (1997) ("The doctrine of unjust enrichment or recovery in quasi contract applies to situations where there is no legal contract but where the person sought to be charged is in possession of money or property which in good conscience and justice he should not retain but should deliver to another or should pay for.").

Here, the jury found there was an implied-in-fact contract between TeamHealth Plaintiffs and Defendants. 11/29/21 Special Verdict Form. TeamHealth Plaintiffs' unjust enrichment claims thus fail as a matter of law, and Defendants are entitled to judgment as a matter of law on those claims. *See* 12/6/2021 Tr. 51:13-18.

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

Neither the Insurance Code nor the Prompt Pay Act itself affords TeamHealth Plaintiffs a private right of action against Defendants. The Nevada Supreme Court has ruled that "the ***insurance commissioner alone has authority to enforce*** the insurance code," *Joseph v. Hartford Fire Ins. Co.*, No. 2:12–CV–798 JCM (CWH), 2014 WL 2741063, at *2 (D. Nev. June 17, 2014) (emphasis added), and that the Insurance Commissioner has "exclusive jurisdiction in regulating the subject of trade practices in the business of insurance." *Allstate Ins. Co. v. Thorpe*, 123 Nev.

565, 572, 170 P.3d 989, 994 (2007). No private right of action exists under the Prompt Payment Act. And even if it did, TeamHealth Plaintiffs are barred from asserting that right of action as a matter of law because they failed to exhaust available administrative remedies created by that Act.

1. TeamHealth Plaintiffs Have No Private Right of Action Under the Prompt Payments Act

No private right of action exists on the face of the Prompt Payments Act. The plain meaning of NRS 690B.012 is that an interest penalty will be imposed if an insurance company has determined that payment is owed, and failed to pay within thirty days. NRS 690B.012(4) ("If the approved claim is not paid within that period, the insurer shall pay interest on the claim … ."). The interest that accrues on the insurance claim acts as a punitive measure, which the Nevada Legislature has imposed on insurance companies to compel them to pay the policyholder's covered medical bills promptly. The statute does not impose any other liability onto insurers, and NRS 690B.012 does not create a private right of action even for policyholders, much less to third-party medical providers such as TeamHealth Plaintiffs.

If there were a private right of action implied in NRS 690B.012—and nothing in the text of the statute suggests there is—that right of action would belong to the ***insured***, not to TeamHealth Plaintiffs. The statute governs how an insurer approves and pays "a claim of its insured relating to a contract of casualty insurance." NRS 690B.012(1). The rights and duties of the statute therefore only accrue and flow to the policyholder, not to third-party medical providers. TeamHealth Plaintiffs are not insureds of Defendants under any contract, and they have repeatedly disclaimed any right to recover by standing in the shoes of insureds through an AOB. SAC at 2 n.1 (Plaintiffs "do not assert claims that are dependent on the existence of an assignment of benefits ("AOB") from any of Defendants' Members.").[19] TeamHealth Plaintiffs have no statutory standing to sue under the Prompt Payments Act, and Defendants are entitled to judgment as a matter of law.

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[19] If TeamHealth Plaintiffs were to rely on EOBs, their cause of action would be preempted by ERISA. *See supra* note 8.

Even if there was a private right of action of which TeamHealth Plaintiffs could avail themselves, TeamHealth Plaintiffs did not prove, nor did they even allege, that Defendants did not pay for the At-Issue claims within 30 days. 11/16/2021 Tr. 226:23-227:10 (Mr. Leathers testified that Defendants' data for the At-Issue Claims includes reimbursement amounts); *id.* 233:12-22 (Mr. Leathers testified that he analyzed claims that were allegedly underpaid as opposed to not paid). In fact, TeamHealth Plaintiffs' corporate representative expressly admitted that Defendants paid ***every single*** At-Issue claim within 30 days. 11/22/2021 Tr. 73:24-74:14. Instead, TeamHealth Plaintiffs' entire case hinged on whether Defendants paid an appropriate amount for each claim. Because TeamHealth Plaintiffs did not present any evidence showing a violation of the Prompt Pay Act, Defendants are entitled to judgment as a matter of law on this claim.

2. TeamHealth Plaintiffs Failed to Exhaust Administrative Remedies

Defendants asserted an affirmative defense of failure to exhaust administrative remedies, and the evidence shows that Plaintiffs did not exhaust the available administrative remedies for their Prompt Payment Act claim. "[A] person generally must exhaust all available administrative remedies before initiating a lawsuit, and failure to do so renders the controversy nonjusticiable. *Allstate*, 123 Nev. at 568, 571–72. Assuming the Prompt Payments Act creates a private right of action for third parties—notwithstanding the text and purpose of the statute—plaintiffs must first exhaust all available administrative remedies created by the Act.

The Insurance Code creates an administrative process that TeamHealth Plaintiffs were required to exhaust before coming to court. The Insurance Code allows a person to apply for a hearing of the Insurance Commissioner where that person is aggrieved by a "failure of the Commissioner to" enforce the Insurance Code. NRS 679B.310(2)(b); *see also Joseph*, 2014 WL 2741063, at *2 ("the insurance commissioner alone has authority to enforce the insurance code"). TeamHealth Plaintiffs were required to make such an application within 60 days of the alleged failure by Defendants to provide timely reimbursement. *See id.* On such an application, the Insurance Commission holds a hearing and makes a decision that can be appealed. NRS 679B.310 (4)–(5); NRS 679B.370. Within 30 days of an adverse final ruling rendered by the Insurance Commissioner, the TeamHealth Plaintiffs had the option of seeking judicial review of the

Commissioner's decision. NRS 233B.130; *see also* NRS 233B.133 (outlining briefing process for judicial review).

TeamHealth Plaintiffs presented no evidence that they complied with any of this administrative process. TeamHealth Plaintiffs have not alleged or proven exhaustion of the available administrative remedies, Defendants are entitled to judgment as a matter of law on TeamHealth Plaintiffs' claim under the Prompt Payments Act.

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).

III. CONCLUSION

For the foregoing reasons, this Court should grant Defendants judgment as a matter of law on all causes of action.

Dated this 6th day of April, 2022.

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CERTIFICATE OF SERVICE

I hereby certify that on the 6th day of April, 2022, a true and correct copy of the foregoing "**DEFENDANTS' RENEWED MOTION FOR JUDGMENT AS A MATTER OF LAW"** was electronically filed and served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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DISTRICT COURT
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FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs,	Case No.: A-19-792978-B Dep't 27 **(HEARING REQUESTED)** **MOTION FOR NEW TRIAL**

LEWIS ROCA

vs.

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

Defendants.

Defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services Inc. ("UHS", which does business as UnitedHealthcare or "UHC" and through UHIC), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Company ("SHL"), and Health Plan of Nevada, Inc. ("HPN") (collectively, "Defendants"), by and through their attorneys, hereby submit this Motion for New Trial ("Motion"), accompanied by a motion for leave to exceed thirty (30) page limit set forth in EDCR 2.20(a).

TABLE OF CONTENTS

TABLE OF CONTENTS
(continued)

Page

TABLE OF CONTENTS
(continued)

Page

TABLE OF CONTENTS
(continued)

Page

TABLE OF AUTHORITIES

Page

Cases

TABLE OF AUTHORITIES
(continued)

Page(s)

TABLE OF AUTHORITIES
(continued)

Page(s)

TABLE OF AUTHORITIES
(continued)

Page(s)

TABLE OF AUTHORITIES
(continued)

Page(s)

TABLE OF AUTHORITIES
(continued)

Page(s)

Statutes

Other Authorities

TABLE OF AUTHORITIES
(continued)

Page(s)

Overview

The grounds for new trial asserted in this Motion are broadly categorized as follows: (1) those emanating from discovery errors; (2) those attributable to errors occurring during the course of, or lead-up to, trial; and (3) those based on jury instruction errors.[1] While these errors are cumulative of one another, this Motion will address those three categories in turn.

Grounds for a New Trial Emanating from Discovery Errors

Introduction

Defendants have been prejudiced at virtually every turn of this lawsuit. From the outset, the Court made numerous errors of law in its discovery orders. Those orders—which denied almost every single category of documents on which TeamHealth Plaintiffs[2] refused to produce documents, and on which Defendants moved to compel—prevented Defendants from obtaining documents and testimony that were critical to their defenses and relevant to TeamHealth Plaintiffs' causes of action.

When trial approached and the time came for the Court to rectify these mistakes through the parties' motions *in limine*, the Court failed to rectify those errors. Instead, it committed numerous evidentiary errors. Those evidentiary errors warrant a new trial under NRCP 59(a)(1)(G) because they constituted errors of law occurring at trial that substantially prejudiced Defendants—indeed,

[1] For internal *infra* and *supra* citations, these broad categories will be referred to as "Discovery Errors," "Course of, or Lead-Up to, Trial Errors," and "Jury Instruction Errors." For example, citations would appear as follows: *infra* Discovery Errors Section I.A.; or *supra* Course of, or Lead-Up to, Trial Errors Section I.A.1. This motion does not address every ground for new trial that may be raised on appeal, and Defendants do not waive any objection merely because of its omission from this motion. *See Rives v. Farris*, 138 Nev., Adv. Op. 17, at *10, ___ P.3d ___, ___ (Mar. 31, 2022) ("a party is not required to file a motion for a new trial to preserve the party's ability to request such a remedy on appeal for harmful error to which the party objected").

[2] TeamHealth Plaintiffs" collectively refers to the three Plaintiffs that initiated this action, each of which is owned by and affiliated with TeamHealth Holdings, Inc. ("TeamHealth"): Fremont Emergency Services (Mandavia), Ltd. ("Fremont"), Team Physicians of Nevada-Mandavia, P.C. ("TPN"), and Crum, Stefanko and Jones, Ltd. d/b/a Ruby Crest Emergency Medicine ("Ruby Crest").

they fundamentally eviscerated Defendants' defenses and deprived the jury of critical facts relevant to the case.

This Motion concerns two sets of motions *in limine* through which the Court committed errors of law that prejudiced Defendants from receiving a fair trial. ***First***, the Court mischaracterized and misapplied its discovery orders with respect to seven topics of evidence that were relevant to the parties' claims and defenses at trial:

1. Improper submission of claims;
2. Rates that are probative of the reasonableness of Defendants' rates and TeamHealth Plaintiffs' billed charges, including the parties' negotiations about entering into provider participation agreements;
3. Provider participation agreements that TeamHealth Plaintiffs had with Defendants and other payers;
4. TeamHealth Plaintiffs' costs of rendering the at-issue emergency medicine services;
5. How TeamHealth Plaintiffs set their billed charges;
6. TeamHealth Plaintiffs' corporate flow of funds; and
7. Absence of record evidence regarding TeamHealth Plaintiffs' balancing billing practices.

Through its motions *in limine* rulings, the Court improperly expanded or otherwise misinterpreted its prior discovery orders to prevent Defendants from presenting evidence and argument at trial that upend the central premise of TeamHealth Plaintiffs' case-in-chief: that Defendants' reimbursements of emergency medicine services rendered by physicians contracted by TeamHealth Plaintiffs were unreasonable. The areas of evidence denied (or, in the case of balance billing arguments, improperly admitted) all prejudiced Defendants and impeded their ability to support numerous affirmative defenses; evidence pertaining to those defenses would have allowed the jury to determine whether TeamHealth Plaintiffs' full billed charges under which TeamHealth

Plaintiffs sought reimbursement were unreasonable. But the Court's erroneous motions *in limine* decisions deprived the jury from considering such evidence.

Second, the Court also made two erroneous motions *in limine* rulings that did not directly concern its prior discovery orders but, ultimately, prejudiced Defendants:

8. Improper exclusion of evidence regarding reference from FAC regarding special relationship between TeamHealth Plaintiffs and Defendants; and
9. Improper inclusion of evidence regarding references to Defendants' conduct after the relevant time period for discovery and evidence.

These rulings prejudiced Defendants' ability to get a fair trial because they influenced the extent of damages that the jury awarded TeamHealth Plaintiffs, including punitive damages, that would not have been awarded but for the Court's erroneous rulings.

The Court's erroneous evidentiary rulings prevented them from presenting centrally relevant evidence relating to the claims and defenses in this lawsuit, including about how TeamHealth Plaintiffs set their full billed charges on which TeamHealth Plaintiffs sought damages; evidence about whether those full billed charges constituted "reasonable value"; evidence of TeamHealth Plaintiffs' prior network contracts with Defendants; evidence of TeamHealth Plaintiffs' decision to terminate those contracts as a negotiating strategy; and evidence that would have allowed Defendants to present alternative damages arguments to the jury. Indeed, the double standard created by many of the Court's evidentiary rulings created a patently unfair outcome that created lopsided evidence in TeamHealth Plaintiffs' favor, depriving Defendants of any iota of fairness throughout the trial. The Court should grant a new trial.

Legal Argument

A court may grant a motion for a new trial on various grounds "materially affecting the substantial rights of the moving party." NRCP 59(a)(1). Those grounds include among other things an "error in law occurring at the trial and objected to by the party making the motion." NRCP 59(a)(1)(G); *see Pizarro-Ortega v. Cervantes-Lopez*, 133 Nev. 261, 269 (2017); *Bass-Davis v. Davis*, 122 Nev. 442, 453 (2006). Additionally, a new trial may be granted if there was an "irregularity in the proceedings of the court, jury, master, or adverse party or in any order of the

court or master, or any abuse of discretion by which either party was prevented from having a fair trial." NRCP 59(a)(1)(A). An abuse of discretion can occur when the district court misinterprets controlling law. *MB Am., Inc. v. Alaska Pac. Leasing*, 132 Nev. 78, 88 (2016); *Gunderson v. D.R. Horton, Inc.*, 130 Nev. 67, 80, 319 P.3d 606, 615 (2014) (holding that a decision made "in clear disregard of the guiding legal principles [can be] an abuse of discretion").

Moreover, courts are permitted to view errors that occurred cumulatively in order to grant a new trial. *Harper v. Los Angeles*, 533 F.3d 1010, 1030 (9th Cir. 2008) (cumulative effect of evidentiary errors basis for new trial). As the Nevada Supreme Court has observed, trial errors that in isolation can sometimes be characterized as "harmless" may, when considered together, prove to be sufficiently prejudicial that a new trial is required. *See, e.g.*, *Pertgen v. State*, 110 Nev. 554, 566, 875 P.2d 361, 368 (1994), abrogated on other grounds by *Pellegrini v. State*, 117 Nev. 860, 34 P.3d 519 (2001); *see also Nelson v. Heer*, 123 Nev. 217, 227, 163 P.3d 420, 427 (2007) (leaving open the question whether the doctrine of cumulative error applies in civil cases).

I.
THE COURT'S EVIDENTIARY RULINGS THAT IT PURPORTED TO BASE ON PRIOR DISCOVERY RULINGS CONSTITUTED ERRORS OF LAW THAT DEPRIVED DEFENDANTS FROM RECEIVING A FAIR TRIAL

A. DEFENDANTS WERE PREJUDICED BY THE COURT'S PROHIBITION OF EVIDENCE ABOUT TEAMHEALTH PLAINTIFFS' IMPROPER CODING AND CLAIMS SUBMISSIONS

In denying Defendants the ability to make a presentation on TeamHealth Plaintiffs' improper coding and claims submissions, the Court prevented Defendants from asserting one of their key defenses and presenting valuable evidence concerning the true and accurate TeamHealth Plaintiffs' services. The Court denied Defendants the opportunity to make this presentation and defense first when it denied discovery into TeamHealth Plaintiffs' clinical records, which can evidence of improper coding and claims submissions. And the Court expanded upon this error by denying Defendants the opportunity to present any evidence concerning claims submissions and coding practices at trial. For these reasons, Defendants are entitled to a new trial on all claims.

On October 26, 2020, the Court ruled that TeamHealth Plaintiffs' clinical records were not discoverable. October 26, 2020 Order at 6 ¶ 18. Specifically, the Court ruled that clinical records

were not relevant because there was no dispute as to whether the disputed claims were allowed and allowable at the CPT code submitted and later adjudicated. *Id.* As Defendants noted in their Opposition to TeamHealth Plaintiffs' MIL No. 3, Defendants did not seek to offer clinical records into evidence at trial. Defs.' Opp. to Pls.' MIL No. 3 at 6. Nevertheless, Defendants' position is that that Order—like virtually every order denying Defendants necessary evidence to defend their case—was incorrect and prejudiced Defendants by preventing them from obtaining clinical records during discovery, for the reasons stated in Defendants' September 21, 2020 Motion to Compel—namely, that without TeamHealth Plaintiffs' clinical records, Defendants were prejudiced throughout this lawsuit because they were unable to rebut TeamHealth Plaintiffs' claims that the services for which they seek additional reimbursement were actually performed as billed and whether there were errors in TeamHealth Plaintiffs' claims data.

The Court then erred once again by granting TeamHealth Plaintiffs' MIL No. 3 and preventing Defendants from introducing *any* evidence or argument a number of relevant topics that relate to the reasonableness of TeamHealth Plaintiffs' billed charges. Those topics include: (i) that the disputed claims were improperly reported and coded; (ii) that those claims were not even submitted to Defendants; and (iii) that the services billed in those claims were not emergency medicine services. Defs.' Opp. to Pls.' MIL No. 3 at 6-7. The Court did not explain its reason for expanding the scope of its October 26, 2020 Order from the discoverability of clinical records to *any* argumentation and evidence about TeamHealth Plaintiffs' improper coding and claims submissions. 10/19/21 Tr. 201:3-14.

While a court's decision to admit or exclude evidence is within its discretion, *M.C. Multi-Family Dev., L.L.C. v. Crestdale Assocs., Ltd.*, 124 Nev. 901, 913 (2008), the Court abused its discretion by improperly expanding the scope of its discovery order on clinical records, which had nothing to do with the admissibility of evidence or argumentation concerning TeamHealth Plaintiffs' improper coding, improper submissions, and submissions of non-emergency medicine services that do not rely on the clinical records. By prohibiting this evidence, Defendants were prejudiced by being prevented from presenting critical data that would have allowed the jury to determine whether TeamHealth Plaintiffs' full billed charges in fact represented the "reasonable

value" of the emergency medicine services and whether there are any disputed claims that should not have been included in this lawsuit. Defendants were also prejudiced because this evidence was critical to support Defendants' affirmative defenses, including their affirmative defenses that TeamHealth Plaintiffs' claims are subject to setoff and/or recoupment with respect to claims for which Defendants made payment on the basis of CPT or other billing codes and TeamHealth Plaintiffs' billed charges, that TeamHealth Plaintiffs submitted claims to the wrong entity, and that they have been unjustly enriched by being awarded damages for services that are out-of-scope. *See* Joint Pre-Trial Memorandum ("JPTO") at 7-9. And Defendants were further prejudiced because the jury was left with the impression that every disputed claim for which it awarded damages was within the scope of TeamHealth Plaintiffs' Second Amended Complaint ("SAC") when, in fact, Defendants were prevented from collecting discovery, and introducing evidence, concerning the improper coding and submission of health benefit claims.

First, a new trial is a warranted because Defendants were prevented from introducing evidence that TeamHealth and its affiliates engaged in a fraudulent scheme to "upcode" the disputed services and unjustly enrich themselves at Defendants' expense. Improper coding, or "upcoding," occurs when a healthcare provider submits a claim for a CPT code corresponding to a service with a higher reimbursement rate than that of the service that the provider actually rendered. The Centers for Medicare and Medicaid Services ("CMS") describes upcoding as "abuse" of the medical billing system that results in "improper payments." Exhibit to Defendants' Opp. to Plaintiffs' MIL No. 3 (hereinafter "Opp. Exhibit") 3, Medical Learning Network, Medicare Fraud & Abuse: Prevent, Detect, Report (Jan. 2021), at 7, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf.

Defendants sought to introduce expert testimony to demonstrate that TeamHealth and its affiliates disproportionately and systematically submitted claims coded at the highest intensity levels for purposes of inflating TeamHealth Plaintiffs' reimbursements from Defendants. MSJ Exhibit 41, Revised Initial Report of Bruce Deal, attached as Appendix C to August 31, 2021 Expert Rebuttal Report of Bruce Deal, ¶ 14, fig. 1 ("Deal Revised Rep."). By way of example, ***TeamHealth Plaintiffs' own expert witness***, Scott Phillips, agreed in his expert report that the

amount of reimbursement for the disputed claims is higher for claims coded at higher intensity levels, and his expert report documents his analysis of the coding intensity relating to the disputed claims. MSJ Exhibit 42, Expert Report of Scott Phillips ("Phillips Rep.") at 17, Ex. 4; *see also* Opp. Exhibit 1, August 31, 2021 Expert Rebuttal Report of Scott Phillips ("Phillips Rebuttal Rep.") at 9, Ex. 12; Opp. Exhibit 2, Dep. of Scott Phillips ("Phillips Dep.") at 189:24-190:13 (Sept. 17, 2021). Defendants also sought to use this evidence to support their Sixth Affirmative Defense, which alleges that "[s]ome or all of Plaintiffs' billed charges are excessive under the applicable standards." JPTO at 7 (Sixth Affirmative Defense). Such inflation is unquestionably probative of whether TeamHealth Plaintiffs' full billed charges on which TeamHealth Plaintiffs obtained damages represented the "reasonable value" of any given emergency medicine service rendered under an upcoded CPT code. Be it through TeamHealth and its affiliates' inflation of the charges billed through this fraudulent upcoding scheme, TeamHealth Plaintiffs were able to present a topline damages value to the jury that, in many instances, was tainted with CPT codes that did not correspond to the actual services they provided. Defendants were prejudiced, moreover, because such evidence would have been compelling in support of their affirmative defense that "TeamHealth Plaintiffs' claims are subject to setoff and/or recoupment with respect to claims … that TeamHealth Plaintiffs' clinical records of their patients' care reveal to have been improperly submitted, either because TeamHealth Plaintiffs' clinical records do not support submission of the codes at all, or because TeamHealth Plaintiffs' clinical records establish that different codes should have been submitted." JPTO at 9 (Twentieth Affirmative Defense).

Second, the Court prevented Defendants from presenting to the jury expert testimony that TeamHealth Plaintiffs sought damages for health benefit claims it improperly submitted—or never even submitted—to Defendants for reimbursement. Evidence presented at trial demonstrated that TeamHealth Plaintiffs did not submit 491 claims found in PX 473, the at-issue claims list created by TeamHealth Plaintiffs, to Defendants. 11/18/2021 Tr. 215:12-217:18, 218:14-23, 226:14-227:4, 254:8-12, 263:8-264:7.

Defendants should have been permitted to offer evidence that some of the disputed benefit claims for which TeamHealth Plaintiffs seek damages were not submitted to any Defendant and

allow TeamHealth Plaintiffs to consider reducing any topline damages figure by the amounts represented by these "non-Defendant" claims. Instead, the jury granted damages relating to the disputed claims in the aggregate, necessarily reflecting that Defendants were prejudiced because they were likely made to pay damages in connection with reimbursement claims that were never submitted to them and are therefore outside the scope of TeamHealth Plaintiffs' SAC. Evidence contesting that some of the disputed claims, or portions of those disputed claims, were not in the scope of this case was clearly relevant to Defendants' affirmative defense that "TeamHealth Plaintiffs' claims are barred, in whole or in part, to the extent TeamHealth Plaintiffs failed to sue the appropriate entity." JPTO at 8 (Eighteenth Affirmative Defense). Indeed, the Court's October 26 Order inhibited Defendants' experts' analysis of market analyses, coding trend analyses, and their examination of TeamHealth Plaintiffs' inflated billed charges. That October 26, 2020 Order—while in of itself err— says nothing whatsoever about the admissibility of evidence that TeamHealth Plaintiffs did not submit certain benefit claims to these Defendants; that Order dealt strictly with whether clinical records related to the disputed claims were discoverable.

Third, TeamHealth Plaintiffs sought to preclude any evidence or argumentation in their MIL No. 3 about TeamHealth Plaintiffs' submission of claims for non-emergency services. The Court granted that requested, once again based on the October 26 Order. *See generally* October 26, 2020 Order. Of course, the October 26 Order had to do with the discoverability of clinical records. But the Court prevented Defendants from introducing evidence from both of TeamHealth Plaintiffs' expert witnesses that some of the At-Issue Claims do not reflect any emergency services. *See* Opp. Exhibit 2, Phillips Dep. at 208:3–14; *id.* at 240:21–25; Opp. Exhibit 4, Dep. of David Leathers ("Leathers Dep.") at 241:16–24 (Sept. 15, 2021); *see also* Defendants' Omnibus Offer of Proof (Nov. 22, 2021) at 183-186. Because TeamHealth Plaintiffs' disputed claims spreadsheet did not break out each claim service-by-service, there was no way for the jury to separate how much of the billed charges were for emergency claims versus non-emergency claims. *See* Defs.' Objection to Report and Recommendation No. 7 at 9. Defendants should have been permitted to offer evidence and argumentation about this issue because TeamHealth Plaintiffs' themselves limited the allegations in the SAC to Defendants' payments for out-of-network emergency medicine services.

See SAC ¶ 15. Instead, Defendants were prejudiced because the jury very likely granted damages for non-emergency services, and Defendants therefore were unable to make arguments in support of their affirmative defense that TeamHealth Plaintiffs were "unjustly enriched." JPTO at 7 (Twelfth Affirmative Defense).

The jury may have returned a different verdict had they known that TeamHealth and its affiliates engaged in a fraudulent upcoding scheme related to claims at issue in this lawsuit, had they known that hundreds of underlying claims for reimbursement were never even submitted to any Defendant, or that hundreds of those claims were not even for emergency services. The Court's unjust and unfair refusal to allow Defendants to present relevant evidence warrants a new trial.

B. THE COURT ERRED BY PROHIBITING EVIDENCE AND ARGUMENTATION ON REIMBURSEMENT RATES THAT INFORM WHAT A WILLING BUYER AND SELLER WOULD CONSIDER REASONABLE

Starting with multiple discovery orders and continuing through trial, the Court has improperly restricted the evidence relevant to this "reasonable value" case. The Nevada Supreme Court, and other sources of precedent and authority, all contemplate a broad presentation of evidence touching on reasonable value. *See Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371 (2012). Factors that are routinely considered, set forth in the Restatement (Third) of Restitution and Unjust Enrichment—which Nevada has adopted, *Koebke v. Koebke*, 476 P.3d 926, 2020 WL 6955291, at *2 (Nev. App. Nov. 25, 2020), and which informs TeamHealth Plaintiffs' unjust enrichment cause of action—include the value of the benefit in advancing the purposes of the defendant, the cost to the claimant of conferring the benefit, the market value of the benefit, and a price the defendant has expressed a willingness to pay, if the defendant's acceptance of the benefit may be treated as valid on the question of price. Restatement (Third) of Restitution and Unjust Enrichment § 49(3); *see also Certified Fire*, 128 Nev. at 380 n.3 (citing the Restatement and noting that "market value" is relevant to liability in restitution). Indeed, it is well established that "reasonable value" encompasses many factors: the Nevada Supreme Court has held that prior contracts, offers, "market value," and "***any other evidence*** regarding the value of services," may be considered to determine the "reasonable value" of services. *Las Vegas Sands Corp. v. Suen*, 2016 WL 4076421, at *4 (Nev. July 22, 2016) (emphasis added). Yet the Court instead denied first

discovery and then presentation of evidence of the full panoply of evidence relevant to reasonable value. As a result the jury heard an improperly limited and slanted presentation of evidence that omitted many categories that the law requires. As a result, Defendants are entitled to a new trial.

This is a case about the reasonable value of Defendants' reimbursement rates of TeamHealth Plaintiffs' health benefit claims and whether TeamHealth Plaintiffs' full billed charges reflect reasonable value. Defendants should have been able to examine the reasonableness of TeamHealth Plaintiffs' full billed charges. By preventing any real argument or evidence about the factors that the jury could consider to determine whether TeamHealth Plaintiffs' charges were reasonable, the Court effectively sanctioned TeamHealth Plaintiffs' carte-blanche ability to set whatever rates they want, and demand that they be reimbursed the entirety of their charges, regardless of whether their full billed charges were reasonable in the first place. In other words, the jury was left with the impression that Defendants' reimbursement rates of those charges were unreasonable, despite evidence produced in this case that Defendants' reimbursement rates far exceeded what Defendants paid Fremont when they were in-network prior to the relevant time period for the current dispute.

Evidence of other rates that inform what a willing buyer and seller would pay for a service in a given market is clearly relevant to the reasonableness of TeamHealth Plaintiffs' billed charges. *Suen*, 2016 WL 4076421, at *4. For instance, "customary method[s] and rate[s] of compensation" may be considered when analyzing a service's "reasonable value." *Flamingo Realty, Inc. v. Midwest Dev., Inc.*, 110 Nev. 984, 988, 879 P.2d 69, 71 (1994). California and other courts are in accord. *E.g. Children's Hosp.*, 226 Cal. App. 4th at 1278, 172 Cal. Rptr. 3d at 875 ("All rates that are the result of contract or negotiation, including rates paid by government payors, are relevant to the determination of reasonable value."); *In re N. Cypress Med. Ctr. Operating Co., Ltd.*, 559 S.W.3d 128, 132–33 (Tex. 2018) (examining multiple cases that look at factors other than the charge itself when evaluating the reasonableness of billed charges); *see also* Keith T. Peters, "What Have We Here? The Need for Transparent Pricing and Quality Information in Health Care: Creation of an SEC for Health Care," 10 J. HEALTH CARE L. & POL'Y 363, 366 (2007) ("The price of a particular provider's services depends on many factors including geography, experience, location, government payment methods, and the desire to make a profit."). Ultimately, the most probative evidence is

that which reveals "the price that would be agreed upon by a willing buyer and a willing seller negotiating at arm's length." *Children's Hosp. Central Cal. v. Blue Cross of Cal.*, 226 Cal. App. 4th 1260, 1275 (Cal. Ct. App. 2014).

Moreover, this evidence was relevant because TeamHealth Plaintiffs placed Defendants' state of mind at issue. In particular, counsel for TeamHealth Plaintiffs have sought a broad scope of admissible evidence for "state of mind, which is always relevant with respect to punitive damages." Tr. 10/22/2021 119:15–17 (argument of K. Gallagher). That places squarely at issue whether Defendants believed the rates they paid were reasonable or whether low rates were paid with a malicious and oppressive intent to harm TeamHealth Plaintiffs. Yet the Court prevented evidence or argumentation concerning what Defendants believe to be a reasonable rate of payment, why Defendants believe that to be a reasonable rate, and how Defendants calculate a reasonable rate of payment, in a case where a central issue is Defendants' state of mind when Defendants set a rate of payment for 11,584 claims for reimbursement.

Defendants should have been permitted to present evidence and argumentation that could have provided the jury with bases for comparing TeamHealth Plaintiffs' inflated and unreasonable charges to charges for similar services in the market, including the amounts that TeamHealth Plaintiffs themselves routinely accept from other health insurers for the exact same services as the disputed claims. This includes (i) amounts that they routinely accept through Medicare, and (ii) amounts that they contractually agreed to accept from other health insurers, including many of Defendants' primary competitors. (The amounts that Fremont agreed to accept in previously agreed-to provider participation agreements with Defendants are also probative of whether Defendants' reimbursement rates for the disputed claims, *see infra* at I.C.) Defendants were therefore prejudiced by the Court's prohibition on argumentation about this relevant evidence that would have supported numerous of Defendants' affirmative defenses, including their defense that "[s]ome or all of TeamHealth Plaintiffs' billed charges are excessive under the applicable standards." JPTO at 8 (Sixth Affirmative Defense). And Defendants were prejudiced by the Court preventing them from introducing their expert witness testify about the relevance of Medicare and

in-networks rates to determine the relevant market, which is central to the reasonableness of Defendants' rates.[3]

1. Rates Offered Through the Parties' Network Negotiations, Including Medicare Rates

On November 9, 2020, the Court ruled that TeamHealth Plaintiffs should not produce claims data relating to Medicare and Medicaid reimbursements. Nov. 9, 2020 Order ¶ 4. In so holding, this Court expressly stated that "[n]otwithstanding the foregoing, the Court does not make any admissibility ruling" regarding Medicare rates. *Id.* The Court then misunderstood that Order when at trial it granted TeamHealth Plaintiffs' request through their MIL No. 3 to preclude *all* evidence or argumentation that Medicare informs what a willing buyer and seller would consider reasonable reimbursement, that Medicare functions as a prime rate in the health care industry, and that Defendants' official corporate position was that reasonable value is Medicare plus a small margin. *See* 10/19/21 Tr. 208:21-209:2.

This determination was erroneous because evidence of Medicare and Medicaid rates[4] satisfy the low burden for relevant evidence at trial. NRS 48.015 (relevant evidence is any evidence that 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"). As noted above, "[a]ll rates that are the result of contract or negotiation, including rates paid by government payors, are relevant to the determination of reasonable value." *Children's Hosp.*, 226 Cal. App. 4th at 1278. In a case predicated on a breach of the implied-in-fact contract that TeamHealth Plaintiffs argued was formed based on rates that the parties negotiated as a percentage of Medicare, it simply makes no sense that Defendants were prevented from arguing that Medicare rates are a relevant metric that

[3] In the antitrust context, the relevant market is composed of products or services "that have reasonable interchangeability for the purposes for which they are produced – price, use and qualities considered." *Oltz v. St. Peter's Comm. Hosp.*, 861 F.2d 1440, 1446 (9th Cir. 1988); *IGT v. Alliance Gaming Corp.*, 2010 WL 4867555, at *3 (D. Nev. Nov. 29, 2010) (quoting *United States v. E.I. dupont de Nemours & Co.*, 351 U.S. 377, 404 (1956)).

[4] This includes evidence of managed Medicare and Medicaid reimbursement rates. The Court's November 9, 2020 Order specifically rejected a sentence from TeamHealth Plaintiffs' proposed order suggesting that managed Medicare and Medicaid reimbursement rates are "unrelated" to TeamHealth Plaintiffs' claims. November 9, 2020 Order ¶ 4.

factors into reasonableness. Indeed, ***TeamHealth Plaintiffs conceded that the Medicare fee schedule informed TeamHealth's setting of the at-issue charges.*** Opp. Exhibit 54, Dep. of Kent Bristow ("TPN NRCP 30(b)(6) Dep.") at 283:21-284:6.

Indeed, there is an enormous bulk of evidence in the record that TeamHealth Plaintiffs used Medicare rates as the basis for their negotiations with Defendants relating to a new network participation agreement. *See, e.g.*, MSJ Exhibit 41, Deal Revised Rep. ¶ 31, n.63; *see also* Opp. Exhibit 5, FESM003066; Opp. Exhibit 6, FESM000662–664; Opp. Exhibit 7, DEF010896; Opp. Exhibit 8, FESM003226–228. They also routinely used Medicare in their internal correspondence as a benchmark for measuring their collection rates and revenue, and even demanded that Defendants express their contractual offers as a percentage of Medicare. *E.g.*, Opp. Exhibit 9, FESM004086; Opp. Exhibit 5, FESM003066; Opp. Exhibit 10, FESM003782–83; Opp. Exhibit 11, FESM004193–95. They even budgeted their operations based on Medicare rates. *See* Opp. Exhibit 12, FESM010333; Opp. Exhibit 13, FESM003382; Opp. Exhibit 14, FESM004080; Opp. Exhibit 15, FESM000357 at 359. That TeamHealth Plaintiffs relied on Medicare rates to set their billed charges is no surprise—there are regulations dedicated to setting forth external factors that may be used by Medicare providers to determine whether a billed charge is reasonable. *See* 42 C.F.R. § 405.502 ("The law allows for flexibility in the determination of reasonable charges to accommodate reimbursement . . . ."). Accordingly, in numerous instances at trial, John Haben for Defendants testified about the importance of Medicare to Defendants' reimbursement rate determinations, yet neither he nor any other witness were permitted to explain that importance for the jury. *See* 11/10/2021 Tr. at 37:3-6 ("Q: What is United's view about how to determine a reasonable value of an out-of-network service? A: We will look at Medicare and we will pay above that with a reasonable premium above that."); *id.* at 39:4-10 ("Q: And what is the amount of the plaintiffs' bill charges when expressed as a percentage of the Medicare rate? A 763 of Medicare. Q And then what is the amount, of the allowed amount for the amount that United pay for these disputed claims when expressed as a percentage amount here? A 164 percent of Medicare."); *id.* at 113:16-116:12; 117:6-13; 117:24-118:3 (discussing Walmart Plan Document that contemplates OON ER reimbursement at 125% of Medicare); 137:15-23 (testimony about the egregious biller program, which was targeted

at 500% of Medicare initially); 159:14-25 (testimony regarding the % of Medicare for Benchmark Pricing).

Defendants' reference to Medicare rates was also central to their defense against TeamHealth Plaintiffs' claim under NRS 686A.310(1)(e) because the fact that Defendants reasonably set rates at Medicare plus a small margin is relevant to whether any of Defendants "fail[ed] to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer ha[d] become reasonably clear." Defendants were prevented from pointing to Medicare rates—or any of the other metrics discussed in this Motion that Defendants considered when setting their reimbursement rates for the disputed claims—to demonstrate that they had an honest, consistent, and reasonable internal operating practice for determining a reasonable rate goes to whether Defendants were fair and equitable in settling claims. Likewise, that Defendants had an internal and consistent understanding that a reasonable rate of payment was the Medicare rate, plus a small percentage, would have been relevant for the jury to determine whether Defendants intended to enter into an implied-in-fact contract to pay full billed charges.

As a result of the Court's erroneous ruling with respect to Medicare rates, Defendants were prejudiced by being prevented from explaining to the jury a key metric to which all parties referred when determining what they believed were reasonable rates of reimbursement. This prejudice was conspicuous throughout trial, as the amounts to which TeamHealth Plaintiffs believed they were entitled as a percentage of Medicare was ubiquitously discussed at trial, yet Defendants were hampered in their ability to rebut relevant testimony. To name just a few examples, Scott Ziemer testified about how the "overwhelming majority of providers" were paid up to a benchmark price of 500% of Medicare "to see what the market reaction was" before they would determine whether to lower that benchmark price. Defendants were prejudiced by Mr. Ziemer being prevented from providing details about the reasonableness of Defendants' benchmark pricing program that relied on Medicare rates, themselves an important benchmark for Defendants' state of mind regarding the reasonableness of their rates. *See* 11/16/2021 Tr. at 39:9-24. Likewise, TeamHealth Plaintiffs were permitted to introduce TeamHealth Plaintiffs' Exhibit 92, a document talking about an "initiative to start speaking in terms of Medicare," to examine John Haben. But the Court admitted the document

despite Mr. Haben's stated lack of sufficient personal knowledge about the document; the Court recognized that information for the document would have come from a different group not under Mr. Haben's purview because it described programs that Mr. Haben was in charge of, including target dates for when programs would go into effect. 11/3/2021 Tr. at 150:17-152:18. Accordingly, the jury heard testimony from Mr. Haben that could not accurately frame the importance of Medicare to Defendants' reimbursement rate determinations.

Similarly, TeamHealth Plaintiffs were allowed to introduce TeamHealth Plaintiffs' Exhibit 12 and elicit testimony from Mr. Haben about Defendants' initiatives that relied on Medicare. 11/2/3021 Tr. at 127:25-8. ("Q: Well, didn't United have an initiative internally that you were going to start changing the language, and instead of talking about -- did United have an internal program initiative in connection with this media outreach that going forward, we're not going to talk about how much of a reduction there is off of billed charges, we're going to convert it and talk about percentages of Medicare because the general public will think 250 percent or 500 percent of Medicare is egregious? Did United have that initiative? A: That's incorrect."). However, Defendants were prohibited from introducing evidence about how TeamHealth Plaintiffs negotiated their own in-network contracts with Defendants and other payors in terms of percentages of Medicare and how frequently TeamHealth Plaintiffs and other providers accepted rates at different percentages of Medicare. This allowed TeamHealth Plaintiffs to paint Defendants' usage of Medicare rates as a nefarious tactic, when in reality, expressing payment rates as a percent of Medicare is industry standard.

Perhaps the clearest example of prejudice that Defendants faced as a result of the Court's erroneous ruling is that Defendants' expert, Bruce Deal, was prevented from effectively testifying about the effect of Medicare rates on "reasonable value," including that Medicare serves as an important benchmark for evaluating reasonable value and comparing different methods of reimbursement on an apples-to-apples basis. It is true that Mr. Deal was permitted to discuss the fact that Defendants paid a "premium" on top of the Medicare amount, that he used Medicare as a comparator for his "reasonable value" calculations, and that he made comparisons of FAIR Health values to Medicare rates. *E.g.* 11/18/2021 Tr. at 85:10-25; 102:8-103:14; 106:7-12, 121:10-122:3,

149:9-156:6, 193:14-21. But this testimony was superficial: Mr. Deal was prevented from opining on necessary details about these issues, including *why* Medicare is a good comparator, or *why* commercial insurers pay a "premium" to Medicare. At most, Mr. Deal was permitted to testify that comparing reimbursement rates to Medicare rates is "the standard approach for lots and lots of studies involving any type of payment analysis." *Id.* at 121:10-122:3. Likewise, Mr. Deal testified that Medicare "is an objective [] payment methodology" that is a common industry standard to use as a comparator. 11/19/2021 Tr. at 62:15-23 ("Medicare is an objective [] payment methodology, and so it's very, very common for an analysis to look at a premium to Medicare."). Yet because of the Court's ruling, Mr. Deal was precluded from explaining why these facts are true and how these facts about Medicare are probative of the reasonableness of TeamHealth Plaintiffs' billed charges and Defendants' reimbursement rates.

The Court's motion *in limine* order on this area of evidence prevented Defendants' witnesses from completely answering questions concerning the process by which Defendants set rates, why they set those rates, or Defendants' state of mind in setting rates. Because Defendants describe rates internally and externally using the currency of "% of Medicare"—as do TeamHealth Plaintiffs—Defendants' witnesses were prevented from even answering questions regarding what a reasonable rate of payment is. Indeed, the very contracts that Defendants sign with emergency room providers, including TeamHealth Plaintiffs, often set forth reimbursement by describing a percentage of Medicare, rather than in dollars. In effect, the Court's orders preventing the parties from describing rates in terms of "% of Medicare" would be like omitting the term "dollars" or the $ symbol from a case involving monetary damages. Indeed, Defendants were prevented from admitting plenty of testimony they procured from depositions demonstrating that Medicare rates are a relevant benchmark for the reasonable value of the emergency medicine services for which TeamHealth Plaintiffs billed Defendants, the reasonableness of the reimbursement paid by Defendants on the disputed claims, and the parties' state of mind during the relevant time period. *See* Defendants' Omnibus Offer of Proof (Nov. 22, 2021) at 178-182.

2. In-Network Rates with Other Payors

A new trial is also warranted because the Court prevented Defendants from introducing

evidence of TeamHealth Plaintiffs' in-network reimbursement data and rates that *they themselves produced* with health insurers other than the Defendants. *E.g.* Opp. Exhibit 20, FESM001548 (TeamHealth Plaintiffs' market data); *see also* Opp. Exhibit 21, FESM016202 (email correspondence describing agreements with payors); Opp. Exhibit 22, FESM008903 (presentation describing in-house rates with Blue Cross/Blue Shield). Specifically, the Court denied Defendants' MIL Nos. 1 and 2 and granted TeamHealth Plaintiffs' MIL No. 3 (10/19/21 Tr. 214:2-9) based on the Special Master's Report and Recommendation No. 5 that denied Defendants' motion to compel particular types of non-commercial and in-network data.

This was wrong. In a healthcare rate payment dispute like this one, "the scope of the rates accepted by or paid to [a medical provider] by other payors [or insurers] indicates the value of those services in the marketplace" and is therefore relevant to the "reasonable value" analysis. *Children's Hosp.*, 226 Cal. App. 4th at 1275; *see also Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc.*, 832 A.2d 501, 508–10 (Pa. Super. Ct. 2003) (finding that the "reasonableness" of payments is based on "what the services are ordinarily worth in the community"); Barak D. Richman et al., Overbilling and Informed Financial Consent--A Contractual Solution, 367 NEW ENG. J. MED. 396, 397 (2012) (the "best proxy for informed bargaining is what similarly situated consumers and providers actually bargain for--namely, the rates negotiated between providers and private insurers"). There can be no meaningful dispute that evidence of TeamHealth Plaintiffs' network contracts with other payors satisfies Nevada's standard for relevant, admissible evidence at trial because it would have made the existence of the fact that TeamHealth Plaintiffs' charges to Defendants were inflated more probable to the jury. NRS 48.015. That evidence would have been probative of the amounts that TeamHealth Plaintiffs were willing to accept in an arm's-length negotiation.

The record was full of such evidence. For example, Defendants would have argued to the jury the fact that TeamHealth negotiated and accepted far lower reimbursement payments with another major health insurance company, Blue Cross/Blue Shield ("BCBS"). Opp. Exhibit 23, FESM008947 (TH-United Contribution and Comparison Report); Opp. Exhibit 24, DEF525474 (TeamHealth Presentation, Emergency Medicine (Apr. 2019)). TeamHealth Plaintiffs produced documents about their rates with BCBS, which they prepared and delivered to a senior executive of

UHS in 2019 as part of network contract negotiations with United. *See, e.g.*, Opp. Exhibit 23, FESM008947 (April 2019 report reflecting BCBS rate ($251 per visit) compared to United proposal ($445 per visit)); Opp. Exhibit 22, FESM008903 at 914 (April 2019 TeamHealth presentation featuring chart reflecting BCBS reimbursement rates from 2015 to 2018, all expressed as a percentage of Medicare fee schedule). TeamHealth provided these documents to Defendants before this lawsuit was filed, in connection with a key meeting between TeamHealth senior executives and a senior executive at UHS that was organized by the Blackstone Group and held at its offices in New York City, to explain TeamHealth's cost structure, revenue needs, and the amounts that TeamHealth would accept as reimbursement. Opp. Exhibit 16, Dep. of David Schumacher ("Schumacher Dep.") at 217:4–19; Opp. Exhibit 25, DEF011058 (April 15, 2019 email from TeamHealth's Murphy to UHC's Schumacher, "attaching some background material on our TeamHealth/UHG relationship"). To pick just another example, subsequent to terminating their network agreement with UHIC, Fremont entered into a direct agreement with MGM Resorts International, a large employer in the Las Vegas area and Defendant UMR's client for self-funded claim administration, to accept an "all-inclusive case rate of $320.00" per visit for the same services in the same geography as the at-issue services, but at a far lower rate than TeamHealth Plaintiffs are demanding in this lawsuit. Opp. Exhibit 26, DEF011280 (MGM Resorts Health and Welfare Plan Participating Provider Agreement (Feb. 27, 2019)); Opp. Exhibit 27, DEF011294 (Amendment No. 1 to the MGM Resorts Health and Welfare Plan Participating Provider Agreement (May 29, 2020)). To be clear, while TeamHealth Plaintiffs on the one hand agreed to that rate in a direct contract with Defendant UMR's customer, MGM, *for much of the same time period at issue in this lawsuit*, they are, on the other, claiming that the same amount or even greater amounts *are not* reasonable for Defendants or Defendants' other Las Vegas self-funded clients. *See, e.g.*, PX 473 at Rows 205, 1588, 1593, 1599, 1601, 1606, 2222, 4696, 4698, 4700, 4701, 4707, 4708, 4711, 4767, 4770, 4771, 4775, 4778, 4779, 4781, 4782, 4785, 4787, 4788, 6877 (listing multiple disputed claims with allowed amounts exceeding $320 per visit for employers including Walmart, Coca Cola, and Caesars Enterprise Services, LLC). The jury should have been permitted to hear this damning evidence.

At trial, Defendants would have introduced evidence and argumentation on their position throughout this case, as well as in the ordinary course of business, that the fair market value for out-of-network services is the Medicare rate plus a small margin. *See, e.g.*, Opp. Exhibit 17, May 21, 2021 Dep. of John Haben ("Haben Dep.") at 57:13–22; Opp. Exhibit 16, Schumacher Dep. at 70:1–8. This claims data—which TeamHealth Plaintiffs produced to Defendants—corroborates Defendants' position. MSJ Exhibit 41, Deal Revised Rep. ¶ 97 nn. 168 & 169. It is clearly unfair that Defendants were prohibited from putting on evidence and argument about their position on the fair market value for out-of-network services that led to the supposed implied-in-fact contract that formed the basis of TeamHealth Plaintiffs' SAC. And this position is more than reasonable: Defendants' expert, Bruce Deal, was prevented from testifying that in-network reimbursement rates are not only relevant to measuring the reasonable value of out-of-network claims, but that they are the *only* economically appropriate basis for comparison. MSJ Exhibit 41, Deal Revised Rep. ¶¶ 56–57, 61–62; *id.* ¶¶ 43–46; *see also* Defendants' Omnibus Offer of Proof (November 22, 2021) at 182-183. Additionally, TeamHealth Plaintiffs' counsel were allowed to insinuate that Defendants' programs that relied on multipliers of Medicare were "unilaterally selected," while Defendants were precluded from introducing evidence about how these programs were in fact tied to percentages of Medicare well over fair market value. 11/3/2021 Tr. at 166:18-21; 11/9/2021 Tr. at 131:23-132:8.

The Court's blanket exclusion of this evidence was particularly prejudicial in that the Court allowed TeamHealth Plaintiffs to introduce evidence of contractual rates that *Defendants* pay to other providers of emergency medicine services, as evidence in support of their claims of underpayment. *See, e.g.*, Opp. Exhibit 16, Schumacher Dep. at 57:24–63:18, 68:23–70:16, 154:11–192:6, 260:22–263:14. This outcome prevented Defendants' witnesses from explaining to the jury their own historical and contemporaneous understanding of the proper reimbursement for out-of-network services and what they consider to be a reasonable value for such services. This double standard is not only unfair, but reversible: if one party is permitted to introduce certain evidence—whether or not that evidence is relevant—the opposing party must be permitted to introduce evidence explaining it. *Nguyen v. Sw. Leasing & Rental Inc.*, 282 F.3d 1061, 1068 (9th Cir. 2002); *see also Hall v. Ortiz*, Case No. 58042, 129 Nev. 1120 (Oct. 31, 2013) (applying the same doctrine

under Nevada law). Put another way, courts have also recognized that exclusion of one party's certain evidence requires the exclusion of the other party's similar evidence. *See, e.g.*, *Centralian Controls Pty, Ltd. v. Maverick Int'l, Ltd.*, No. 1:16-CV-37, 2018 WL 4113400, at *5 (E.D. Tex. Aug. 29, 2018) (applying the idiom "what is sauce for the goose is sauce for the gander" to preclude either party's expert from offering testimony not specifically set forth in written reports).

To be clear, Defendants should have never been prevented from obtaining this evidence in the first place. TeamHealth Plaintiffs used Report and Recommendation No. 5 as a basis for refusing to produce this evidence. For the reasons explained above, that Report and Recommendation, and the Court's September 21, 2021 affirmance of that Report and Recommendation, erred because that data was relevant and necessary for Defendants to demonstrate that the rates for reimbursement that TeamHealth Plaintiffs sought for individual services was not reasonable. And the Court's trial ruling misinterpreted its September 21 affirmance by expanding Report and Recommendation No. 5 from preventing particular types of market data to *all* in-network data being inadmissible at trial.

Defendants were therefore prejudiced at trial by the Court's errors of law preventing Defendants from admitting evidence of the market data produced by the TeamHealth Plaintiffs, as well as discrete network contracts that they had with other payors during the period in dispute, because such data and contracts are relevant as a matter of Nevada law. While not conclusive, that evidence constitutes clearly probative evidence of the price for which they are willing to sell their services and for which other payors or insurers are willing to pay. The Court's *in limine* rulings prevented Defendants from receiving a fair trial by constructing a one-way street whereby the jury overwhelmingly only heard evidence about the reasonableness of Defendants' reimbursement rates, without any consideration as to the reasonableness of *TeamHealth Plaintiffs' charges*. This manner of "grotesquely lopsided" evidence warrants a new trial. *See Echevarria v. Ruiz Hernandez*, 364 F. Supp. 2d 149, 152 (D.P.R. 2005).

C. THE COURT ERRED BY PREVENTING EVIDENCE ABOUT PROVIDER PARTICIPATION AGREEMENTS

Through pretrial discovery orders and at trial, the Court denied access to a critical category of evidence that would have provided the jury important evidence of reasonable value. Evidence of

the parties' course of dealing—including what Defendants paid TeamHealth Plaintiffs—would have been relevant to the implied contract claim and what is a reasonable value for an underlying claim for reimbursement. Likewise, what TeamHealth Plaintiffs accepted from other payors would be relevant under Nevada law to set reasonable value. That is because evidence of the TeamHealth Plaintiffs' prior agreements with certain Defendants is key to understanding the parties' prior course of dealing, from which TeamHealth Plaintiffs allege arises an implied-in-fact contract between the parties. Indeed, prior contracts are relevant to the reasonableness of subsequent rates as a matter of Nevada law, *Suen*, 2016 WL 4076421, at *4, as evidence of the parties' course of dealing and course of performance. And evidence of TeamHealth Plaintiffs' agreements with other payors besides Defendants—*evidence that they themselves produced*—is also relevant because it is informative of the TeamHealth Plaintiffs' view of what constitutes the reasonable value of the emergency medicine services that they bill for. The market data produced by TeamHealth Plaintiffs revealed that the rates they accepted from other payors was dramatically less than what they sought in this case. 11/19/2021 Tr. 188:3-9. That is clearly probative of the reasonableness of Defendants' reimbursement rates, *see Certified Fire*, 128 Nev. at 380 ("market price" is a relevant metric in unjust enrichment actions), yet the jury was deprived of this evidence.

The Special Master's Report and Recommendation No. 2, and the Court's adoption of that Order, sustained TeamHealth's and CollectRx's objections to Defendants' subpoena duces tecum seeking the parties' contracts (*i.e.*, provider participation agreements) and TeamHealth Plaintiffs' provider participation agreements with other healthcare payors. August 9, 2021 Order regarding Report and Recommendation No. 2 ¶ 9(e). Based on a misunderstanding of that Order, which only dealt with a subpoena duces tecum to non-parties, the Court granted TeamHealth Plaintiffs' MIL No. 3 and held that these provider participation agreements were inadmissible.

Like the Court's erroneous rulings regarding the admissibility of the Medicare rates and in-network rates with other providers, the Court's preclusion of evidence and argumentation about TeamHealth Plaintiffs' agreements with Defendants and other payors—agreements that laid out the rates on which TeamHealth Plaintiffs agreed to base their charges—was an error of law. Defendants were therefore prejudiced by the Court's prohibition on argumentation about this relevant evidence

that, like evidence of Medicare rates and in-network rates with other payers that informed TeamHealth Plaintiffs' charge setting, would have supported numerous of Defendants' affirmative defenses, including their defense that "[s]ome or all of TeamHealth Plaintiffs' billed charges are excessive under the applicable standards." JPTO at 8 (Sixth Affirmative Defense). Indeed, Defendants elicited voluminous testimony from John Haben, Kent Bristow, and Vince Zuccarello during their depositions that Defendants were prohibited from probing at trial. *See* Defendants' Omnibus Offer of Proof (November 22, 2021) at 108-156.

1. The Contracts that Were in Place Between Fremont and Various Defendants Prior to the Period in Dispute Are Relevant to the Claims and Defenses in this Litigation

"[I]n an action for the reasonable value of services, a written contract providing for an agreed price is admissible in evidence" and may be used to "demonstrate the value of the services rendered." *Children's Hosp.*, 226 Cal. App. 4th at 1274. The factfinder can only determine the "going rate" of a service by "accept[ing] a wide variety of evidence" to determine the "reasonable value" of the services. *Id.* Thus, relevant evidence includes among other things: (i) a party's testimony "as to the value of [its] services"; (ii) a party's "agreements to pay and accept a particular price"; (iii) a "price agreed upon by the parties," including in "a written contract"; and, (iv) a "professional's customary charges and earnings." *Id.* (internal citations omitted).

Given the SAC's repeated allegations about the parties' negotiations and contracts preceding and during the period in dispute are relevant to the "reasonable rate" for the claims at issue, *e.g.*, SAC ¶¶ 16, 31, 39, 46 and given the legal relevance of this information to the "reasonable value" of the full billed charges, *Suen*, 2016 WL 4076421, at *4, what a plaintiff offered to accept as payment for those services cannot logically be irrelevant to a dispute about the reasonable value of those same services. These allegations make relevant the rates that pre-dated the negotiations and from which the parties were negotiating a new potential agreement, as well as the rates that were exchanged during the course of these negotiations. Prior to the period in dispute, Fremont was a long-standing participating provider with UHC, UHIC, Sierra and HPN. MSJ Exhibit 41, Deal Revised Rep. ¶¶ 97–98. Then, after TeamHealth terminated those contracts in June 2017 and February 2019, the parties continued to negotiate over a new agreement, and TeamHealth offered

to contract at various reimbursement rates well below their billed charges. Opp. Exhibit 42, FESM001217 (email offering up to 300% of Medicare).

The Court's error of law resulted in a glaring absence of historical context for the rate dispute at the heart of the trial. Numerous witnesses at trial testified about the parties' contract renewal negotiations and Fremont's termination of its contracts with Defendants. For example, both John Haben and Rebecca Paradise were asked whether they "set 350 percent of Medicare as a rate that you were paying at first in order to slash reimbursement, and then you slashed it again to 250 percent of Medicare," yet they were prevented from discussing the fact that Defendants' rates of reimbursements to Fremont actually went up after Fremont terminated its contract with Defendants. 11/15/2021 Tr. at 144:14-145:17.

Furthermore, the Court errantly disregarded Nevada's rule of completeness, NRS 47.120(1), and allowed TeamHealth Plaintiffs to present select, favorable portions of PX 313 by redacting all reference to prior contracts and TeamHealth Plaintiffs' decision to terminate those contracts. 11/16/2021 Tr. 68:22-70:22, 96:24-97:23. In fact, TeamHealth Plaintiffs were able to inform the jury about their "policy" not to balance bill and avoid the fact that the balancing billing statement was in response to an email that: (1) explained that insureds "were unaware that TeamHealth Plaintiffs terminated their contract with S[HL]; (2) asked whether TeamHealth Plaintiffs would balance bill due to their terminating the contract; and (3) noted that HPN and SHL wanted to "work together to figure something out." *See* PX 313. However, TeamHealth Plaintiffs' termination of contracts was directly related, and thus relevant, to the balance billing information that was admitted into evidence. As such, pursuant to NRS 47.120(1), Defendants had the right to explore prior contracts and why they were terminated. *See also Nguyen*, 282 F.3d at 1068; *Hall*, 129 Nev. 1120.[5]

Defendants were prejudiced by being prevented from showing the jury the provider participation agreements between the parties, and the negotiations that took place related to Fremont's termination of those agreements. The jury clearly could have used this evidence to

[5] Likewise, TeamHealth Plaintiffs offered PX 314 and PX 325 in redacted form. Pursuant to NRS 47.120(1), Defendants should have been allowed to explore the information that was redacted before the jury because it was directly related, and relevant, to the evidence that was admitted.

determine whether the rates that TeamHealth Plaintiffs offered during those negotiations were reasonable.

2. Contracts Between TeamHealth Plaintiffs and other Healthcare Payors and Health Insurers Are Relevant to the Claims and Defenses in this Litigation

Likewise, the contracted rates between TeamHealth Plaintiffs and other healthcare payors serve as valuable reference points for assessing the reasonable value of the at-issue services because they reflect reimbursement amounts that the TeamHealth Plaintiffs willingly agreed to accept for the same services in the same geographic area. *Suen*, 2016 WL 4076421 at *4 (prior contracts, offers, and "any other evidence regarding the value of services," may be considered to determine the "reasonable value" of services). For example, after terminating their network agreements with Defendants and their affiliates, Fremont entered into a direct agreement with MGM Resorts International, a large employer in the Las Vegas area that is a self-funded client of Defendant UMR, to accept an "all-inclusive case rate of $320.00" for the same services in the same geography as the at-issue services, but at a far lower rate than TeamHealth Plaintiffs demanded from Defendants. Opp. Exhibit 26, DEF011280 (MGM Resorts Health and Welfare Plan Participating Provider Agreement (Feb. 27, 2019)); Opp. Exhibit 27, DEF011294 (Amendment No. 1 to MGM Resorts Health & Welfare Plan Participating Provider Agreement (May 29, 2020)). They also refused to extend this reimbursement rate to Defendants (or their other self-funded clients) after Defendants offered to contract at that rate. Opp. Exhibit 21, FESM016202 (email exchange refusing United's offer). In addition, TeamHealth negotiated and accepted far lower reimbursement payments with BCBS, one of Defendants' largest competitors. *See* Opp. Exhibit 23, FESM008947 (TH-United Contribution & Comparison Report); Opp. Exhibit 24, DEF525474 (TeamHealth Presentation, Emergency Medicine (Apr. 2019)). The Court erred by preventing Defendants from discussing the probative nature of these rates that the jury could have used as helpful guideposts for determining whether the rates that TeamHealth Plaintiffs demanded from Defendants fairly compare in light of the rates that they accepted from other payors—including some of Defendants' own clients.

Indeed, Defendants sought to have their expert Bruce Deal testify that "the correct economic approach to determining reasonable value is to examine actual market transactions and observe rates

paid in the marketplace between willing buyers and willing sellers in a competitive market." MSJ Exhibit 41, Deal Revised Rep. at 3. This "market framework" is a standard and accepted economic methodology for determining reasonable value, one which Mr. Deal has applied dozens of times in his work as an expert on the reasonable value of healthcare services. *Id.* at 36. Mr. Deal's market framework reflects a commonly understood methodology in the healthcare market. In fact, TeamHealth's CEO endorsed a similar framework for this analysis when he explained to a senior UHS executive during the parties' negotiations over a new national contract that "UCR [or the usual and customary rate] [is] ultimately defined by our in-network rates with the same payor, rates from other payors, and rates from the defendant to other providers." Opp. Exhibit 43, FESM008944 (Email from L. Murphy to M. Wiechart (Apr. 18, 2019)).

Further, as Bruce Deal explained in his report with respect to emergency department services, only payments for contracted services (as opposed to payments for non-contracted services) are relevant to determining reasonable value because a key assumption of the market framework is that either party must have the option to walk away from the transaction. MSJ Exhibit 41, Deal Revised Rep. at 41. While providers and payors negotiating a network agreement have the option to walk away, a patient receiving services from an out-of-network emergency physician generally does not have the ability to shop around and select another provider. *Id.* Mr. Deal therefore calculated benchmarks for assessing reasonable value based on (1) the allowed amounts that TeamHealth Plaintiffs actually received from other contracted commercial payors and (2) the amounts allowed by the Defendants to other contracted emergency medicine providers. *Id.* at 42–48.

3. Wrap/Rental Network Agreements Are Relevant to the Claims and Defenses in this Litigation

The Court determined during discovery that Defendants' "rental, wrap, shared savings program or any other agreement that United contends allows it to pay less than full billed charges" were discoverable. Opp. Exhibit 44, Mot. to Compel Ds' List of Witnesses, Production of Documents, and Answers to Interrogatories at 3 (referencing Pls' RFPs to Def. Nos. 9, 16). Defendants were compelled to produce, and ultimately did produce wrap/rental network agreements

with various third-parties, including contracts with third-parties Private Healthcare Systems, Inc. ("PHCS"), MultiPlan, Inc., and First Health Group Corp. Services. *See id.* Likewise, the Court ordered TeamHealth Plaintiffs to produce a wrap/rental network summary document that Mr. Bristow reviewed prior to his deposition. Report and Recommendation No. 11 at 5-6. There can be no meaningful dispute that the parties' wrap/rental network agreements are relevant to this action because the rates, and shared savings programs, underneath those agreements are probative of the existence of an implied-in-fact contract (or lack thereof). Nevertheless, the Court ruled that the parties could not use the rates paid under these agreements as evidence to inform whether Defendants' reimbursement rates for the disputed claims were reasonable. 11/20/2021 Tr. at 20:15-20.

Defendants were prejudiced by the Court's ruling, as both parties ultimately examined numerous witnesses about the wrap/rental agreements in this case. For example, Leif Murphy was examined at length about the fact that TeamHealth Plaintiffs had contracts with wrap networks, and he explained his view that rates paid under those agreements were reasonable. 11/16/2021 Tr. at 63:22-66:2. Yet Defendants were deprived of being able to elicit testimony about how the existence of these wrap/rental agreements informed the reasonableness of Defendants' reimbursements. Likewise, TeamHealth Plaintiffs examined John Haben extensively about TeamHealth Plaintiffs' Exhibit No. 3, the network access agreement between MultiPlan, Inc. and UHC. 11/2/2021 Tr. at 166:24-167:25; 11/3 Tr. 16:24-21:6, 24:13-26:10.

By preventing evidence and argumentation on this topic, Defendants were prejudiced because they were unable to elicit testimony that would allow the jury to further evaluate Defendants' state of mind on numerous topics that bear on the parties' wrap/rental network agreements, including with respect to the parties' disputes over reimbursement rates under TeamHealth Plaintiffs' statutory causes of action; and with respect to TeamHealth Plaintiffs' arguments for punitive damages that required proof that Defendants acted with malice and intent to defraud. TeamHealth Plaintiffs should not have been allowed to serve discovery requests on Defendants that seek the production of wrap/rental network agreements and then take the position at trial that such evidence of their own wrap/rental network agreements is irrelevant.

D. THE COURT'S RULING THAT EVIDENCE OF TEAMHEALTH PLAINTIFFS' COSTS WAS IRRELEVANT WAS ERRONEOUS

TeamHealth Plaintiffs' costs of doing business would have been relevant to TeamHealth Plaintiffs' breach of implied-in-fact contract claim and unjust enrichment claim. That is because the costs incurred by TeamHealth Plaintiffs to perform the at-issue emergency medicine services are directly relevant to the issue of whether any payment by Defendants was "reasonable" vis-à-vis the value of any services rendered. As a general rule, the actual costs to provide a service is probative of the reasonable value of that service. *See Fairbanks N. Star Borough v. Tundra Tours, Inc.*, 719 P.2d 1020, 1030 (Alaska 1986) ("[E]vidence of actual costs is relevant to a determination of reasonable value."); *see also* NRS 48.025(1) (recognizing that "[a]ll relevant evidence is admissible" unless an exception applies); NRS 48.015 (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"). Courts routinely allow evidence of the cost of a service in determining its reasonable value, as one factor to be considered by the factfinder. *See, e.g.*, *Doe v. HCA Health Servs. of Tenn., Inc.*, 46 S.W.3d 191, 198–99 (Tenn. 2001). And the concept that costs are an integral component in determining what constitutes "reasonable value" for healthcare services is endorsed by the Restatement (Third) of Restitution and Unjust Enrichment, which—as noted above—Nevada courts have adopted. *Koebke*, 2020 WL 6955291, at *2. Section 49(3)(c) of the Restatement states specifically that "the cost to the claimant of conferring the benefit" is one measure of damages resulting from unjust enrichment. Restatement (Third) of Restitution and Unjust Enrichment § 49.

A new trial is therefore necessary because the Court erred by relying on its February 4, 2021 Order to determine that evidence of TeamHealth Plaintiffs' costs are inadmissible, which prevented Defendants from presenting to the jury crucial evidence that TeamHealth Plaintiffs *themselves* produced that is probative of the reasonableness of their full billed charges. For example, TeamHealth Plaintiffs themselves produced evidence of how their costs related to their billed charges. *E.g.*, Opp. Exhibit 22, FESM008903; Opp. Exhibit 23, FESM008947. Defendants would have also presented evidence from the parties' experts that opined on the significance of costs to the

reasonableness of billed charges. For example, TeamHealth Plaintiffs' expert witness, Scott Phillips, specifically testified that when setting billed charges, he considered the cost of services one of three key factors relevant to determining the appropriate charge for emergency physician services. Opp. Exhibit 2, Phillips Dep. at 175:3–176:24; *see also* Defendants' Omnibus Offer of Proof (November 22, 2021) at 169-175. Defendants should have been allowed to offer testimony on costs from TeamHealth Plaintiffs' own expert witnesses, as well as Leif Murphy, who opined on TeamHealth Plaintiffs' costs during this deposition, but Defendants were prevented from admitting that testimony. *See* Defendants' Omnibus Offer of Proof (November 22, 2021) at 168-169. In fact, in an offer of proof outside the presence of the jury, Defendants elicited testimony from Mr. Murphy indicating that TeamHealth's average cost per emergency encounter was $150 per encounter. 11/16/2021 Tr. at 117:7-17; *id.* at 122:1-4. In the same offer of proof, Mr. Murphy confirmed that TeamHealth collected an average of $350 per encounter from commercial insurers. *Id.* at 123:8-124:1. Defendants should also have been permitted to present the expert testimony of Bruce Deal, who opined about the relative costs between hospitals and emergency department physicians generally, the relationship between providers' costs and the established Medicare rates for various services, and TeamHealth Plaintiffs' billing strategies. MSJ Exhibit 41, Deal Revised Rep. ¶¶ 13, 26–27, 40.

The Court also erred by preventing evidence of TeamHealth Plaintiffs' internal communications about their contracts with hospital facilities. 10/20/21 Tr. 48:6-19, 49:4-25, 50:2-6. This, despite TeamHealth Plaintiffs' deposition testimony that a provider's hospital relationships is an important factor that providers use to set their billed charges because those contracts can hold staffing companies harmless for uncompensated care. Specifically, TeamHealth Plaintiffs produced, without objection, their internal correspondence in which their employees discuss their agreements and relations with various Nevada hospitals, impliedly conceding their relevance. *E.g.*, Opp. Exhibit 34, FESM001238; Opp. Exhibit 35, FESM013515–17; Opp. Exhibit 21, FESM016202. For example, there was a series of exchanges between HCA and TeamHealth in which HCA learned that TeamHealth had gone out of network with Defendants and terminated Defendants' contract with Fremont. The two sides then discussed what HCA thought was

appropriate in terms in the payment of reasonable services and reasonable value for those services. Ultimately, the two sides compromised and agreed that TeamHealth would work out direct agreements with Defendants' customers—the Las Vegas Police Department, MGM Grand, and Caesars. *See* 10/20/2021 Tr. at 47:7-20.

In other words, commercial clients such as the Las Vegas Police Department, MGM Grand, and Caesars were concerned about their need to have to effectively subsidize TeamHealth Plaintiffs for uncompensated care. Defendants were prejudiced because Defendants would have shown the jury evidence of these communications to demonstrate that such subsidization was not a valid and reasonable basis for demanding their full billed charges that built into their price for this uncompensated care. This would have been valuable impeachment evidence that Defendants could have used to rebut trial testimony from TeamHealth Plaintiffs' executives that claim that uncompensated care justified the charges they set for the disputed services.

Moreover, Mr. Phillips himself submitted an affidavit saying that hospitals typically compensate staffing companies like TeamHealth for certain types of patients for whom reimbursement is expected to be low and that these hospital payments are key factors for staffing companies to evaluate when setting their charges for reimbursement by commercial health insurers. Opp. Exhibit 2, Phillips Dep. at 172:24–173:7. Thus, even TeamHealth Plaintiffs' own experts recognize the relevance of hospital payments to emergency room staffing companies when assessing the reasonableness of billed charges. But instead of allowing Defendants to argue the persuasiveness of this evidence to the jury and how it affects the reasonable value of TeamHealth Plaintiffs' billed charges, Defendants were precluded from offering evidence that TeamHealth Plaintiffs effectively conceded was relevant by producing it without objection during discovery.

E. THE COURT ERRED BY PROHIBITING EVIDENCE OF HOW TEAMHEALTH PLAINTIFFS SET THEIR BILLED CHARGES

Evidence that concerns TeamHealth Plaintiffs' practices and policies for setting their billed charges is clearly relevant to this lawsuit: TeamHealth Plaintiffs' position that their billed charges represent the "reasonable value" of the disputed services. *E.g.* SAC ¶¶ 39, 46. Evidence about TeamHealth Plaintiffs' processes for setting charges would have been probative of whether their

practices and processes are arbitrary, or, likely to result in a reasonable price for emergency medicine services. A number of factors may be considered by the jury when determining whether rates are reasonable, such as the "customary method[s]" used to set those rates. *Flamingo Realty*, 110 Nev. at 988. Simply put, because TeamHealth Plaintiffs are seeking to recover their full billed charges, the reasonableness of those billed charges is directly at issue.

Yet, in its February 4, 2022 Order, the Court determined that evidence as to how TeamHealth Plaintiffs set their charges was not discoverable. Feb. 4, 2021 Order ¶ 11. The February 4, 2022 Order was erroneous and significantly prejudiced Defendants throughout this lawsuit because Defendants were deprived from fully collecting discovery about a central premise of TeamHealth Plaintiffs' lawsuit: that their full billed charges were reasonable.

Defendants were then prejudiced at trial on this area of evidence again. Rather than rectify its erroneous February 4 Order, the Court used the February 4 Order to deny Defendants' MIL Nos. 3-4, 11-12 precluding Defendants from discussing how TeamHealth Plaintiffs set their billed charges, *i.e.*, TeamHealth Plaintiffs' methodology for determining a dollar figure.

It is hard to overstate the prejudicial effect of the Court's motions *in limine* orders with respect to the parties' respective rate determinations and processes. Throughout trial, TeamHealth Plaintiffs were permitted to argue that their billed charges were reasonable, yet Defendants were prevented from impeaching that testimony with evidence about the reasonableness of the process by which TeamHealth Plaintiffs came to set those charges. For example, TeamHealth Plaintiffs' counsel suggested that Defendants' falsely created a narrative that emergency physician prices rose substantially over time. 11/3/2021 Tr. at 123:3-9 ("Q: Tactics, they make you all look good and make the doctors look like they're egregious billers is you're going to develop extensive messaging, including media statement, general talking points, questions and answers, and other materials to support our media and other outreach efforts, right? A: That was a pretty long question. I don't agree with your context in the beginning.") However, Defendants were precluded from introducing ample evidence that TeamHealth Plaintiffs inflated charges to increase profits.

For example, Kent Bristow provided testimony that would allow the jury to infer that TeamHealth Plaintiffs were able to inflate the billed charges because they had data on what services,

in what regions, paid what rates. Opp. Exhibit 48, Dep. of Kent Bristow ("Fremont NRCP 30(b)(6) Dep.") at 23:15-25; *see, e.g.*, 11/22/2021 Tr. at 76:3-12 (discussing TeamHealth Plaintiffs' increasing charges to Defendants). Yet Defendants were unable to show TeamHealth Plaintiffs' arbitrary inflation of their billed charges, and in turn why Defendants' refusal to pay TeamHealth Plaintiffs' full billed charges was reasonable, without referencing TeamHealth Plaintiffs' decision-making and strategy in setting those rates. Similarly, Leif Murphy testified that TeamHealth Plaintiffs use a "process" that incorporates "factors that go into the setting of the chargemaster involving chargemasters to set their billed charges" (11/16/2021 Tr. at 82:25-84:20), yet Defendants were prevented from following up about what those factors were. *See* 11/16/2021 Tr. at 98:12-99:2. And in a multitude of instances during trial, despite the Court's determination that evidence of rates offered between the parties' during their negotiations was off-limits, TeamHealth Plaintiffs opened the door to these arguments. Defendants sought to introduce evidence of how TeamHealth Plaintiffs set their billed charges, but the Court rejected Defendants' arguments at every turn. *See, e.g.*, 11/15/2021 Tr. at 39:14-41:10, 144:14-146:8 (Defendants' counsel stating that in order to ask about provider participation agreements terminating between the parties, he would need to discuss "the fact that there was a network agreement. But the fact is they've left an impression with this jury that Fremont's rates were being continuously cut over this period of time by United when in fact, they were going up during this period of time and the reimbursements were going up over $1.1 million"); 11/16/2021 Tr. at 82:7-23, 98:12-100:2 (Defendants' counsel prevented from asking whether the amount of money that TeamHealth Plaintiffs collect is "the same or different than the way standard billing companies charge fees in the industry" to set chargemasters); *see also* 11/22/2021 Tr. at 209:2-14, 214:6-10 (door to TeamHealth Plaintiffs' costs not opened despite discussion of TeamHealth Plaintiffs' cost methodologies).

TeamHealth Plaintiffs also disclosed documents during discovery showing that they specifically chose to forego becoming participating providers with Defendants "to get better leverage" and to push Defendants into paying over 400 percent beyond what is paid under Medicare. Exhibit 4 to Defendants' MIL No. 3, Nov. 2, 2017, Email; *see also* Opp. Exhibit 48, Fremont NRCP 30(b)(6) Dep. at 109:8-11. In other words, what TeamHealth Plaintiffs ultimately were paid for out-

of-network rates was more than what their internal analysis showed was reasonable: strategizing to forego a contract and set rates based on that strategy is similarly relevant for determining whether what was ultimately paid as a percentage of those rates is reasonable. *See also id.* at 103:21-104:11. Defendants should have been permitted to offer this evidence as impeachment evidence to rebut any of TeamHealth Plaintiffs' witnesses' testimony or positions that their full billed charges represented the value of disputed services, let alone the *reasonable* value of those services. Defendants would also have admitted testimony that they procured from deposing John Haben and Kent Bristow that would have been clearly probative and relevant to this reasonable value analysis, but were prohibited from eliciting at trial. *See* Defendants' Omnibus Offer of Proof (November 22, 2021) at 156-167.

Besides being clearly relevant, the Court's decision to permit TeamHealth Plaintiffs to introduce and argue similar evidence about how Defendants set their reimbursement rates had the effect of creating an unfair double standard. The Court in its October 27, 2020 Order found that discovery regarding Defendants' approach to reimbursement was permitted. Ord. Granting Pl.'s Mot. to Compel Defs.' List of Witnesses, Production of Documents and Ans. To Interrogatories on Ord. Shortening Time (Oct. 27, 2020), at ¶ 6. The Court used this order as a basis for denying Defendants' MIL No. 4 and allowing TeamHealth Plaintiffs to offer evidence and discuss Defendants' approach to reimbursement, on the basis that TeamHealth Plaintiffs had the burden of proof. 10/20/21 Tr. 44:18–23; 10/22/21 Tr. 40:7-9. Accordingly, the trial featured immense amounts of discussion and testimony concerning Defendants' processes for determining the reimbursement rates that they believed were reasonable.

The double standard allowed by the Court exacerbated its error of law that prevented Defendants from introducing evidence and argument about this clearly relevant area of discovery. Logically, if TeamHealth Plaintiffs' charge-setting methodology is irrelevant, then arguments and evidence that those charges are reasonable from the outset (before Defendants act on them) must also be irrelevant. Fairness dictates that if one party is permitted to introduce evidence pertaining to a topic, the other party must be permitted to do so as well, or both parties should be precluded from offering the irrelevant evidence. *Nguyen*, 282 F.3d at 1068.

To be sure, Defendants should have never been denied discovery concerning TeamHealth Plaintiffs' processes for setting their billed charges. But even to the extent the February 4 Order was not erroneous—it was, for the reasons stated above—that Order should not have controlled at trial because TeamHealth Plaintiffs changed their litigation strategy to seek reimbursement for full billed charges. Previously, TeamHealth Plaintiffs' theory of their case was that a certain, fixed percentage of their billed charges constituted the "reasonable value" on which they were entitled to reimbursement from Defendants. With their full billed charges being the basis for the damages they sought from the jury, Defendants should have been allowed to introduce evidence and argumentation to the jury as to how TeamHealth Plaintiffs set those charges because such evidence would have been unquestionably relevant and probative of the reasonableness of those charges. That Defendants were denied from doing so after TeamHealth Plaintiffs changed their litigation strategy on the eve of trial is yet further evidence that Defendants were unfairly prejudiced by the Court's determination that evidence and argumentation concerning how TeamHealth Plaintiffs set their charges was inadmissible.

F. THE COURT ERRED BY PREVENTING EVIDENCE AND ARGUMENTATION ABOUT TEAMHEALTH PLAINTIFFS' CORPORATE FLOW OF FUNDS

Evidence of how TeamHealth Plaintiffs built into their full billed charges amounts that TeamHealth Plaintiffs sought as profits above physicians' costs for rendering services should have been admitted. By preventing Defendants from explaining to the jury how TeamHealth Plaintiffs' charges considered their own profit-making, Defendants were prejudiced by being hamstrung from developing its defense that TeamHealth Plaintiffs' charges did not reflect the reasonable value of their emergency medicine services, which was a core issue at trial. Defendants should have been allowed to present this relevant evidence to the jury that any collections above the physicians' costs become TeamHealth's profits; that is, the physicians who actually provide the emergency medicine services at issue are not entitled to any profit sharing or ownership in the proceeds of their services, which flow to TeamHealth. Opp. Exhibit 38, September 17, 2021 Expert Rebuttal Report of Bruce Deal to Dr. Joseph T. Crane ¶ 11. At the least, this evidence would have been yet another datapoint for the jury to consider as to whether TeamHealth Plaintiffs' billed charges were tied to reasonable

value. At most, this evidence could have shed light on whether TeamHealth Plaintiffs exhibited bad faith in setting excessive charges to line their own pockets.

Defendants' position is that the Court erred with respect to numerous discovery orders—the result being that Defendants were prejudiced in their ability to collect relevant, non-privileged discovery in preparation for trial. The Court's February 4 Order is no exception: as it pertains to TeamHealth Plaintiffs' corporate flow of funds, the Court's February 4 Order found that TeamHealth Plaintiffs were not required to produce discovery regarding certain aspects of the TeamHealth business structure, particularly the portion that related to Blackstone—its business relationship with Blackstone and its profitability. Feb. 4, 2021 Order ¶¶ 7, 11.

Throughout the trial, TeamHealth Plaintiffs were permitted to introduce evidence and argument suggesting that Defendants' conduct resulted in underpayment of physicians or reduced payment to physicians or firing of physicians. Indeed, the very first thing that TeamHealth Plaintiffs' counsel told the jury was that this case is not just "about passing money from one corporate pocketbook to another," but rather it was about "to be treated the same as others . . . when it comes to reimbursement for emergency medical care paid to . . . health care practitioners"—thus suggesting that Defendants were not treating members receiving emergency medicine services from TeamHealth Plaintiffs equally or fairly. 11/2/2021 Tr. at 23:19-24:15. Further, TeamHealth Plaintiffs offered testimony from a physician, Dr. Frantz, regarding the immeasurable value of TeamHealth's services to the physicians and to the communities they serve. Opp. Exhibit 41, Dep. of Robert Frantz ("Frantz 9/24/21 Dep.") at 13:24–16:10; 69:12–17 (Sept. 24, 2021). Similarly, TeamHealth Plaintiffs' counsel asked Bruce Deal repeatedly about whether low reimbursement rates from insurance companies could affect physicians' pay and, in turn, the quality of care. 11/19/2021 Tr. at 141:15-144:13. Other examples abound where TeamHealth Plaintiffs were permitted to laud their physicians and suggest that their physicians deserved income that they were not in fact being paid based on the way that corporate funds flowed within TeamHealth. *See, e.g.*, 11/16/2021 Tr. 56:1-19 (questioning Leif Murphy) ("Q: … What kind of attrition was TeamHealth having among its doctors? A: We -- plus or minus a couple of percentage points. It's always going to be around 10 percent. Q: Okay. Now, do some of the TeamHealth doctors burn out? A:

Unfortunately, yes. Q: Why? A: It is an extremely difficult, high-intensity role in healthcare. Burnout is probably the highest in emergency medicine over any other specialty. You're standing ready at all hours of the day for a patient to arrive with a completely unknown condition. It could be trauma. It could be a heart attack. It could be any number of different things. And you have got be on your game and ready to take care of that patient."); 11/17/2021 Tr. 256:8-18 (questioning Robert Frantz) ("Q: Okay. Now, even though you don't think you have any expertise about what 282 should be compensated as, et cetera, do you have a point of view about reimbursement with a larger company? MR. ROBERTS: Objection. Calls for a narrative. For relevance. THE COURT: Overruled. THE WITNESS: Well, sure. I mean, if reimbursement is not adequate, then we're going to have difficultly, you know, for sure recruiting and retain -- retaining physicians to work in these facilities, and it can undermine the care and the community for the safety net of emergency medicine."). And the prejudicial effect of the Court's erroneous motion *in limine* ruling was felt greatly during closing argument, in which counsel for TeamHealth Plaintiffs repeatedly suggested that Defendants were bullying TeamHealth without an adequate ability to refute that TeamHealth was not being taken advantage of because of the enormous profits they were making as a result of Defendants' payments on the disputed charges. *See, e.g.*, 11/23/2021 Tr. at 151:4-8 ("[I]f you're a doctor in a practice of three or four people . . . are you really going to hire a lawyer or do something about it? I mean [Defendants] know that they have all the power and all the leverage. . . . I mean this is unbelievable."); *see also id.* at 268:1-3 ("And if you [the jury] haven't figured out already why a lot of providers just give up and take the rate" Defendants remit, "it's because of" Defendants. "This isn't easy, and most providers frankly won't do it.").

Defendants were prejudiced by being preventing from introducing evidence to rebut TeamHealth Plaintiffs' insinuation that Defendants' alleged underpayments directly impacted doctor pay. *E.g.* 11/2/2021 Tr. at 151:5-151:7 ("Q: Okay. So here's what I want to know, Mr. Haben, is it correct that with every percentage you cut, United makes more, and the doctors are paid less?"); 11/2/2021 Tr. at 150:12-13 ("Q: Okay. So back to my question. The more you cut, the less we get paid, and the more you make?"); 11/3/2021 Tr. at 120:25-121:8 ("Q: But when it comes to our doctors, who are asking for the reasonable rate, you don't agree with that? MR. ROBERTS:

Objection. Foundation. THE COURT: Overruled. BY MR. ZAVITSANOS: Q: Right? A: I don't agree with what? Q: You're entitled to be treated reasonably, but he's not. A: That's not what I said.") TeamHealth Plaintiffs' counsel also mischaracterized witness testimony by insinuating that UMR "deserves to make more on a given emergency room visit than the ER doctors, whose job is to treat patients and save lives." 11/15/2021 Tr. at 192:6-14; *id.* at 193:3-11; *id.* at 203:3-7 ("Is it reasonable for UMR to make 75 more dollars per 99285 visit than the ER doctors who are treating the patients; is that reasonable?"); *id.* at 204:23-205:2 ("I'm asking whether you're proud that you made more than the doctors? Does that make you feel good inside?"). If Defendants had been allowed to introduce evidence showing that physicians were not entitled to profit sharing and that profits flowed exclusively to TeamHealth, these emotional appeals would have clearly been proven false. For example, in an offer of proof outside the presence of the jury, Leif Murphy clearly testified that physicians would not be entitled to any portion of the proceeds of this lawsuit. 11/16/2021 Tr. at 115:18-21 ("Q Under the physicians' various employment contracts and independent contractor agreements, is there a provision entitling them to a portion of the amount the jury awards in this case? A: In these particular contracts, I don't believe so.").

Had the Court permitted Defendants to introduce evidence of the corporate flow of funds within TeamHealth, it would have been relevant and helpful rebuttal evidence that Defendants were not taking advantage of TeamHealth Plaintiffs' physicians or ordinary Nevadans. By successfully arguing that Defendants should be precluded from offering rebuttal evidence showing that the money TeamHealth skims from the top of Defendants' reimbursements does not benefit the physicians or the larger community, TeamHealth Plaintiffs improperly gained a double-standard on who can offer evidence on relevant issues at trial. Defendants were prejudiced by the large swath of this evidence harming their ability to defend against the massive punitive damages amount that the jury awarded TeamHealth Plaintiffs based on the unfair admission of this evidence. A new trial is warranted on this basis.

G. THE COURT ERRED BY PERMITTING TEAMHEALTH PLAINTIFFS TO DISCUSS THEIR POLICY NOT TO BALANCE BILL WHEN DEFENDANTS WERE PRECLUDED FROM COLLECTING DISCOVERY ON THIS TOPIC

The Court's decisions throughout this lawsuit concerning TeamHealth's balance billing policies and procedures were inconsistent and constituted unfair prejudice to Defendants. TeamHealth Plaintiffs have wielded balance billing as a sword and shield: precluding Defendants from obtaining any evidence on these balance-billing policies and then asserting at trial that Defendants have introduced no evidence that TeamHealth Plaintiffs have a policy to balance bill. This prejudice stands as yet another error that warrants a new trial.

TeamHealth Plaintiffs successfully prevented Defendants from discovering information related to their balance billing policies. On March 29, 2021, the Special Master submitted a Report & Recommendation to the Court that Plaintiffs' Objections to United's Notices of Intent to Issue Subpoena Duces Tecum to TeamHealth and Collect Rx should be granted in their entirety. This included Defendants' request for policies, procedures and communications regarding balance billing. Based on Plaintiffs' objection that "documents about balance bill … is clearly irrelevant," the Special Master determined that documents regarding balance billing were not discoverable. Report and Recommendation No. 2, March 29, 2021 at 4:24-26 and 5:5-6. On August 9, 2021, the Court affirmed and adopted in its entirety Report and Recommendation No. 2. Defendants therefore sought to prevent TeamHealth Plaintiffs from presenting evidence and argumentation on TeamHealth Plaintiffs' policies about balance billing because its prejudicial effect would substantially outweigh its probative value, through Defendants' MIL No. 15. The Court rejected the MIL, finding that there was "sufficient discovery." 10/22/21 Tr. 88:11-12.

Because Defendants have been precluded from probing the veracity of TeamHealth Plaintiffs' balance billing claims through discovery, they were stripped of any means of impeaching TeamHealth Plaintiffs' balance billing testimony. By way of just some examples, when Defendants' counsel sought to cross-examine Leif Murphy about TeamHealth Plaintiffs' balance billing policy, Defendants' counsel was unable to corroborate or confirm Mr. Murphy's testimony that TeamHealth Plaintiffs did not balance bill a patient receiving emergency medicine services from 2006 through 2019, assuming no error in remit advice. 11/16/2021 Tr. at 85:18-86:19. Similarly, TeamHealth

Plaintiffs' expert, David Leathers, was permitted to state that he had seen no evidence indicating that any of TeamHealth Plaintiffs balance billed any of Defendants' members for the disputed services. 11/17/2021 Tr. at 49:8-50:6. And during Leslie Hare's trial testimony, TeamHealth Plaintiffs were permitted to question and effectively argue that TeamHealth Plaintiffs provided a benefit to Sierra Health and Life as well as Health Plan of Nevada that no balance billing occurred. 11/16/2021 Tr. at 178:19-185:17. This, despite Defendants' repeated objections, and despite Defendants' inability to rebut this testimony with anything more than meager testimony at disparate points in trial that witnesses were unsure whether *no* balance billing took place with respect to any of the disputed claims. *See, e.g.*, 11/8/2021 Tr. at 20:15-20 ("Q: And you know that for every single one of the claims at issue in this case, there was no balance billing, right? A: I don't know that to be true. Q: If that was true, the statement would be a little Pinocchio-ish, would you agree? A: I would -- I would disagree."); *id.* at 73:3-19 ("Q: Well, you know that TeamHealth, for the claims at issue in this case, did not balance bill one person. A: No, I don't know that for a fact. I believe they had collection efforts. Q: No, sir. I'm talking about the claims at issue in this case. A: I don't know for a fact."). In fact, in an offer of proof outside the presence of the jury, Defendants elicited testimony from Leif Murphy that TeamHealth balance billed nearly $30,000 to patients in 2017. 11/16/2021 Tr. at 124:2-6.

By preventing Defendants from impeaching TeamHealth Plaintiffs' balance billing testimony, the Court permitted an unfair outcome whereby TeamHealth Plaintiffs were allowed to point to the absence of evidence from the record of instances in which they balance billed—an absence resulting from their stonewalling of any discovery on this issue—and argued that it demonstrated that they did not, in fact, balance bill. This is exactly the scenario that NRS 48.035 seeks to protect against. *See, e.g.*, *State v. Eighth Judicial Dist. Court (Armstrong)*, 127 Nev. 927, 933, 267 P.3d 777, 781 (2011) (noting that "unfair prejudice" under NRS 48.035 is "an appeal to the emotional and sympathetic tendencies of a jury, rather than the jury's intellectual ability to evaluate evidence" (internal quotation marks omitted)); *see also United States v. Skillman*, 922 F.2d 1370, 1374 (9th Cir. 1990) (holding that unfair prejudice under FRE 403—which is substantially similar to NRS 48.035—"appeals to the jury's sympathies, arouses its sense of horror, provokes its

instinct to punish, or otherwise may cause a jury to base its decision on something other than the established propositions in the case").

Thus, under NRS 48.035, the probative value of this evidence was substantially outweighed by the danger of unfair prejudice, of confusion of the issues, or of misleading the jury. That is because the admission of this evidence would impermissibly serve to induce sympathy in the jury. TeamHealth Plaintiffs' purpose of offering testimony that they do not balance bill patients and do not want patients in the middle of the dispute when they vehemently opposed any other discovery regarding balance billing is designed to inflame and unfairly prejudice the jury against Defendants. This unfair result should not have been permitted.

II.
THE COURT'S MOTIONS *IN LIMINE* RULINGS BASED ON ISSUES THAT AROSE AT THE START OF TRIAL WERE ALSO ERRONEOUS AND MERIT A NEW TRIAL

A. THE COURT'S IMPROPER EXCLUSION OF TEAMHEALTH PLAINTIFFS' REFERENCE TO THEIR "SPECIAL RELATIONSHIP" WITH DEFENDANTS IN THEIR PRIOR COMPLAINT IS AN ERROR OF LAW THAT SUPPORTS A NEW TRIAL

On October 7, 2021—just three weeks before trial, and in response to Defendants' Motion for Partial Summary Judgment—TeamHealth Plaintiffs filed their SAC, in which they dismissed half of their causes of action, dropped three of the eight Defendants from the action entirely, and deleted every mention of MultiPlan, Data iSight, and "conspiracy" from their complaint. Not surprisingly, amending their complaint mooted most of the issues in Defendants' Motion for Partial Summary Judgment.

The parties then met and conferred to discuss what allegations from the FAC could be addressed at trial. 10/20/2021 Tr. at 95:12-15. The parties agreed on virtually everything, but one point of contention that the parties raised with the Court concerned what was in paragraph 209 of the FAC: "A special element of reliance or trust between the Health Care Providers and the Defendants [existed], such that, Defendants were in a superior or entrusted position of knowledge" (hereinafter "Paragraph 209"). *Id.* at 96:19-20. In anticipation of TeamHealth Plaintiffs' trial theme that TeamHealth Plaintiffs were assisting community-based health providers that were taken advantage of by Defendants, Defendants sought to discuss the fact that TeamHealth Plaintiffs dropped Paragraph 209 as impeachment evidence. TeamHealth Plaintiffs' counsel argued that

Paragraph 209 should not come in because, according to him, it is a purely legal conclusion that supported its now-dropped claim for tortious breach of implied covenant of good faith and fair dealing. 10/20/2021 Tr. at 93:12-15. Most importantly, *TeamHealth Plaintiffs agreed that factual allegations are fair game*. *Id.* at 95:1-2. But despite the direct relevance of Paragraph 209 to rebutting this central theme, the Court ruled that the *entirety* of the FAC, other than the issues agreed-to by the parties, was irrelevant as a matter of law.

The Court's determination was erroneous and contradicted by Nevada law. It is well established in Nevada that "an admission against the interest of a pleader contained in a prior abandoned pleading may be received in evidence." *Las Vegas Network, Inc. v. B. Shawcross & Assocs.*, 80 Nev. 405, 407–08, 395 P.2d 520, 521 (1964) (permitting statements in prior abandoned pleading to be introduced as evidence). Thus, the presumption is that any statements made in TeamHealth Plaintiffs' FAC are judicial admissions that could have been used against them with respect to any contradictory positions they asserted at trial.

Importantly, TeamHealth Plaintiffs appear to have successfully convinced the Court that this well-established Nevada law draws a distinction between factual versus legal assertions in prior complaints that may be used as impeachment evidence. *See* Mot. at 9 ("To be clear, the Health Care Providers do not seek to exclude factual statements made in prior pleadings or discovery responses. Both sides' prior admissions in their pleadings and discovery responses, regardless of amendment or supplementation, remain fair game."); *see also* 10/19/2021 Tr. at 95:1-2 ("[T]he parties are in complete agreement that factual allegations are fair game."). But that distinction was made up out of whole cloth by TeamHealth Plaintiffs: in neither TeamHealth Plaintiffs' MIL No. 4, nor in TeamHealth Plaintiffs' arguments before the Court, could TeamHealth Plaintiffs point to any controlling Nevada law that supports this distinction. That is because prior inconsistent statements are admissible as impeachment evidence. NRS 51.035. Regardless of TeamHealth Plaintiffs' distinction as to statements in a prior pleading being "factual" or purportedly "legal," Paragraph 209 is still a statement that "has the same force and effect as any other admission of a party and constitutes substantive evidence." *State Farm Mut. Auto. Ins. Co. v. Porter*, 186 F.2d 834, 840 (9th Cir. 1950).

But even if that distinction was real, that TeamHealth Plaintiffs included that allegation in the cause-of-action section of their FAC does not make it a purely legal conclusion. As Defendants' counsel pointed out to the Court, the statement in the FAC was that there "existed" a special element of reliance or trust between the parties. The plain language of TeamHealth Plaintiffs' allegation reads clearly as a factual statement about what "existed" between the parties during the relevant time period. No reasonable interpretation can be made that Paragraph 209 is a purely legal conclusion when it is clearly a statement about a fact that existed between the parties specific to this lawsuit.

The Court's error of law substantially affected Defendants' ability to defend against a central theme pervading TeamHealth Plaintiffs' case-in-chief: that Defendants were large, national insurers that took advantage of TeamHealth Plaintiffs. Accordingly, TeamHealth Plaintiffs obtained testimony on numerous occasions throughout trial that gave the jury the false impression that Defendants were able to exert undue power over TeamHealth Plaintiffs and their contracted physicians. *See, e.g.*, 11/12 Tr. 111:11-16 ("do you think that a mom and pop operation with four, or five, or six doctors has the resources to take on UnitedHealthcare? . . . I mean, do you see how many people are in this room, sir?"); 11/12 Tr. 171:7-16 ("Do you know what percent of emergency room doctors in Nevada are out-of-network if you exclude Team Physicians, Ruby Crest, and Fremont? A: I don't know that. Q: Do you know whether it's almost 50 percent? A: I don't know that. Q: And you understand that the decision that this jury makes in this case affects them as well?"); 11/8 Tr. 95:25-96:9 ("Q: And you knew that Team Health has more resources than an individual little mom and pop ER practice in some small town where there are maybe three or four doctors? Team Health has more resources, right? A: I believe Team Health is a very large company. Q: Yes, sir. And so one of the things this Yale study was intended to do was go after these companies that work with emergency room physicians. Because if you could take them out, the mom and pops are no problem, right? A: I don't agree with that."). Paragraph 209 would have been a valuable piece of evidence to rebut that contention.

In other instances, TeamHealth Plaintiffs elicited testimony about TeamHealth Plaintiffs' relationship to Defendants. For example, TeamHealth Plaintiffs' own witness, Dr. Scherr, discussed

the administrative and charge-setting benefits that TeamHealth provides to TeamHealth Plaintiffs. 11/15/2021 Tr. at 168:8-171:12. Clearly, TeamHealth Plaintiffs were not acting as "insureds" towards Defendants if they were receiving such services from TeamHealth. Defendants could have rebutted the point that a special relationship, in the way of an insurer and insured, existed between TeamHealth Plaintiffs and Defendants with the fact that TeamHealth Plaintiffs retracted Paragraph 209.

Most importantly, the Court's error was prejudicial because it influenced the punitive damages awarded by the jury. As a matter of law, the jury could only award punitive damages to TeamHealth Plaintiffs based on NRS 42.005(2)(b) if Defendants were acting in their capacity as an "insurer." Therefore, the statute's use of the term "bad faith" is limited to the context of insurance coverage. *See Rural Telephone Co. v. Public Utilities Commission*, 133 Nev. 387, 389, 398 P.3d 909, 911 (2017). In the insurance context, bad faith is a term of art that Nevada courts defined long before the Legislature added that language to NRS 42.005. *See, e.g.*, *U.S. Fidelity & Guaranty Co. v. Peterson*, 91 Nev. 617, 619-20, 540 P.2d 1070, 1071 (1975) (defining insurer bad faith); *Beazer Homes Nevada, Inc. v. Eighth Jud. Dist. Ct.*, 120 Nev. 575, 585, 97 P.3d 1132, 1139 (2004) (finding a term of art exists when the term is subject to "extensive case law"). When the Legislature uses a term that has a well-defined meaning at common law, it is presumed that the term is used in the common law sense. *Moser v. State*, 91 Nev. 809, 812-13, 544 P.2d 424, 426 (1975). Thus, as used in NRS 42.005, "bad faith" is limited to bad faith by an insurer as defined at common law.

At the punitive damages phase of trial, Defendants were hamstrung by the Court's error of law and prevented Defendants from arguing to the jury that none of the bad faith conduct that TeamHealth Plaintiffs argued Defendants undertook was not tortious as required by NRS 42.005(1)—meaning it the claim must arise out of a "special relationship" characterized by "fiduciary responsibility." *Ins. Co. of the W. v. Gibson Tile Co.*, 122 Nev. 455, 461–62, 464, 134 P.3d 698, 702, 703 (2006) (without a special relationship, claim for bad faith did not support punitive damages).[6] TeamHealth Plaintiffs' retraction of Paragraph 209 would have provided Defendants

[6] Generally, liability for bad faith by an insurer occurs when the parties are in an insurer and insured relationship and the insurer has an actual or implied awareness that no reasonable basis exists

with evidence to demonstrate that, in fact, a special relationship did *not* exist between the parties. Indeed, while "[e]xamples of special relationships include those between insurers and insureds, partners of partnerships, and franchisees and franchisers," the Nevada Supreme Court has never said that such a relationship exists in the arm's-length transactions between an insurer and a staffing company for providers of medical services. *Id.* Because there was no real dispute at trial that TeamHealth Plaintiffs are not insureds and were not parties to an insurance contract with Defendants, Defendants should have been permitted to explain to the jury this fact and use Paragraph 209 as evidence that TeamHealth Plaintiffs understood this to be the case. By preventing Defendants' use of Paragraph 209, Defendants were prevented from demonstrating key evidence that could have prevented the jury from determining that punitive damages were warranted in this case.

B. THE COURT ERRED BY ALLOWING TEAMHEALTH PLAINTIFFS TO ADMIT EVIDENCE THAT IS BEYOND THE SCOPE OF THIS LAWSUIT

There is no dispute that the relevant time period for evidence governing this action is January 31, 2020. *See* 11/2/2021 Tr. at 136:10-13 (TeamHealth Plaintiffs' counsel confirming that January 31, 2020 is the relevant time period for the discovery cut-off). Defendants accordingly filed two motions *in limine* that sought to prevent evidence and argumentation that is irrelevant to this action because that evidence and argumentation exceeded the scope of discovery in this case.

One of those motions *in limine* was Defendants' MIL No. 32, which sought generally to prevent TeamHealth Plaintiffs from introducing evidence or argumentation relating to events of Defendants' conduct that occurred after the relevant time period governing this case. Aside from a small subset of disputed benefit claims that TeamHealth Plaintiffs voluntarily dismissed and were not sent to the jury, Defendants argued in their MIL No. 32 that passage of Nevada's Surprise Billing Act meant that the Court should not have allowed any evidence about Defendants' adjudicated of claims with dates of service after January 1, 2020. Specifically, the Surprise Billing Act created a comprehensive framework for resolving payment disputes between out-of-network emergency

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regarding its coverage obligation. *Pioneer Chlor Alkali Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pennsylvania*, 863 F. Supp. 1237, 1242-44 (D. Nev. 1994).

services providers and third-party payors became effective. *See* NRS 439B.160; NRS 439B.700 et seq. It establishes a mandatory and exclusive process for contesting the amount of reimbursement for professional emergency services rendered by out-of-network providers, including by TeamHealth Plaintiffs. Additionally, the Act establishes mandatory pre-arbitration negotiation protocols. Namely, if the parties cannot reach resolution, "the parties are required to submit the dispute to binding arbitration," with the out-of-network provider responsible for initiating that arbitration. S.B. No. 68, Comm. on Gov't Affairs, Ch. 62, AB 469, Legis. Counsel's Digest (approved May 14, 2019). There is no dispute that TeamHealth Plaintiffs did not adhere to this statutory requirement, which required binding arbitration. NRS 439B.754(5). Therefore, anything related to Defendants' rate setting determinations that occurred after January 1, 2020 should have been precluded.

The other motion *in limine* was MIL No. 29, which sought to preclude irrelevant evidence of documents and events concerning Naviguard, a company that United purportedly supported that could allegedly provide services similar to those offered by MultiPlan. Naviguard—known also within United at certain times as Project AirStream—was an initiative to establish an internal entity that provides advocacy services for members with out-of-network claims. Opp. Exhibit 17, Haben Dep. at 217:18-20. Naviguard, while under the UHG umbrella, is a separate entity from UHC. 11/12/2021 Tr. at 51:19-54:16. Naviguard does not price or process out-of-network claims, but instead helps members address out-of-pocket costs, including copays, coinsurances, deductibles, and balance bills. *Id.* It also helps members understand the value of their benefits. *Id.*

Be it evidence of conduct related to the submission of health benefit claims after January 1, 2020 (MIL No. 32) or evidence related to Defendants' consideration of Naviguard (MIL No. 29), this case is about what is the reasonable value of out-of-network emergency services rendered in Nevada. Not one iota of evidence in the record shows that Naviguard had any role in pricing or processing a single out-of-network emergency claim, and thus, has no bearing whatsoever on the case. Nevertheless, throughout the trial, TeamHealth Plaintiffs questioned Defendants' witnesses about Naviguard. *See, e.g.*, 11/9/2021 Tr. at 152:17-183:11; 11/12/2021 Tr. at 161:10-174:3; 11/15/2021 Tr. at 115:3-116:24; 11/22/2021 Tr. at 265:15-269:25. The Court's error of law which

allowed for evidence to be admitted beyond the scope of this action highly prejudiced Defendants' right to receive a fair trial because it not only confused the jury, it inflamed their passions. The effect of the enormous volume of prejudicial testimony about Naviguard and Project AirStream was to provide the jury with the impression that Defendants were furthering an uncorroborated scheme to underpay providers. *See, e.g.*, 11/9/2021 Tr. at 152:17-153:21 ("And this NewCo is Naviguard, you're going to hold them out as being a third party. In other words, they're not going to have 'United' in their name, so that people don't associate them with United, so that you could tell clients you're going to a third party, just like you went with Multiplan. … ***[D]o you think this shows unchecked greed?***" (emphasis added)); *id.* at 182:18-183:11 (TeamHealth Plaintiffs' counsel suggesting that UHG "replaced one Wizard of Oz with another" when describing replacing MultiPlan, Inc. with Naviguard); 11/22/2021 Tr. at 269:19-270:6 ("[D]oes it seem to you, sir, that United figured out that all you all do is just buy something off the shelf, so instead of paying you 300 million, they're going to do it themselves and package it under some new company [Naviguard] that sounds official?"); 11/23/2021 Tr. at 156:3-158:6 (TeamHealth Plaintiffs' counsel stating: "And so Naviguard, we [*i.e.*, United] don't want people knowing it's associated with United Healthcare, we're going to position it as a third-party."). TeamHealth Plaintiffs' counsel also asked MultiPlan's VP of Healthcare Economics, Sean Crandell, inflammatory questions about Naviguard. *See, e.g.*, 11/22/2021 Tr. at 266:25-3 ("Q Does this appear to be an internal United discussion where trying to see if they could swap out Naviguard from MultiPlan without having to go back to the clients and getting them to sign off on it based on how loose the language is in the planned benefits? A: Yeah, I can't comment on -- I don't deal with clients directly. Like I don't even recognize anything like this. If this is a United document, I don't -- I shouldn't really comment on this.").

Moreover, these and any other pieces of evidence relating to events occurring after both the relevant discovery cut-off and the relevant dispute period in this action is not probative of how Defendants adjudicated the at-issue health benefit claims. There is no dispute that the record lacks any evidence that Naviguard came into fruition during the dispute period in this case, or that Naviguard that was ever used to price or process any claims. As a matter of law, evidence or argument concerning claims accruing, documents created, or actions taken beyond January 31, 2020

are irrelevant. *See Broughton v. Saul*, 2020 WL 1327401, at *6 n.10 (D. Nev. Mar. 3, 2020) (declining to discuss "evidence from outside the relevant period" (citing *Carmickle v. Comm'r of Soc. Sec.*, 533 F.3d 1155, 1165 (9th Cir. 2008))); *Turner v. Comm'r of Soc. Sec.*, 613 F.3d 1217, 1223–24 (9th Cir. 2010) (holding that date of evidence is germane reason to exclude). Therefore, Defendants sought, through both of these MILs, to prevent any evidence from being admitted that concerned conduct occurring after January 31, 2020. Because such evidence was irrelevant as a matter of law, the Court erred by not granting Defendants' MILs.

That TeamHealth Plaintiffs' counsel suggested in front of the jury that UHG created Naviguard out of "unchecked greed" to replace MultiPlan and reap more profit from out-of-network programs is manifestly inappropriate and prejudicial to Defendants: in fact, Mr. Haben testified that Naviguard and MultiPlan offered different services, and that Naviguard was not created to replace MultiPlan. *Id.* at 51:19-54:16. In combination with TeamHealth Plaintiffs' inflammatory arguments about Defendants' shared savings programs, the jury was left with the impression that Defendants' supposed scheme continued beyond January 2020—despite Naviguard never coming into fruition and having no bearing on the out-of-network emergency claims in dispute. And by allowing the jury to hear discussion about this evidence, Defendants were greatly prejudiced because it allowed the jury to equate this additional volume of information to guilt or attribute it to its finding of damages, including the punitive damages awarded to TeamHealth Plaintiffs.

The fact remains that there is no evidence that Naviguard applied to any disputed claim. Nor could it, as United's clients did not start to adopt Naviguard until late 2020 and therefore could not have played any role with respect to any of the disputed claims. A new trial is therefore warranted based on this irrelevant topic being used to improperly influence the jury.

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Grounds for a New Trial Attributable to Errors Occurring During the Course of, or Lead-Up to, Trial

Introduction

In the span of about three months, from pre-trial to the jury's two verdicts (liability phase and punitive phase), an array of errors and misconduct necessitating a new trial arose.

TeamHealth Plaintiffs unabashed trial strategy was to inflame the jury's passions. This fact, *i.e.*, that Defendants would not receive a fair trial, started to come into focus just before trial began. Throughout litigation TeamHealth Plaintiffs, despite being staffing companies, branded themselves "Health Care Providers." Not wanting these entities to play on the jurors' natural emotions and sympathies that medical providers save lives, Defendants sought to preclude TeamHealth Plaintiffs from dubbing themselves "Health Care Providers" at trial. In fact, Defendants merely wanted the same protection afforded to other litigants defending themselves from TeamHealth affiliates. In a case in Texas, other TeamHealth staffing company subsidiaries sued an insurer and were ordered not to call themselves doctors, providers, or the like. They were to just refer to themselves as plaintiffs without the use of inflammatory adjectives. Defendants showed this Court the order in that case and demonstrated that a neutral naming convention was feasible. The Court, however, disagreed, ordering the "Health Care Providers" to be careful that they make clear to the jury that they are staffing companies. As foreseen by Defendants, this protection was inadequate. Worse, it was illusory. Defendants were subjected to immense prejudice without the slightest indication to the jury from TeamHealth Plaintiffs that they were staffing companies.

Having their "Health Care Provider" rebrand sanctioned by the Court, TeamHealth Plaintiffs' inflammatory trial strategy became more forceful. In the first minutes of the case, TeamHealth Plaintiffs told the jury that this case was about the quality of health care in Nevada. Defendants were shocked and believed the Court would be, too, at hearing this statement. For the past year, TeamHealth Plaintiffs and this Court had told Defendants that this was a rate-of-payment case. Nothing more. But now, TeamHealth Plaintiffs were Health Care Providers on a mission to vindicate the quality of health care of all Nevadans. This was improper because it was designed to overcome the jurors' intellect in evaluating evidence by replacing their thoughts with a sense of duty

to use their verdict as a means to remedy a social ill that was larger than the case itself. Indeed, TeamHealth Plaintiffs' preyed on the jurors emotions and called on them to remedy a social ill by telling the jury: (1) that Nevadans receive the worst quality of care in the country due to the reimbursement being remitted by Defendants; (2) that they should be embarrassed about the reimbursement that Defendants are paying for their claims; (3) that the case is more than just about the money claimed to be owed; and (4) that, with the world watching, they have more power than Congress because they can pull all of Nevada up from the bottom to receive equal treatment from Defendants. These statements are not allowed and constitute misconduct requiring a new trial. But beyond that misconduct, the Court did not allow Defendants an opportunity to rebut these inappropriate notions planted into the jurors' minds.

Additionally, to further prejudice Defendants, TeamHealth Plaintiffs' repeatedly conditioned the jury that Defendants needed to pay more money by analogizing the emergency medicine services rendered to the value of human life. The story went, "look at what Defendants are paying and look at the billed charge to save someone's life, how can it be that more money is not owed." In fact, TeamHealth Plaintiffs argued to the jury that they save lives and have a standard charge that does not change. They also told the jury that the jury needs to focus on the impact to patients and that they should be thinking about saving someone's life. But, the value of human life is not a measure of TeamHealth Plaintiffs' services. And, TeamHealth Plaintiffs knew that the jury could not tell what at-issue claims concerned life saving treatment because Dr. Scott Scherr told the jury that they would be unable to do so by looking at the claims. Nonetheless, TeamHealth Plaintiffs told the jury that Defendants are "screwing" them and the patients. This analogy and argument was unbelievably prejudicial and its only purpose was to prey on the jurors' emotions.

TeamHealth Plaintiffs' brazen misconduct and trial strategy to inflame the jurors passions knew no bounds. As detailed below, opposing counsels' misconduct was an avalanche that plagued this case's liability and punitive phases. This Court in reflection should, as Defendants always have been, be astounded by the sheer volume of opposing counsels' misconduct in providing their own personal opinions as to the justness of their clients' cause, the credibility of witnesses, the Defendants' culpability, the belittlement of witnesses and Defendants, and at their conduct that

otherwise inflamed the passions of the jury. It simply does no justice to try and summarize what Defendants had to endure here, but the sampling below shows that a new trial is required.

Next, another central theme to TeamHealth Plaintiffs trial strategy was to convince the jury that Defendants should be found liable for having engaged in conduct protected by the First Amendment. Specifically, that Defendants should be liable for having assisted a researcher at Yale University in exploring the dynamics of rising medical costs, which many news outlets and other research institutes also discussed. Because the Petition Clause of the First Amendment immunizes all genuine activities incidental to influencing government action, including public relations campaigns and related private communications, from statutory and common-law liability, Defendants moved *in limine* to preclude TeamHealth Plaintiffs from their desired theme. In opposition to that motion, TeamHealth Plaintiffs conceded that Defendants' conduct was genuine and caused sweeping legislation to be enacted across the country. Yet, without even a glancing reference to any legal authority, TeamHealth Plaintiffs argued that Defendants' constitutional protections should be denied. TeamHealth Plaintiffs knew their position was unsound based on the legal authority cited by Defendants. Nonetheless, they managed to convince the Court to break with longstanding, clear, and contrary precedent.

Still, Defendants were left with some hope that that their constitutional rights would not be completely denied. In errantly siding with TeamHealth Plaintiffs, Court signaled that it would be vigilant in the admission of exhibits and questioning of witnesses because it found that Defendants were engaged in genuine petitioning activity. But this protection, too, was illusory. Numerous exhibits regarding Defendants First Amendment activities were admitted into evidence without proper foundation. And, TeamHealth Plaintiffs were able to realize their central theme and further inflame the passions of the jury. As a result, the jury held Defendants liable for constitutionally immunized conduct. Therefore, a new trial is required.

A new trial is also required because the proceedings were fraught with irregularity and errors of law. First, TeamHealth Plaintiffs were able to change their punitive damages theory whenever they saw fit. They did so multiple times before trial in response to Defendants' Motion for Partial Summary Judgment. This unfairly hampered Defendants' trial preparations by having to both

formally respond to ever changing arguments and to change their trial strategy to adapt to the changing landscape. Additionally, just before the case was submitted to the jury, the Court permitted TeamHealth Plaintiffs to amend the Joint Pre-Trial Memorandum to request that the jury award punitive damages based on their unjust enrichment cause of action. However, the Joint Pre-Trial Memorandum did not state TeamHealth Plaintiffs were seeking punitive damages for unjust enrichment because Defendants insisted that they disclose the theories of relief that would be presented to the jury. Defendants did so to be able to prepare for trial and present their case. Also, none of the complaints filed in this case by TeamHealth Plaintiffs requested punitive damages based on unjust enrichment. So, Defendants justifiably relied on TeamHealth Plaintiffs' representations.

Second, the Court did not permit Defendants to exercise their peremptory challenges in the manner prescribed by statute. Defendants wanted to alternate strikes with TeamHealth Plaintiffs against any name on the list of persons on the panel, per NRS 16.030(4). TeamHealth Plaintiffs wanted the parties to waive their right to challenge a juror if the party first challenges a later drawn juror—*i.e.*, juror 1 cannot be challenged after juror 3 was challenged. However, this is not the approach that the statute proscribes. Thus, Defendants did not receive the full protection of the statute, which is designed to ensure a fair and impartial jury.

Third, exhibits were improperly admitted both before and during trial. Just before opening statements, TeamHealth Plaintiffs requested that numerous exhibits be pre- or conditionally admitted. However, they did not follow the proper procedure for doing so, *i.e.*, filing a motion *in limine*. Despite this failure, the Court agreed to conditionally admit numerous exhibits over objection without an individualized analysis for each document. Additionally, the Court admitted numerous documents during trial that lacked foundation. Pursuant to Nevada law, as pertinent to this case, an exhibit can only be admitted through a witness if the witness has personal knowledge of the exhibit, is a custodian, or, if being admitted as a business record exception to hearsay, is familiar with the entity's record keeping system. However, many documents were admitted even though the witness did not know how, why, or when the document was written, the witness was not a custodian, and there was no testimony that the witness was familiar with Defendants' record-

keeping system. As such, the jury was presented with numerous documents that it should have never considered in rendering its verdict.

Fourth, during the punitive damages phase, the Court improperly admitted irrelevant or improper evidence that tainted the jury's verdict. Before the punitive damages phase begun, Defendants made clear that they were not going to argue inability to pay damages or financial hardship as a mitigating factor against the amount of punitive damages. As such, Defendants' financial information was irrelevant and only served to inflame the jury's passions. Additionally, the Court admitted evidence related to Defendants' historical conduct that was not admitted during the liability phase. This meant that the jury was determining liability and the amount of punitive damages at the same time. This is prohibited under Nevada law. Thus, the jury's punitive damages verdict was tainted.

Fifth, the process of using deposition testimony and the presentment of that testimony was unorthodox. Going into trial, TeamHealth Plaintiffs designated an inordinate amount of deposition testimony. In fact, they designated multiple weeks' worth of deposition testimony. under the guise of preserving their right to call witnesses. However, pursuant to the disclosure rules, TeamHealth Plaintiffs were required to tell Defendants what testimony they ***expected*** to present. This disclosure rule is to prevent trial by ambush and allow meaningful trial preparation. TeamHealth Plaintiffs could not have expected to present the testimony that they designated because they only requested seven trial days for their case and represented that one witness would take nearly half that time. Then, in the midst of trial, TeamHealth Plaintiffs ambushed Defendants and slashed their designations. Next, the method by which the Court allowed TeamHealth Plaintiffs to present witnesses by deposition testimony only violated Nevada law. TeamHealth Plaintiffs were allowed to be the "master of their case" and present witnesses by deposition testimony in the same manner as a live witness. However, Nevada law requires that the opposing party can require the simultaneous presentment of any other additional deposition testimony that in fairness should be presented at the same time. As such, the jury heard one question and answer during TeamHealth Plaintiffs' presentment and then heard the remaining context during Defendants presentment. By that time, the link between the related testimony was lost. Similarly, the Court did not require

TeamHealth Plaintiffs to abide by the rule of completeness when attempting to impeach witnesses with deposition testimony. As such, Defendants were prejudiced because the jury was confusingly presented with deposition testimony and the ascertainment of truth was defeated. Therefore, a new trial is to remedy each of these irregulates and errors of law required.

Finally, Defendants were denied a fair trial because TeamHealth Plaintiffs were able to present expert testimony by ambush. TeamHealth Plaintiffs only relied on the expert testimony of David Leathers to establish damages. However, the expert report that formed the basis of his opinion to the jury was submitted a month after affirmative reports were due and a week after rebuttal reports were due. TeamHealth Plaintiffs conceded their error and provided no justification for why their failure to follow the rules should be ignored. Instead, they claimed Defendants were not prejudiced. But this was not true. Defendants had less than a week to prepare to depose Mr. Leathers. And, the night before his deposition, more work papers and opinions were disclosed. The Court excused these ambush tactics and Mr. Leathers was permitted to testify at trial. Then, less than two days before his trial testimony, Mr. Leathers disclosed to Defendants that he was going to opine on a brand new method to calculate damages. Even though Defendants got Mr. Leathers to admit that his last minute disclosure contained a new methodology, the Court did not strike his testimony. As such, Defendants were ambushed at trial and denied a meaningful opportunity to defend themselves. A new trial is required to remedy this prejudice.

Legal Argument

A court may grant a motion for a new trial on various grounds "materially affecting the substantial rights of the moving party." NRCP 59(a)(1). Those grounds include among other things, there was "[m]isconduct of the jury or prevailing party." NRCP 59(a)(1)(B). This includes misconduct during voir dire, *Hogan v. State*, 103 Nev. 21, 23, 732 P.2d 422, 423 (1987); *Azucena v. State*, 135 Nev. Adv. Op. 36, 448 P.3d 534 (2019), and closing argument, *Lioce v. Cohen*, 124 Nev. 1, 174 P.3d 970 (2008), and throughout the trial for violations of the Court's orders or pretrial rulings *in limine*, *Bayerische Motoren Werke Aktiengesellschaft v. Roth*, 127 Nev. 122, 132– 33, 252 P.3d 649, 656–57 (2011). A new trial is also appropriate for an "error in law occurring at the

trial and objected to by the party making the motion" or if there was "surprise that ordinary prudence could not have guarded against." NRCP 59(a)(1)(C), (G).

Additionally, a new trial may be granted if there was an "irregularity in the proceedings of the court, jury, master, or adverse party or in any order of the court or master, or any abuse of discretion by which either party was prevented from having a fair trial." *Id.* 59(a)(1)(A). An abuse of discretion can occur when the district court misinterprets controlling law. *MB Am., Inc. v. Alaska Pac. Leasing*, 132 Nev. 78, 88, 367 P.3d 1286, 1292 (2016); *Gunderson v. D.R. Horton, Inc.*, 130 Nev. 67, 80, 319 P.3d 606, 615 (2014) (holding that a decision made "in clear disregard of the guiding legal principles [can be] an abuse of discretion").

An excessive verdict can, on its own, warrant a new trial. NRCP 59(a)(1)(F); *see also Hazelwood v. Harrah's*, 109 Nev. 1005, 1010, 862 P.2d 1189, 1192 (1993) (citing *Stackiewicz v. Nissan Motor Corp.*, 100 Nev. 443, 686 P.2d 925 (1984)), overruled on other grounds by *Vinci v. Las Vegas Sands, Inc.*, 115 Nev. 243, 984 P.2d 750 (1999). The factors a court considers in determining the excessiveness of an award are the reasonableness of the award in light of the evidence, *K-Mart Corp. v. Washington*, 109 Nev. 1180, 1196–97, 866 P.2d 274, 284–85 (1993); *Nev. Indep. Broad. Corp. v. Allen*, 99 Nev. 404, 419, 664 P.2d 337, 347 (1983), and inappropriate conduct at trial designed to arouse passion or prejudice in the jury favorable to the plaintiffs, *Born v. Eisenman*, 114 Nev. 854, 962 P.2d 1227, 1231-32 (1998); *DeJesus v. Flick*, 116 Nev. 812, 7 P.3d 459 (2000).

Moreover, courts are permitted to view errors that occurred cumulatively in order to grant a new trial. *Harper*, 533 F.3d at 1030 (cumulative effect of evidentiary errors basis for new trial). As the Nevada Supreme Court has observed, trial errors that in isolation can sometimes be characterized as "harmless" may, when considered together, prove to be sufficiently prejudicial that a new trial is required. *See, e.g.*, *Pertgen v. State*, 110 Nev. 554, 566, 875 P.2d 361, 368 (1994), abrogated on other grounds by *Pellegrini v. State*, 117 Nev. 860, 34 P.3d 519 (2001); *see also Nelson v. Heer*, 123 Nev. 217, 227, 163 P.3d 420, 427 (2007) (leaving open the question whether the doctrine of cumulative error applies in civil cases).

I.
TEAMHEALTH PLAINTIFFS' TRIAL STRATEGY UNABASHEDLY REVOLVED AROUND INFLAMING THE JURY'S PASSIONS, WHICH INVOLVED ATTENDANT ERRORS THAT ARE ALSO INDEPENDENT GROUNDS FOR A NEW TRIAL

Until trial, it was TeamHealth Plaintiffs' position and this Court's belief that this was a "rate-of-payment case." First Amend. Compl. ¶ 1 & n.1; Second Amend. Compl. ¶ 1 & n.1; 10/26/2020 Order at 2 ¶¶ 1-2. That all changed once trial began and the passions of the jury could be manipulated.

Throughout trial, this Court erred in allowing TeamHealth Plaintiffs to make this case about local providers versus a national-behemoth insurer. Specifically, they were allowed to: (1) call themselves "Health Care Providers" despite being staffing companies backed by one of the largest private equity firms in the world; (2) reframe the case as being about the quality of care in Nevada; (3) juxtapose the average reimbursement of Nevada emergency medicine services against the average reimbursement in other states; and (4) condition the jury into believing more reimbursement is owed by repeatedly analogizing to their services to the value of human life. Additionally, TeamHealth Plaintiffs' counsels' examination of witnesses was replete with misconduct. While the Court sustained some of Defendants' objections regarding this misconduct, curative instructions and admonishment were scarce. As a result, opposing counsels' misconduct continued unabated and at every opportunity they inflamed the passions of the jury, including during closing argument. Due to this prejudice, Defendants were left with no choice but to address the rampant misconduct in their own closing argument. These errors individually and cumulatively require a new trial. *See also* NRS 50.115(1)(a) (requiring courts to "exercise reasonable control over the mode and order of interrogating witnesses and presenting of evidence" so that "the interrogation and presentation" is "effective for the ascertainment of the truth").

The rules of proper examination and argument are simple. Counsel cannot attempt to have the jury "send a message about some social issue that is larger than the case itself or because the result dictated by law is contrary to the jury's sense of justice, morality, or fairness." *Lioce*, 124 Nev. at 20, 174 P.3d at 982-83. "[A]n attorney shall not state to the jury 'a personal opinion as to the justness of a cause, the credibility of a witness, or the culpability of a civil litigant.'" *Lioce*, 124

Nev. at 21 (quoting NRPC 3.4(e)) (brackets in original omitted); *Earl v. State*, 111 Nev. 1304, 1311 (1995) (holding counsel cannot "ridicule or belittle" a witness, an opposing party, or the case, including by insinuating that testimony or evidence is not true); *Yates v. State*, 103 Nev. 200, 204, 734 P.2d 1252, 1255 (1987) (recognizing that certain characterizations of testimony can improperly transform an attorney "into an unsworn witness on the issue of the witnesses credibility and are clearly improper"). And, "[a]ny inclination . . . to inflame the passions of the jury must be avoided." *Shannon v. State*, 105 Nev. 782, 789 (1989). This includes unfairly prejudicing an opponent through "an appeal to the emotional and sympathetic tendencies of a jury, rather than the jury's intellectual ability to evaluate evidence." *See, e.g.*, *State v. Eighth Jud. Dist. Ct. (Armstrong)*, 127 Nev. 927, 933, 267 P.3d 777, 781 (2011) (internal quotation marked omitted); *United States v. Skillman*, 922 F.2d 1370, 1374 (9th Cir. 1990) (holding that unfair prejudice under FRE 403—which is substantially similar to NRS 48.035—"appeals to the jury's sympathies, arouses its sense of horror, provokes its instinct to punish, or otherwise may cause a jury to base its decision on something other than the established propositions in the case").[7]

[7] Any attempt by TeamHealth Plaintiffs to argue that their counsels' misconduct should be overlooked because of a lack of objection should be rejected. In *Lioce*, the Nevada Supreme Court made clear that the failure to object to every instance of opposing counsels' "persistent" misconduct is not required. 124 Nev. at 23 ("Regarding the failure to object, we conclude that, because of the persistent nature of [the] misconduct, the . . . objections to . . . other [misconduct] sufficiently preserved the issue"); *see also* 11/23/2021 Tr. 271:13-16 ("[Defendants] had similar objections denied. We were put in the position of having to object constantly before the jury."). Indeed, *Lioce* explained that a party is absolved of objecting to each and every instance of "repeated or persistent misconduct" because "the nonoffending attorney is placed in the difficult position of having to make repeated objections before the trier of fact, which might cast a negative impression on the attorney and the party the attorney represents, emphasizing the improper point." 124 Nev. at 18. Thus,

> when the district court decides a motion for a new trial based on repeated or persistent object-to misconduct, the district court shall factor into its analysis the notion that, by engaging in continued misconduct, the offending attorney has accepted the risk that the jury will be influenced by [the] misconduct. . . . [And] the district court shall give great weight to the fact that single instances of improper conduct that could have been cured by objection and admonishment might not be curable when that improper conduct is repeated or persistent.

Id. at 18-19.

A. ERROR OF LAWS AND/OR ABUSE OF DISCRETION THAT ENABLED TEAMHEALTH PLAINTIFFS TO INFLAME THE PASSIONS OF THE JURY

1. Allowing TeamHealth Plaintiffs to Refer to Themselves as "the Health Care Providers"

Defendants filed Motion *in Limine* No. 24 so that they would not be unfairly prejudiced by TeamHealth Plaintiffs referring to themselves as "Healthcare Providers." That motion was necessary because TeamHealth Plaintiffs referred to themselves as "Healthcare Providers" throughout this litigation to convey the false impression that they are doctors or medical professionals. Accordingly, it would have been unfair for TeamHealth Plaintiffs to be permitted to play to the jury's emotions by claiming, expressly or impliedly, that any award of damages would result in a payment to an actual emergency medicine service provider or otherwise result in better quality of emergency medicine care. This Court denied that motion, causing Defendants to suffer undue prejudice at trial. Further, Defendants were subjected to further prejudice because TeamHealth Plaintiffs used their false "Healthcare Provider" identity to inflame the passions of the jury. Accordingly, a new trial is required.

TeamHealth Plaintiffs affirmatively implied a false identity to the jury throughout trial by referring to themselves as the "Health Care Providers." However, TeamHealth Plaintiffs are not themselves medical service providers; they are corporate persons that are for-profit staffing companies. **Exhibit** 1 at 5-8 (showing that TeamHealth Plaintiffs do not provide medical services). Indeed, another court presiding over a nearly identical jury trial brought by TeamHealth and tried by opposing counsel ordered that plaintiffs could not be called healthcare providers. *Id.* at 13. TeamHealth Plaintiffs did not deny that order, that their lawsuit was nearly identical to that trial, or that there was an effort to rebrand "as if to play on the jurors' natural sympathies that doctors save lives." *See* 10/22/2021 Tr. 136:4-12. Instead, they argued that this Court should not similarly preclude their desired rebrand because that order fell by the wayside during trial. *Id*. However, just because a different defendant in a different lawsuit did not enforce a properly granted motion *in limine* to prevent undue prejudice does not mean that Defendants should not have been protected against the same undue prejudice.

Sensing that the same ruling would be rendered in this case, opposing counsel stood because

he "forgot to mention one important point that [he] th[ought] might be dispositive." *Id.* 140:2-4. Specifically, TeamHealth Plaintiffs should be allowed to call themselves "Healthcare Providers" because "the legal owner of" one of the plaintiffs, Fremont, "is a physician. . . . [T]he legal owner of record is a physician." *Id.* 140:5-10. That argument prevailed. This Court denied Defendants' motion "only because of the way that the professional corporations are set up." *Id*. 140:12-14. Despite the errant denial, this Court recognized the prejudice that would befall Defendants and "caution[ed]" TeamHealth Plaintiffs that they "need[ed] to be really clear with the jury that these are organizations that staff ER rooms in hospitals under contract." *Id*.

TeamHealth Plaintiffs never observed that caution and preyed on the jury's emotions that doctors save lives and insurers do not. 11/15/2021 Tr. 191:11-17 ("And the ER doctors, the ER providers, the Plaintiffs in this case, their job is to treat patients and save lives"); 11/3/2021 Tr. 120:25-122:22 ("But when it comes to our doctors, who are asking for the reasonable rate, you don't agree with that?"). As detailed below, TeamHealth Plaintiffs littered their examinations of witnesses with questions or statements designed to inflame the passions of the jury. *Infra* Course of, or Lead-Up to, Trial Errors Sections I.A.2-3, I.B & II.C. For example, opposing counsel repeatedly conditioned the jury to believe that more money was owed to TeamHealth Plaintiffs by analogizing the emergency medicine services rendered to the value of human life. *Id*. They engaged in rampant examination misconduct such as the belittlement that UMR "deserves to make more on a given emergency room visit than the ER doctors, whose job is to treat patients and save lives." 11/15/2021 Tr. 192:6-14; *id.* 193:3-11 (same); *id*. 203:3-7 (same); *id.* 203:24-204:6 (same).[8] And by "asking whether [an adversely called defense witness was] proud that you made more than the doctors? Does that make you feel good inside?" 11/15/2021 Tr. 204:23-205:2. Further, opposing counsel used the belittlement of UMR to inflame the jury's passions into awarding a massive punitive

[8] Even though Defendants also lodged asked and answered objections, the Court did not "exercise reasonable control over the mode and order of interrogating witnesses . . . [t]o protect witnesses from undue harassment or embarrassment." NRS 50.115(1)(c). Tellingly, opposing counsel characterized this examination as "more courteous" than what other witnesses were subjected to on the stand. 11/15/2021 Tr. 229:15-16; *see also id*. 230:2-13 (noting how opposing counsel was "cutting off the witness," "going through . . . theatrics to get to a point," and how the first witness in the case was subjected to worse "for days and days and days").

damages award. 12/7/2021 Tr. 102:5-8 ("Mr. McManis question[ed]" the witness from UMR: "Whose job it is to treat the patient that saves lives? Who do you think deserves more?"). In short, TeamHealth Plaintiffs' desire to rebrand themselves as "Healthcare Providers" was part of their ploy inflame the passions of the jury to obtain additional reimbursement and punitive damages.

Furthermore, the error in allowing Defendants to endure this undue prejudice was compounded when the Court did not allow Defendants to impugn Dr. Scott Scherr's credibility. As noted, the Court denied Defendants' motion "because of the way that the professional corporations are set up." 10/22/2021 Tr. 140:12-14. Or as TeamHealth Plaintiffs put it, "a physician . . . [was] the legal owner of" Fremont. *Id.* 140:5-10. Dr. Scherr is that "legal owner." *See* 11/15/2021 Tr. 176:2-5. However, the Court denied Defendants the ability to fully question Dr. Scherr on his relationship to Fremont. *Id.* 176:9-14, 180:3-21. So, on the one hand, TeamHealth Plaintiffs were allowed to benefit from that ownership and rebrand themselves the "Healthcare Providers," but on the other, Defendants were barred from rebutting that misconception. Thus, the Court allowed TeamHealth Plaintiffs to call themselves Healthcare Providers, but impeded Defendants from diminishing that prejudice.

Furthermore, instead of being very clear that their clients were staffing companies, opposing counsel appealed to the emotions and sympathies of the jury during closing argument to further prejudice Defendants. For example, opposing counsel pointed to Dr. Scherr and asked the jury to look at the doctors they represent. 11/23/2021 Tr. 137:2-4. Opposing counsel also told the jury that the case is "about emergency room doctors because we really are different." *Id*. 139:25-140:1. And, opposing counsel told the jury that he was arguing "[o]n behalf of all of my healthcare clients, all the doctors." *Id*. 257:10-23 ("And this whole trial, you [the jury] can image what the effect it's had on Dr. Scherr and the other doctors."). Opposing counsel, in direct violation of the Court's *in limine* ruling, was purposefully not "really clear with the jury that" their clients "are organizations that staff ER rooms in hospitals under contract," so that they could prejudice the jury against Defendants.

Because Defendants were highly prejudiced by TeamHealth Plaintiffs being able to use the moniker "Healthcare Providers" instead of simply plaintiffs or their real names, this Court must grant a new trial. Additionally, a new trial is required because TeamHealth Plaintiffs did not exercise

any caution in using that moniker. Instead, they inflamed the passions of the jury. Thus, a new trial is required.

2. Allowing TeamHealth Plaintiffs to Tell the Jury the Case is About Quality of Care in Nevada

Until TeamHealth Plaintiffs' opening statement, their unqualified litigation position was that this was a mere "rate-of-payment" case. *See* 10/26/2020 Order at 2 ¶¶ 1-2. Nothing more, nothing less. But the first thing TeamHealth Plaintiffs told the jury was that this case is not just "about passing money from one corporate pocketbook to another," but rather it was about:

> ***the quality of healthcare in Nevada, not simply here in southern Nevada, but across the State*** . . . , [and] particularly about the quality of emergency medical case. . . . [So] you're going to hear us ask the question as to ***whether or not Nevadans*** . . . ***deserve*** at the very minimum ***to be treated the same as others*** . . . ***when it comes to reimbursement*** for emergency medical care ***paid to*** . . . ***health care practitioners***.

11/2/2021 Tr. 23:19-24:15 (emphasis added). This is a direct violation of *Lioce* because TeamHealth Plaintiffs were appealing to the emotional and sympathetic tendencies of a jury and preparing them to "send a message about some social issue that is larger than the case itself." 124 Nev. at 20. No juror will vote against improving the quality of care in Nevada. Moreover, opposing counsel made this case about the jurors when she announced that the issue of reimbursement is about Nevadans, *i.e.*, the jury, receiving equal treatment in the payment of their emergency medical care. No Nevadan will vote against receiving equal treatment, especially when they a mislead to believe that their medical care is directly at issue.

That prejudice was made worse moments later when opposing counsel juxtaposed the average reimbursement paid by "United" per emergency room visit in Nevada against other states. 11/2/2021 Tr. 24:16-21; Opening Statement Presentation at 2; 11/2/2021 Tr. 13:13-15:6 (objecting to page 2). She then injected herself as a witness by telling the jury that "[she] identified where Nevada fit. And that's key. . . . You know what's at the very bottom? Nevada." 11/2/2021 Tr. 24:16-21. And after inflaming the jury's passions by leading them to believe that they were receiving the worst emergency medicine care in the country, opposing counsel told the jury that "[t]his case is going to give [them] an opportunity . . . to pull Nevada up from the bottom" and that TeamHealth Plaintiffs "we're going to ask you [the jury] to say enough is enough." *Id.*; *Lioce*, 124

Nev. at 8-10, 13, 20-23 (ruling "enough is enough" arguments improper). This was clearly an improper request for the jury to remedy a social ill. No juror will resist that opportunity.

This strategy was designed to prejudice Defendants in the eyes of the jury from the outset of the case. To be sure, TeamHealth Plaintiffs conceded that they only wanted to compare the average reimbursement in Nevada against other states because they wanted to show what "[Defendants] afford to other states but that they don't afford to Nevada." *Id*. 14:13-14; *see also* 11/16/2021 190:20-191:6 (seeking to belittle a witness by asking "would [she] care" whether she had "any information that" would let her be "able to confirm that Nevada's rate of reimbursement to emergency room providers . . . is the lowest across our nation"). However, the "rates in other states [are not] relevant to what's determined in Nevada" because every "market[] is unique . . . [and] independent," having different "rate structures . . . [and] competitors" 11/2/2021 Tr. 14:15-15:6; *id.* 131:9-132:3 ("There are multiple rates across the country, geographically, in a market."). Moreover, there was no cause of action or claim in the case that would allow the jury to render a verdict that will improve the quality of healthcare in Nevada. *Id*. 60:25-61:3. But, in order to inflame the jury's passions, TeamHealth Plaintiffs told the jury otherwise.[9]

This prejudice and inflaming of the jury's passions by appealing to their emotions also set the tone for what was to come throughout trial. Indeed, in justifying why they could inflame the jury's passions and violate *Lioce*, TeamHealth Plaintiffs told the Court that they will call "witnesses that will provide . . . testimony speaking to the fact that . . . ***you get what you pay for***." *Id*. 61:24-62:5 (emphasis added). *But see* 11/23/2021 Tr. 173:4-10 (conceding the jury is "not going to find . . . what happens to this money, what happens . . . after [the jury] make[s] a decision . . . [and] what the consequences are" because they cannot "speculate about what happens after" their decision). Two such witnesses were Drs. Scott Scherr and Robert Frantz. For example, Dr. Scherr testified that the emergency departments that Fremont operates are "especially" important compared to other communities and are the "safety net in the community." 11/15/2021 Tr. 152:19-23. And to help

[9] Defendants should have been allowed to present evidence on a host of categories, including TeamHealth Plaintiffs' cost to provide service, the reimbursement they receive from all other payors, and whether any damages that the jury award will flow to the actual providers instead of TeamHealth Holdings, Inc.'s ("TeamHealth"), coffers. *Id*. 60:8-61:19.

provide for that safety net, Fremont gets quality of care support from TeamHealth. *Id*. 168:8-170:2. Dr. Frantz reiterated that because TeamHealth Plaintiffs are affiliated with TeamHealth, they have better quality of care. *See* 11/17/2021 Tr. 249:3-20. Then he went on to say that "if reimbursement is not adequate, then we're going to have difficulty . . . recruiting and . . . retaining physicians, and it can undermine the care and the community for the safety net." *Id*. 256:8-18. Additionally, TeamHealth Plaintiffs were permitted to show Dr. Jody Crane's deposition testimony during opening statement. Plfs' Opening Statement Presentation at 14. That testimony told the jury that TeamHealth's role is to "improve the quality of care" that TeamHealth Plaintiffs deliver. *See id.* However, Dr. Crane was never called to testify, so the jury was presented with evidence that they were not allowed to rely upon.

This strategy was designed to inflame the passions of the jury into believing that TeamHealth Plaintiffs needed more reimbursement so that the quality of care in Nevada would improve. However, the evidence presented to the jury did not enable them to determine that reimbursement that was already remitted was insufficient to prevent these harms. 11/17/2021 Tr. 274:3-276:2; 11/19/2021 Tr. 141:15-21 (sustaining Defendants' objection that there was "zero evidence connecting compensation" to the quality of medical care). And because Defendants were precluded from offering any evidence regarding TeamHealth Plaintiffs' cost to provide care or physician pay, the jury was left believing that quality of care in their community, and in Nevada, will suffer if they do not award damages. 11/17/2021 Tr. 274:3-276:2.

Opposing counsel preyed off of the jury's emotions and further made them part of the verdict during closing argument. For example, opposing counsel wanted the jury to remedy a social ill by telling them that they "have no idea how important you all are in this case. This is the first case to go to trial where the value of emergency room services against a major commercial carrier is going to be decided." 11/23/2021 Tr. 138:13-18; *see also* 11/16/2021 Tr. 50:15-23 (TeamHealth CEO, Leif Murphy, testifying that he took the stand "because [the case is] a big deal . . . . [I]t's important to all of our clinicians . . . And I think it sets a precedent for insurance across the United States"). Opposing counsel also reemphasized the improper opening statement that this case is not just about determining reasonable value and that the jury's decision will affect the quality of care when he

argued that the jury should not think of the case as "two big companies fighting against each other." 11/23/2021 Tr. 145:25-9. Instead, the jury should think about how Defendants went after the "biggest kid in the school yard," which in his opinion was "TeamHealth" and not TeamHealth Plaintiffs, to get "all the[] small emergency practices" to get in line. *Id*. So, "this case is going to affect what happens" to the quality of emergency medicine care. *Id*. Opposing counsel also inappropriately told the jury that they are

> going to have the ability to speak about what that value is, and let me tell you something, ***the world is watching***. I think we've got like 200 people watching . . . right now. Insurers, other healthcare professionals, they're all watching. ***You have more power right now than Congress does***, because this is so much more, ***it's about so much more than just this 10 and a half million dollars that we're owed. It really is***."

Id. 138:19-25 (emphasis added). And, opposing counsel inflamed the jury's passions and injected the jurors into the verdict by declaring that "this is the part that frankly, ***anybody living in this state out to be embarrassed about***. . . . 99285, the most serious [code], $185 [in reimbursement]. I mean, come on. . . . I mean, this is unbelievable." *Id*. 166:11-21. This was golden rule argument. They were asking the jury to remedy a social ill. And it was highly inflammatory emotional appeal directed at overcoming the jurors' intellect. Therefore, a new trial is required to remedy these errors.

3. Allowing TeamHealth Plaintiffs to Repeatedly Condition the Jury into Believing that More Money was Owed By Analogizing Their Services to the Value of Human Life

No issue in this case asked the jury to decide the monetary equivalent of life. However, TeamHealth Plaintiffs conflated the value of life to the reasonable value of the services that they provide to prey on the emotional and sympathetic tendencies and otherwise inflamed the passions of the jury. *See also supra* Course of, or Lead-Up to, Trial Section I.A.1 (demonstrating that TeamHealth Plaintiffs wanted to be called "Health Care Providers" as opposed to Plaintiffs "to play on the jurors' natural sympathies that doctors save lives"). Doing so improperly blinded the jury from using their intellectual abilities to evaluate the evidence and render a verdict.

TeamHealth Plaintiffs misconduct was designed to have the jury believe that because they were saving lives and that anything they charged would be reasonable reimbursement. However, there was no way for the jury to tell that the claims that they were asked to evaluate actually

concerned lifesaving emergency medicine services. 11/12/2021 Tr. 173:21-174:6 ("[I]s the jury going to be able to tell by looking at [the claims] which one . . . saved someone's life[] and which one didn't? [Dr. Scherr:] No").[10] Yet, opposing counsel analogized to lifesaving emergency medicine services as a means to belittle and opine on Defendants' culpability or to otherwise inflame the jury's passions. *See* 11/17/2021 Tr. 252:1-21 ("I have said, you know, [TeamHealth Plaintiffs] save lives, [TeamHealth Plaintiffs] save lives, [TeamHealth Plaintiffs] save lives. . . . Do we always save lives? . . . What I'm trying to ask . . . is do you ever have situations where . . . you lose a patient?"). For example, while questioning Mr. Haben, opposing counsel wanted to belittle Defendants' use of the term "egregious billers." 11/2/2021 124:16-24. So, opposing counsel provided the jury with his personal opinion that Mr. Haben was "the guy who drove down reimbursements" before attempting to extract an admission that TeamHealth Plaintiffs' billed charge of $1,400 for claims involving "gunshot[s], heart attack[s], or stroke[s]" were not egregious because "emergency room doctors . . . save people's lives." *Id*. 124:18-125:6. This improper analogy also had the effect of inflaming the jury's passions against Mr. Haben by portraying him as a person who does not care about the value of other people's lives.

Opposing counsel also belittled Mr. Haben and inserted his own opinion as to Defendants' culpability by inappropriately analogizing the airfare that Defendants' provided to Mr. Haben for his flight to Nevada to the reimbursement that his clients received to provide lifesaving treatment. *Id*. 132:22-133:15. And, opposing counsel did the same thing with Mr. Haben's living accommodations while in Nevada. *Id.* 133:16-19. These were prejudicial comparisons that went well beyond an attempt to show bias. *Id.* 171:4-12.

Furthermore, during closing arguments, opposing counsel further conditioned the jury into believing that the value of life was a factor in determining reasonable value of his clients' services. For example, opposing counsel inflamed the jury's passions by telling the jury that his clients' were

[10] Defendants were precluded from obtaining and using clinical records. *Supra* Discovery Errors Section I.A. Additionally, the Court prevented Defendants from asking Mr. Haben about his expectations regarding claims for life saving treatment. 11/10/2021 Tr. 179:6-180:17. Thus, the Court prevented Defendants from rebutting the notion that the at-issue claims were for emergency medicine services that saved lives.

"not selling stadium seating here. We're saving lives. . . . We have a standard charge. Our charge does not change." 11/23/2021 Tr. 150:5-10. Also, opposing counsel inflamed the jury's passions by telling the jury that Defendants' underpayments impact patients because his clients save lives. *Id.* 153:15-13 ("So what's the impact on the patients? And listen, we're talking about lives here. We're talking about lives. . . . You're thinking about one thing and that's saving someone's life."). "So," opposing counsel opined, Defendants "[a]re screwing us, they're screwing the patients." *Id*. 153:15. Aside from the fact that there was no evidence in the case about patients being medically harmed by the reimbursement that TeamHealth Plaintiffs received, no juror is going to resist that emotional appeal and find that human life is not a reason for Defendants to pay more money, especially when they could be the patent getting "screw[ed]."

Thus, a new trial is required to correct these errors.

B. A New Trial is Required to Cure Opposing Counsels' Rampant Injection of Personal Opinion as to the Justness of Their Clients' Cause, the Credibility of Witnesses, or the Culpability of Defendants and Otherwise Inflaming the Jury's Passions

1. Liability Phase Misconduct.

Opposing counsel knew it engaged in misconduct, admitting that he was "getting sick of the sound of my own voice up here." 11/9/2021 Tr. 46:13; *Lioce*, 124 Nev. at 25, 174 Nev. at 986 ("A claim of misconduct cannot be defended with an argument that the misconduct was unintentional. Either deliberate or unintentional misconduct can require a new trial."). That misconduct included opposing counsels' repeated and improper statements of their own personal opinions as to the justness of their clients' cause, to the credibility of witnesses, and to the culpability of Defendants. Their examinations often ridiculed or belittled adverse witnesses. And, they took every opportunity to otherwise inflame the passions of the jury. However, the Court seldom granted Defendants' objections, leaving Defendants in the untenable "position of having to object constantly before the jury." *See supra* footnote 7. On the rare occasion that it did, there was typically no curative instruction given. And, there was never an admonition to prevent further misconduct. *Gunderson v. D.R. Horton, Inc*., 130 Nev 67, 75, 319 P.3d 606, 611-12 (2014) (requiring that the court to "admonish the jury and counsel . . . by advising the jury about the impropriety of counsel's conduct

and reprimanding or cautioning counsel against such misconduct").

But before delving into the extraordinary volume of misconduct engaged in by opposing counsel, Defendants must point out the disparate treatment that they received from this Court. During defense counsel's examination of Mr. Haben, opposing counsel made three leading objections over the span of 124 pages of transcript. *See* 11/10/2021 Tr. 36:20-23; *id.* 105:24-4; *id.* 124:3-7. Of which, opposing counsel conceded that "a little leeway [wa]s in order." *Id.* 105:24-4. After defense counsel withdrew the third objected to question on his own initiative, the Court reprimanded defense counsel in front of the jury: "You will have to refrain, or I'll assist in the objections." *Id*. 124:3-11. Being reprimanded in front of the jury was not appropriate and Defense counsel was immediately taken aback. *See id*. 124:12; *Azucena v. State*, 135 Nev. 269, 272, 448 P.3d 534, 537-38 (2019) (citing judicial canons) ("We have previously 'urged judges to be mindful of the influence they wield' over jurors, as a trial judge's words and conduct are likely 'to mold the opinion of the members of the jury to the extent that one or the other side of the controversy may be prejudiced.'" (quoting *Parodi v. Washoe Medical Center*, 111 Nev. 365, 367-68, 892 P.2d 588, 589-90 (1995)
). Further, this reprimand stands in stark contrast to the Court's treatment of opposing counsels' rampant and flagrant misconduct, which amounted to some sustained objections but only an occasional curative instruction and no admonishment to deter future misconduct:

- Opposing counsel ridiculed Mr. Haben, imparted his personal belief that his clients' cause was just and Defendants were culpable, and otherwise inflamed the jury's passions by interpreting PX 370 himself and repeatedly exclaiming "Uh-oh." 11/3/2021 Tr. 15:7-15 (exclaiming Defendants "are experiencing a continued reduction in non-par bill charges . . . Uh-oh. Right? [overruled objection] Uh-oh").
- Opposing counsel repeatedly injected his personal opinions as to whether Mr. Haben was credible, belittled or ridiculed Mr. Haben, and otherwise inflamed the passions of the jury, including through erosion of the attorney-client privilege. 11/3/2021 Tr. 21:8-22:4 (allowing, over objection, TeamHealth Plaintiffs' counsel to ask Mr. Haben whether defense counsel instructed him "to be as technical and as difficult in [his] response[s] to [opposing

counsel's] questions as possible" even though the Court had just ruled that opposing counsel could not ask about was discussed the night before); 11/12/2021 Tr. 114:22-115:1 (telling the jury that he, opposing counsel, "know[s] that [Mr. Haben] had an opportunity to visit with counsel. I know you had an opportunity to go through what he was going to ask you" in response to not obtaining the testimony that he desired regarding plan documents); 11/3/2021 Tr. 43:12-19 (overruling an objection that allowed opposing counsel to cut Mr. Haben off and state "I don't want to hear your re[hearsed] speech. I want to know . . . even though MultiPlan did all the work, and even though already get a PMPM fee, [Defendants] take a fee on that percentage discount."). Moreover, opposing counsel improperly injecting his personal belief that Mr. Haben was not credible by asking "before . . . com[ing] into Court" whether Mr. Haben "look[ed] into . . . explaining to the jury why [Data iSight] [wa]s really objective or proprietary." 11/9/2021 Tr. 126:4-9 (sustaining objection without curative instruction). Opposing counsel knew this question had no foundation and that there were people on the witness list to testify to that exact question. *Id.*

- Opposing counsel sought to prey on the passions of the jury, demonstrate that his clients' cause was just, and evince Defendants' culpability by equating Defendants' use of the word "egregious" vis-à-vis emergency room doctors to the term "fake news." 11/3/2021 Tr. 117:6-24 (overruling objection). Opposing counsel knew that the term was loaded and invokes the passions of any person regardless of political party. *Id.*
- Opposing counsel injected his personal opinion as to the justness of his clients' cause and Defendants' culpability and otherwise inflamed the passion of the jury when he ridiculed that Defendants did nothing to earn $830 million and that earning that money harmed insureds because it subjected insureds to balancing billing. 11/8/2021 Tr. 46:17-24 ("Well, and here's my favorite word. Due to egregiousness. Is it egregious, Mr. Haben, to turn off wrap agreements that protect the member, allow you to make $830 million for doing nothing, and pay the provider an amount that they've agreed to take? Is that egregious? . . . [objection compound and argumentative] THE COURT: [sustaining compound objection] But otherwise overruled."); *see also id.* 45:3-6 ("let's go back [PX] 246. Now the problem with

these Wrap Network agreements is that even though you were making over $800 million a year for literally doing nothing, you needed more").

- Opposing counsel injected his personal opinion as to the justness of his clients' cause and Defendants' culpability and otherwise inflamed the passion of the jury by insinuating that Defendants were greedy by "ramrodding" new programs onto clients and being two-faced. 11/8/2021 Tr. 58:5-9 (sustaining objection without curative instruction or admonishment); *see also id.* 141:21-142:2 ("So at the end of the day, Mr. Haben, United gets the full rack rate, the 35 percent. You don't get cut, but we do. Do as I say, not as I do."). Opposing counsel testified that Defendants were greedy by misinterpreting PX 368 and stating Defendants "need more money because you got a little taste here, and now you want more. Get [clients] off this. Get [clients] onto something deeper." 11/3 Tr. 57:23-58:6. This was one of the few times the Court saw fit to give a curative instruction to the jury: "disregard that last sentence." *Id*. However, the last sentence was "let me move on." *Id*.
- To further the greed narrative, opposing counsel testified as to Mr. Haben's credibility and inflamed the jury's passions by telling the jury that Defendants were akin to the "Blob" from the movie "The Blob." *Id*. 59:20-60:12 ("Have you ever seen the movie What About Bob? A: Bits and pieces. Q: Fine movie, right? A: Bill Murray's a funny guy. Q: And it's about this really annoying guy . . . [a]nd there's a part in the movie where he says, I need, I need, I need, I need"); *id.* 196:6-22 ("The blob needs to feed. And there's nobody in sight because bill charges are coming down and you're not making as much as you did before; . . . now what you've got to do is in order to get rid of this anxiety, you got to cut some more"); 11/9/2021 Tr. 142:15-20 ("So you're migrating over to Total Cost of Care, which is going to raise the PMPM fee. But like the movie, The Blob, you want more and now, you're coming up with something to replace the Shared Savings earnings stream"). Opposing counsel also belittled Mr. Haben in trying to further the greed narrative. 11/8/2021 Tr. 30:21-31:6 ("The reason y'all did what you did is because you were driven by that one word, more, right? A: I disagree. It says in there our mission is to help people live healthier lives. That's the primary mission at the very top. Q: ***And I believe the children are our future too***." (emphasis

added)).

- Opposing counsel also provided his personal opinion as to the justness of his clients' cause and Defendants' culpability and otherwise inflamed the passion of the jury by mischaracterizing witness testimony to insinuate that UMR "deserves to make more on a given emergency room visit than the ER doctors, whose job is to treat patients and save lives." 11/15/2021 Tr. 192:6-14; 11/15/2021 Tr. 193:3-11; 11/15/2021 Tr. 203:3-7 ("Is it reasonable for UMR to make 75 more dollars per 99285 visit than the ER doctors who are treating the patients; is that reasonable?"). Not only does this inflame the passions of the jury, but (1) what UMR receives pursuant to its services agreement with one of its clients is not relevant to the reasonable value of the rendered emergency medicine services; (2) there was no foundation for the lay witness to opine on reasonable value; and (3) Defendants were not allowed to present any evidence regarding whether doctors would receive additional money if the jury ruled in TeamHealth Plaintiffs favor. Also, after receiving a responsive answer to the impermissible question, opposing counsel was permitted to ask the question again over objection. 11/15/2021 Tr. 203:8-17. finally, opposing counsel admitted to inflaming the jury's passion by announcing, "I'm asking whether you're proud that you made more than the doctors? Does that make you feel good inside?" 11/15/2021 Tr. 204:23-205:2.
- Opposing counsel belittled and ridiculed Mr. Haben and Defendants when he gave his personal opinion as to the justness of his clients' cause and Defendants' culpability and otherwise inflamed the passion of the jury by asking whether Mr. Haben thought it was "embarrassing" for Defendants to get a "fee for doing nothing other than just paying the rate" and that Mr. Haben "cut the doctor down to 300, and [he] cut him so [he] could get this" fee for Defendants. 11/8/2021 Tr. 28:15-20. Similarly, opposing counsel opposing counsel provided his personal opinion that Defendants were "just cutting the reimbursement" to "get a percentage of that cut in addition to the PMPM" and whether Defendants were really even offering programs to justify the fees. 11/2/2021 Tr. 143:10-21 ("I'm going to get to the programs in just a minute. Whether these are really programs"); *id*. 143:25-2, 144:21-145:5 ("you cut the amount of the reimbursement, you are literally

taking money out of our pocket and putting it in yours."); *id.* 136:14-22 ("I'm going to get to whether they're really programs or not, or whether they're just—they're just something else. But I digress"); *id.* 150:12-13 ("The more you cut, the less we get paid, and the more you make"); *id*. 156:13-20 ("You're just cutting the rates. You're already servicing the client. You're not doing a thing for that 35 percent"). In doing so, opposing counsel also improperly testified as to the meaning of PX 368 to provide his personal opinion that Mr. Haben was not credible: "I'm asking you, was it your goal -- I mean it's literally staring us in the face." 11/3/2021 Tr. 58:18-60:12 ("Oh. I left out the most important thing. Percentage of savings fee applies. . . . Get them off of this. No fee. And get them onto one of the other ones. Percentage applies.")

- Opposing counsel also belittled and ridiculed Mr. Haben and Defendants when he gave his personal opinion as to the justness of his clients' cause and Defendants' culpability and otherwise inflamed the passion of the jury by falsely portraying the lawsuit as being brought by doctors that just want to be treated fairly. 11/3/2021 Tr. 120:25-122:22 ("But when it comes to our doctors, who are asking for the reasonable rate, you don't agree with that? . . . You're entitled to be treated reasonably, but he's not. A: That's not what I said. Q: But your position in this case is we should not get the usual, customary and reasonable rate the way United Healthcare defines it. Right, sir? A: That's different than the term reasonable. Q: Oh, reasonable doesn't mean reasonable."); *see also* 11/12/2021 Tr. 86:25-88:7 (opining as to Defendants definition of reasonable).
- Opposing counsel gave his personal opinion that his clients had a just cause and were credible when he asserted that FAIR Health is more credible than MultiPlan. 11/12/2021 Tr. 164:14-165:1 (opining that FAIR Health is more credible than MultiPlan, "one thing we know -- 20 percent of FAIR Health's revenue is not dependent on UnitedHealthcare"); 11/3/2021 Tr. 36:17-19 ("And the name FAIR Health, I mean, fair is kind of baked into their name"). Also, opposing counsel provided his personal opinion that Defendants were culpable because FAIR Health has more credible information regarding reimbursement than Defendants. 11/15/2021 Tr. 121:8-19 ("Well, but what I didn't see is that information coming

from somebody besides [Defendants], and then we'll get to another one, by a MultiPlan, okay, not from FAIR Health"). Whether and how FAIR Health should be used by the jury was a central dispute at trial, so opposing counsel's misconduct also invaded the province of the jury.

- Opposing counsel also inflamed the passions of the jury when he was allowed to improperly invade the province of the jury by soliciting Mr. Haben's opinion about the credibility of FAIR Heath, documents, and Defendants' other witnesses. 11/3/2021 Tr. 12:9-13:3 (asking whether the jury should believe Defendants' experts over "real time information about what was going on with those charges at the time, or the testimony of some $2,400 an hour expert? Which one?"); *id.* 16:13-16 ("Which statement should the jury put more stock into, what your paid expert is going to tell this jury or what Ms. Paradise was telling you on this email, sir?").[11]
- Opposing counsel also provided his personal opinion as to the culpability of Defendants and improperly invaded the province of the jury by trying to solicit testimony from Scott Ziemer that UMR's claim file is not more credible than TeamHealth Plaintiffs claim file. 11/16/2021 Tr. 20:23-21:4 ("You haven't provided any reason for the jury to accept UMR's claims file, as opposed to the [TeamHealth] Plaintiffs' claim file"); *id*. 21:16-21 (same); *id*. 22:7-12 (same).
- Opposing counsel also provided his personal opinion as to the justness of his clients' cause and Defendants' culpability and otherwise inflamed the passion of the jury by claiming Defendants were greedy and lazy because MultiPlan does all the work but Defendants get $1 billion, *i.e.*, a Bellagio. 11/3/2021 Tr. 171:11-16; *see also id.* 65:16-25 ("But when you go to the Bellagio, you see bricks, you see mortar, you see fixtures, rooms, plumbing. You're getting a billion dollars every year for doing nothing other than just cutting the rate").[12]

[11] *Butler v. State*, 120 Nev. 879, 898, 102 P.3d 71, 84 (2004) (holding that it is misconduct to "disparage legitimate defense tactics").

[12] Additionally, there was no foundation to ask about the witness about how much it cost to build the Bellagio. 11/3/2021 Tr. 65:16-25 ("Do you know what it cost to build the Bellagio Hotel? A: I do not.")

While the Court told the jury to disregard the Bellagio comment, opposing counsel was not deterred from coming back to the analogy and engaging in further misconduct. In fact, when opposing counsel returned to the Bellagio analogy the Court overruled Defendants' objection. 11/12/2021 Tr. 156:17-24 (opining that Defendants' earnings are unjustified because they do not do enough to earn "a Bellagio every year").

- Opposing counsel provided his personal opinions as to the culpability of Defendants and belittled Defendants by likened Data iSight to a "shill," a "front," and being Defendants' "tiny monster" that just does what it is told. 11/8/2021 Tr. 21:19-22:25. Opposing counsels' misconduct continued when he injected his personal belief that Data iSight was the "Wizard of Oz" in that it is purported to be a deity that can grant wishes using magic but in reality was a hoax. 11/9/2021 Tr. 95:5-18; *id.* 103:8-105:8 ("Wow. What a coincidence, right, Mr. Haben? It just happens to be exactly what the Wizard of Oz says it comes out to."); *id.* 105:12-21 ("[Y]ou all decided you don't want to pay more than 350. But to be fair, you're going to let Data iSight run these sophisticated calculations and whichever is higher, 350 or Data iSight, that's what you're going to go with"); Further, opposing counsel opined on the justness of his client's cause by placing PX 376 before the jury claiming that his clients' actions were admirable because they that the Wizard of Oz was as a fraud without having the aid of Toto. 11/9/2021 Tr. 139:4-8 ("And when we did it, we didn't have Toto to go behind the curtain?"). Opposing counsel's Wizard of Oz misconduct continued when he described Naviguard as being the new Wizard. 11/9/2021 Tr. 182:1-5 (regarding PX 418). Furthermore, opposing counsel provided his personal belief as to Defendants culpability by telling the jury that Defendants "used Data iSight[] because they can specify what the outcome is going to be under the guise of a proprietary formula that sounds fancy and defensible." 11/22/2021 Tr. 240:1-6; *see also id*. 248:19-22 ("And these documents say -- you've heard the golden rule, he who has the gold makes the rules?"); *id*. 250:5-12.
- Opposing counsel also injected his opinion as to the justness of his clients' cause and the culpability of Defendants by stating that Medicare is "largely flat" and Defendants have arbitrarily lowered reimbursement "from 350 percent to 250 percent" of Medicare.

11/15/2021 Tr. 131:14-19 ("Well, the one thing we do know is that you have taken Medicare, which is largely flat, and gone from 350 percent to 250 percent.").

- Opposing counsel also gave his personal belief that the public facing statements contained in PX 413 regarding the service that Data iSight provides were ""fiction because the Data iSight amount always works out, always, always, always, always works out to the amount that United wants to pay." 11/9/2021 Tr. 102:3-10. Also, regarding PX 229, opposing counsel continued to inject his beliefs that MultiPlan was a sham by sarcastically noting that "MultiPlan is the umpire. I thought they were supposed to be objective?" 11/9/2021 Tr. 113:11-12, 114:24-115:3. Opposing counsel made similar umpire comments by improperly misconstruing PX 376. 11/9/2021 Tr. 135:9, 136:11-137:7 ("So it looks like what that's saying is because the umpire is on team United, they don't talk about this with doctors, right?"); *see also* 11/3/2021 Tr. Tr. 92:5-16 ("And you all -- these insurance companies and MultiPlan, the umpire was getting paid. . . . And so, if a lawyer gets up in a trial and says look at what other insurance companies are doing, what they're paying and what they're not paying, you all got it scripted out already, right, with all the other carries from MultiPlan."); 11/9/2021 Tr. 115:7-9 ("So this, Mr. Haben, is a wink-wink. We set your Data iSight engine to come out to 250.").
- Opposing counsel continually opined that Defendants and Mr. Haben were liars by analogizing their statements to Pinocchio. 11/8/2021 Tr. 20:18-20 ("If that was true, the statement would be a little Pinocchio-ish"); *id.* 41:5-10 ("And this, Mr. Haben, no doubt about it, even Pinocchio would laugh at this. This is a bald-faced lie."). While the Court told the jury to disregard opposing counsel's Pinocchio statement, it had no deterring effect and he did it again. 11/8/2021 Tr. 91:24-93:7 (counsel testifying that United being referred to as a "large carrier" in Yale study and that Defendants' "'support is expected to remain behind the scenes' in quotes, that means United Geppetto, the person controlling the puppet, nobody knows he's behind the curtain.").
- Opposing counsel likened his clients' action to being a just cause because this clients were standing up to United, which a "mom and pop operation" cannot do. 11/12/2021 Tr. 111:11-

16 ("do you think that a mom and pop operation with four, or five, or six doctors has the resources to take on UnitedHealthcare? . . . I mean, do you see how many people are in this room, sir?"); 11/12 Tr. 171:7-16 ("Do you know what percent of emergency room doctors in Nevada are out-of-network if you exclude Team Physicians, Ruby Crest, and Fremont? A: I don't know that. Q: Do you know whether it's almost 50 percent? A: I don't know that. Q: And you understand that the decision that this jury makes in this case affects them as well?"). This was improper because it further conditioned the jury into believing that they must remedy a social ill.

- Opposing counsel also testified that his clients' cause was just and drawing on the sympathies of the jurors that emergency room doctors should be rewarded from not having a sense as to what they provide society, as their safety net. 11/17/2021 Tr. 256:20-257:7 ("You know, when I first started working on the case, I realized that the ER doctors didn't . . . really have a sense of what the rate of payment should be and what I was used to is lawsuits where a doctor would come in and say I treated a patient and my charges were this, and they're reasonable and they're customary. And so those doctors have a good idea of what those rates should be, and the -- and so I -- why do you suppose that is about ER doctors, in the sense that they don't -- they don't really have a sense of what the rates should be?").
- Opposing counsel attempted to inflame the passions of the jury and make the case about remedying a social ill by expanding the boundaries of the case to include all health care providers, as opposed to just the TeamHealth Plaintiff staffing companies. 11/15/2021 Tr. 37:21-38:1 ("And you know, for example, with respect to some of the providers, such as a TeamHealth, it can cause millions of dollars, its OCM program can cause millions of dollars in reductions in reimbursement"). This also had the effect of furthering TeamHealth Plaintiffs improper theme that this case was about the quality of care in Nevada.
- Opposing counsel's examination of their expert witness was filled with unnecessary verbiage designed to inflame the passions of the jury, is own beliefs as to the culpability of Defendants, and unfounded questions directed at Defendants' intent. *See* 11/16/2021 Tr. 245:25-246:10 ("the jury has heard evidence that Data iSight is supposed to be an objective

third party, neutral, proprietary patented system, to spin out reasonable value, you accept all that. Do you have some explanation for why you denied Healthcare Services, ignored that supposed fair value, with all that fancy programming, and a paid a whole lot less on all these other claims"); 11/17/2021 Tr. 40:6-13 ("You think maybe the Defendants thought our board certified ER doctors just somehow don't do as good a job treating the folks that are in need of care as the rest of the ER doctors in the state"); *id*. 211:23-212:3 ("Does it at a minimum put a question in your mind about what the Defendant's had as a motive and what they were doing with my clients during this period?").

- Opposing counsel also provided his personal belief that Defendants' expert was not credible. 11/18/2021 Tr. 266:9-19 ("you could have sat in that chair right there if you truly were not picking a side, if you truly were trustworthy, if you truly put yourself in an independent, objective, neutral state of mind, you could have said, ladies and gentlemen, there were 270 claims that I know the Plaintiffs had the record of and I know they have a sophisticated system. I couldn't find those same 270 on United's side. That's for you to decide whether you want to count them or not. You could have done that, but you didn't"); *id*. 267:16-21 (same); *id*. 269:13-270:4 ("So our file's not reliable, but you did not -- did not check to see if any meaningful difference in total charges or total allowed."). Opposing counsel also attempted to inflame the jury's passions through improper questions designed to condition the jury into believing they needed to remedy a social ill. 11/19/2021 Tr. 54:2-11 ("Do you think the consuming public would prefer to have board certified emergency room physicians where insurance companies would allow them $1,100 a claim where they were paying $66? Do you think the consuming public would prefer that over a situation where ERs didn't have board certified doctors, but maybe were staffed by someone less than that, but have a few dollars less on co-insurance?"); *id* 55:22-56:8 (same); *id*. 101:15-24 ("So on one hand, we could have a world like TeamHealth where the top guy is an emergency room physician that's only focused on patients, and on the other hand, we could have emergency room physicians whose boss are insurance executives. And I just want to know which do you think is less likely to endanger the community?").

- Opposing counsel testified as to the meaning of documents and credibility of PX 379. 11/8/2021 Tr. 160:23-161:5 ("Oh, I see. So when you're telling the sales staff that we need a slide, meaning a puff piece, on a reasonable and a customary that creates the sense of urgency, that's not United needs to create the sense of urgency to the client, that's the client telling United, it's urgent, we need to get off this reasonable and customary as soon as possible?"). In order to further invoke the passions and prejudices of the jury against Defendants, opposing counsel injected his personal belief that Defendants were cheating insureds out of protection, such as the member in PX 470, by migrating clients off of reasonable and customary plan language. 11/9/2021 Tr. 45:18-46:1 ("Sorry. I'm asking -- remember when we looked yesterday, when we were talking about migrating clients off of reasonable and necessary and one of the phrases you all used was that some clients are paternalistic, because they want to protect their members, right? A: Understood. Q: What we just saw cheated this member out this protection"). Also, to discredit Mr. Haben's testimony that Defendants use of MutliPlan was proper because they always follow the plan documents, opposing counsel pointed to an AT&T plan document that used reasonable and customer to argue that Defendants "should not have applied Data iSight. [Defendants] shouldn't have cut [TeamHealth Plaintiffs'] reimbursement by taking the money out of our pocket and putting it into yours." 11/12/2021 Tr. 115:19-24. Opposing counsel cannot testify as to the meaning of documents.
- Regarding PX 10 page 2, opposing counsel also provided his personal belief as to Mr. Haben's credibility and mischaracterized the exhibit and Mr. Haben's testimony when he told the jury that "what [he] highlighted here does not mean that this is the amount that would have been payable to the health care provider. It simply means it's a formula to calculate shared shavings." 11/16/2021 Tr. 74:17-75:5. The Court also let the witness improperly opine as to the meaning of the document despite having no foundation to do so, which invaded the province of the jury. *Id*. 75:7-16.
- Regarding PX 25, opposing counsel injected his personal opinion that his clients' cause was just and that Defendants were culpable because Defendants did nothing to earn $830M in

2016, which also inflamed the passion of the jury. 11/8/2021 Tr. 134:10-14 ("Well, okay. Are you telling the jury that in January of 2017, after netting $830 million in 2016 for doing nothing that there was a financial strain on United?"). The prejudice is even more pronounced because Mr. Haben had no way of knowing why the document stated there would be financial strain because he did not write the document or have personal knowledge about it. 11/8/2021 Tr. 134:10-20.

- Regarding PX 25, counsel had no foundation or legal basis to ask Mr. Haben about either parties' exhibit list to impeach PX 25's statement that there is financial strain on plan sponsors. 11/8/2021 Tr. 133:12-17 ("Q This is during your public education. Can you point us to any document in evidence that explicitly says there's a financial strain either on plan sponsors or UnitedHealthcare? . . . [C]an you point us to any document on either exhibit list that supports that statement that explicitly says there's a financial strain on United or on plan sponsors?"). The only purpose for doing so was to vilify Defendants in the minds of the jury.
- Regarding PX 418, opposing counsel inflamed the passions of the jury and that Defendants were not credible because they were acting arbitrarily in determining the percentage of Medicare to be used as a floor when adjudicating ER claims. 11/9 Tr. 120:1-4 ("I mean Mr. Haben, you all just kind of reached in the pocket and just pulled out a number, right?").
- Regarding PX 230 page 2, opposing counsel improperly testified that Defendants' business strategy was "just going to keep -- that snowball . . . going downhill," which paints an improper picture. 11/9 Tr. 131:23-132:5. Namely, it was opposing counsels' testimony that Defendants chose to let things snowball out of control and be on a path of destruction.
- Regarding PX 273 page 8, opposing counsel was allowed to mischaracterize the exhibit, which Mr. Haben did not write, and inflame the passions of the jury by injecting his belief that "ASO profitability is driven heavily by making the customer buy the extended warranty of the rustproofing." 11/9/2021 Tr. 120:12-121:5. This improper testimony likened Defendants' actions to that of fraudulent telemarketing schemes. *See also* 11/9/2021 Tr. 132:25-136:7 ("So you know some of the casinos here in town, I'll get fliers from them

periodically that say, hey, come out to Las Vegas, we'll give you a discounted room rate. And when I show up, I see they're charging me a resort fee. When you add those two together, it's what the old room rate used to be.").

- Regarding PX 96, opposing counsel inflamed the jury's passion by providing his belief that the exhibit's statement that MultiPlan and United wanted to discuss improving the Outlier Cost Management program by $900M meant that they "were going to meet at some conference so that they could coordinate how this program could cause even deeper cuts." 11/9/2021 Tr. 74:25-75:6.
- Regarding PX 239, opposing counsel provided his personal belief as to the meaning of the exhibit and the credibility of Mr. Haben by repeatedly asking if the difference in between the terms "TCOC" and "shared shavings" represented a mere redesign of shared savings by using "fancy sounding new terms." 11/9/2021 Tr. 89:2-17; *id*. 90:15-22 ("My question, sir, is it's almost as if somebody took an eraser and erased the word shared savings -- erased the word, "shared" and subbed that for the TCOC? . . . Q Isn't that what it seems like to you?"). Opposing counsel used similar tactics regarding PX 380. *Id*. 123:10-11, 125:11-14 (stating that Defendants "bur[ied] the truth in a bunch of fancy words.").
- Regarding PX 423 page 23, opposing counsel told the jury that Defendants received a "windfall" of money from the "stuff inside the parenthesis," which listed "states" including Nevada. 11/9/2021 Tr. 191:21-24. Regarding page 12, opposing counsel further inflamed the passions of the jury by giving his personal belief of Defendants' culpability by stating that the document showed that Defendants "blew the doors off what [it] did in [20]16, in the West Region." 11/9/2021 Tr. 196:16-18. And, opposing counsel stated that "[n]obody in the industry and I mean nobody, is earning what [UnitedHealthcare is] earning in 2016." 11/12/2021 Tr. 139:2-5.
- Regarding PX 470, opposing counsel engaged in misconduct by mischaracterizing the document to inflame the passions of the jury and to provide his own belief as to Defendants' culpability: "I mean, it looks like we appealed, and you all wouldn't even talk to us." 11/9/2021 Tr. 43:15-16. However, the document said that Ruby Crest, not Defendants, failed

to engage in dialogue after the appeal was lodged. 11/9/2021 Tr. 43:7-12. Additionally, the Court erred when it allowed opposing counsel to solicit legal opinions from Mr. Haben about the appeal and the role of the jury. 11/9/2021 Tr. 44:1-6 ("Q And you understand, Mr. Haben, that in terms of fairness, having the jury evaluate whether you all followed this plan or not and whether you all reimbursed this at reasonable rates is going to be more fair than having United decide that, right?").

Further, opposing counsels' misconduct was a pervasive part of closing arguments:

- Opposing counsel began with an emotional story about the life saving emergency room visit that he experienced that could not be rebutted. 11/23/2021 136:9-138:1; *see also* 154:4-9 ("[W]hen I was in the ambulance, we passed this little community hospital. And . . . my wife [who] does not swear . . . screamed at th[e] ambulance driver and said, don't you dare stop here. . . . We're going to go to Memorial Herman."). Opposing counsel used that story as a prelude to reference that he represents "doctors" that get urinated, defecated, thrown up, and blead on or attacked "everyday." *Id.* 138:2-12; *see also id*. 174:18-21 ("Take a moment and go down to Sunrise Hospital and just sit in that emergency room for 15 minutes, and just watch what happens. Listen to the screaming, and hysteria, and the medical illness, and the people bleeding, the people complaining."). This was an emotional appeal designed to inflame the passions of the jury. It was also a violation of the Court's *in limine* ruling that opposing counsel needed to be very clear with the jury that they represent staffing companies.
- Opposing counsel injected his personal belief as to his clients' cause and Defendants' culpability and belittled Defendants by saying "greed . . . overtook them." 11/23/2021 Tr. 140:20-21, 142:21.
- Opposing counsel violated the *in limine* ruling that precluded them from arguing about the Ingenix settlement when he told the jury that Defendants "did not admit one document, not one, showing what the reimbursements were before 2016." 11/23/2021 Tr. 140:22-24; *see* 11/12/2021 Order re Defs' Mot. *in Limine* No. 26. Defendants had no way of rebutting this information.

- In addition to violating the Ingenix *in limine* ruling, opposing counsel injected his personal belief as to the credibility of witnesses when he told the jury that instead of presenting reimbursement rate evidence from before 2016 Defendants presented "testimony [from] jokers like . . . Mr. Haben. Take my word for it, take my word for it . . . that's what they did." 11/23/2021 Tr. 140:140:21-141:1.
- Opposing counsel injected himself into the lawsuit and otherwise inflamed the jury's passions when he argued to the jury that "egregious" is "now [his] favorite word. I barely knew what it meant when I got in this case, I use it all the time now as a joke, because the use of this word with what [TeamHealth Plaintiffs] were doing is a joke." 11/23/2021 Tr. 145:3-7.
- Opposing counsel continued to belittle Defendants and testify as to their culpability through renewed use of his analogy that Defendants were motivated by greed because they were the Blob from the movie "The Blob" and needed to keep feeding by cutting more allowed amounts even further. *See* 11/23/2021 Tr. 147:23-148:3; *id.* 150:19-20 ("[T]hey're making more and more money, . . . up to a billion dollars. The blobs now gotten bigger. It needs to feed more."); *supra* at 67 (detailing improper examination regarding "The Blob"). Likewise, opposing counsel inflame the jury's passions and provide his own opinion that his clients' cause was just when he renewed his inappropriate "Wizard of Oz" analogy that non-party MultiPlan was a fraud. 11/23/2021 Tr. 149:7-12 ("this mythical tool, behind the curtain, the Wizard of Oz, well Toto actually pulled the curtain back during the trial"); *supra* at 71 (detailing improper examination regarding the "Wizard of Oz").
- Opposing counsel injected his personal belief as to the justness of his clients' cause and the culpability of Defendants and otherwise inflamed the jury's passions by telling the jury that TeamHealth Plaintiffs are protecting the little guys who cannot afford to take on Defendants. 11/23/2021 Tr. 151:4-8 ("[I]f you're a doctor in a practice of three or four people . . . are you really going to hire a lawyer or do something about it? I mean [Defendants] know that they have all the power and all the leverage. . . . I mean this is unbelievable."); *see also id*. 268:1-3 ("And if you [the jury] haven't figured out already why a lot of providers just give up and

take the rate" Defendants remit, "it's because of" Defendants. This isn't easy, and most providers frankly won't do it.").

- Opposing counsel inflamed the jury's passions and attacked defense counsel's wardrobe to convince the jury that they should award damages to his clients because Defendants are paying for lawyers to afford extravagant lifestyles instead of paying for the cost to save lives. 11/23/2021 Tr. 153:3-9 ("So my dear friend, Mr. Roberts, . . . I guarantee you the boots he's wearing today cost more than" what TeamHealth Plaintiffs were reimbursed per claim and "more than what we're getting for" saving people's lives. "You can stop this. Because this is going to go lower and lower and lower. You can stop it. You can stop it."); *supra* Course of, or Lead-Up to, Trial Error Sections I.A.2-3. (detailing error in allowing jury to believe this is a quality-of-care case and to be conditioned that reasonable value can be determined based on the value of life).
- Opposing counsel also made his co-counsel witnesses to the case when he told the jury that "Louis, if the one that figured out that the two formulas," Data iSight and Medicare, "are identical. He's a genius." 11/23/2021 Tr. 154:19-21 ("They," Jason McManis, Michael Killingsworth, and Louis Liao, "stayed up all night, last night putting this together."). Mr. Liao never took the stand, so Defendants were never given the opportunity to cross-examine him. As such, they were left unable to rebut this misconduct. But not only was this improper, it waived privilege and Defendants should be given discovery into what Louis did, including taking his deposition.
- Opposing counsel also belittled Defendants by telling the jury that UMR gets "$1.3 billion for doing nothing" except "answer[ing] the phone" or "hit[ting] send." 11/23/2021 Tr. 154:22-155:6.
- "I'm going to use the word -- and I know it's kind of strong, but what this company has done, . . . is nothing short of evil." 11/23/2021 Tr. 173:10-16.

As noted, Defendants had to

Any of the aforementioned instances of misconduct demands a new trial. Cumulatively, there is no question. As such, a new trial is required so that Defendants can receive a fair trial.

* * *

The Court should have never allowed opposing counsels' misconduct and improper themes detailed in the proceeding sections to plague this trial. But it did. That left Defendants with no choice but to try and mitigate the prejudice during their closing argument. 11/23/2021 Tr. 181:5-16 ("There was a lot of testimony from the lawyers in this case. A lot of testimony from the lawyers. And sometimes, more testimony from lawyers than witnesses. That's not evidence. . . . I urge you [the jury] . . . to be guided by [the evidence], and not what you heard from lawyers."); *id.* 185:7-186:7; *id.* 193:25-194:4 ("I want to point out that I think the lawyers we were dealing with . . . know how to appeal to a jury."); *id.* 206:12-13 ("you [the jury have] got to read the document and not just listen to the lawyers"); *id*. 213:22-23 ("[TeamHealth Plaintiffs] didn't give you evidence of [a gunshot wound]. What they did was they had lawyers talk about it.); *id*. 247:12-21 ("what we heard from the lawyers . . . is that Nevada is not going to get adequate medical care [unless] you give them a lot of money today. That's lawyer talk. . . . They've been talking about [it] a lot, but there is no proof in the record."); *id.* 249:24-250:6 ("[O]ther than having a lawyer talk about [losing doctors due to insufficient reimbursement], they didn't show you proof of that. There's no evidence of whether they're making money or losing money."); *id.* 250:6-13 ("[TeamHealth Plaintiffs] just want you [the jury] to think about saving lives is big. It's important, so . . . we should get paid whatever we say. . . . [T]hey know that's not the standard. It is just a distraction."). However, Defendants should not have been forced into protecting the integrity of the trial. Because they had to subsume the Court's duties, which proved inadequate, a new trial is required.

2. Punitive Damages Phase Misconduct or Errors of Law.

The Court erred in allowing various lines of examination over objection that prejudiced Defendants. And just as the liability phase of trial was steeped in misconduct that denied Defendants a fair trial, opposing counsel used these errors to plague the punitive damages phase. Therefore, a new trial is required.

To show that Defendants' conduct was reprehensible, opposing counsel asked numerous questions about non-party UnitedHealth Group, Inc.'s ("UHG"), stock buybacks. 12/7/2021 Tr. 13:19-14:1, 14:5-11, 14:22-25, 16:1-3, 16:10-16, 17:4-13, 18:1-6. However, this questioning

subjected Ms. Paradise to harassment and belittlement because she testified that she is not involved in and unaware of non-party UHG's stock buyback program. *Id*. There was no foundation to ask these questions and the Court should have put a stop to them. NRS 50.025(1)(a) ("A witness may not testify to a matter unless . . . the witness has personal knowledge"); NRS 50.115(1)(c) ("The judge shall exercise reasonable control over the mode and order of interrogating witnesses . . . [t]o protect witnesses from undue harassment or embarrassment."). It was also inappropriate to allow the actions of a non-party to be used as a means to measure reprehensibility of Defendants' conduct. 12PD.2 (limiting jury's consideration to the conduct of the defendant); *accord* NEV. J.I. 12.1 (same and limiting jury's consideration to "the defendants' financial condition"). Indeed, when defense counsel's slip of the tongue mentioned TeamHealth during closing argument, opposing counsel objected because "TeamHealth [wa]s not a party." 12/7/2021 Tr. 117:6-10; *see also id.* 122:24-123:8 (objecting to "and their clients" because the clients are not defendants). As a result of these errors, TeamHealth Plaintiffs were able to inflame the passions of the jury by having the jury believe that Defendants' conduct was reprehensible because of the actions of a non-party. 12/7/2021 Tr. 17:4-20 (opposing counsel testifying, "when the company," not Defendants, "takes its cash . . . and decides to use that cash . . . to buyback the stock . . . it increases the price of the stock").

Moreover, there was no evidence presented that non-party UHG's stock buyback program had any effect of the conduct at issue in the case. In fact, no connection could be drawn from that program to the conduct at issue because Ms. Paradise testified that she has no role in the stock buyback program. 12/7/2021 Tr. 14:5-14 ("I just have nothing to do with that program"); *id*. 16:1-5 ("This is the first time I've seen this"); *id.* 16:17-21 ("I don't know what the net result of a Share Buyback Program is. I've never interacted with it."). Therefore, the Court should not have permitted TeamHealth Plaintiffs to belittle Ms. Paradise and prejudice Defendants.

Similarly, Ms. Paradise was subjected to prolonged, harassing examination regarding the jury's liability verdict and Defendants' reaction to it. Opposing counsel began this line of inquiry by asking what she was able to convey "in terms of any changes that the company," not Defendants, was "considering as a result of the verdict." 12/7/2021 Tr. 24:13-25:15. Ms. Paradise provided a responsive answer: that the verdict was one-week old and there is a lot the needs to be reviewed, so

it will take time to evaluate to ensure that appropriate steps are taken. *Id*. Opposing counsel was then permitted to mischaracterize that testimony and continually belittle Defendants because they needed time to properly evaluate the verdict. *Id.* 25:16-30:19 (objecting to the Court allowing harassing examination). The Court also permitted TeamHealth Plaintiffs to solicit improper opinion testimony from Ms. Paradise, including by allowing her to speak for every entity affiliated with Defendants and how large of a punitive damages award was needed to affect Defendants conduct. *Id.* 28:22-29:8, 33:11-34:25, 40:5-11. Ms. Paradise, however, has no responsibility over management of Defendants' profit and losses, so she did not have personal knowledge to testify about this subject. And, questions about the amount of punitive damages needed to affect Defendants' conduct invades the province of the jury as it is their responsibility to determine that amount. Moreover, having the jury measure punitive damages based on what Defendants will do to address the liability verdict is impermissible use of subsequent remedial measures. *See* NRS 48.095(1) ("When, after an event, measures are taken which, if taken previously, would have made the event less likely to occur, evidence of the subsequent measures is not admissible to prove . . . culpable conduct"). Further, opposing counsel was permitted to harass Ms. Paradise and prejudice Defendants by asking her whether Defendants' conduct was reprehensible or fraudulent, malicious, or oppressive. *Id*. 35:11-38:23. However, Ms. Paradise is not a lawyer, so it was inappropriate to ask her for legal conclusions.

Additionally, opposing counsel was able to inflame the jury's passions during closing arguments. For example, opposing counsel used non-party UHG's stock buyback program, which Ms. Paradise had no personal knowledge of, to inflame the jury's passions to obtain a massive punitive damages award. *Id*. 108:3-9. In fact, opposing counsel provided his own personal belief as to the culpability of Defendants by telling the jury that the stock was being repurchased "to drive up the share price of the executives at United." *Id*.

Opposing counsel also furthered the prejudice inflecting on Defendants stemming from Ms. Paradise being harassed regarding Defendants' reactions to the jury verdict when he told the jury that she "couldn't commit to making any recommendations but will digest and evaluate" it. *Id*. 125:3-4. Again, it had only been one-week since the verdict was issued, Ms. Paradise was not a

lawyer, and it is inappropriate to use the lability verdict as a means to measure reprehensibility because post-remedial measures are inadmissible. But worse, opposing counsel injected his personal belief as to the credibility of Ms. Paradise and the culpability of Defendants by telling the jury that it was "disingenuous" for Ms. Paradise to seek refuge in the liability verdict only being a week old because "everybody in this courtroom has been thinking about the result for quite sometime . . . [a]nd so for any witness to suggest in this chair . . . [that they] don't really know" is a lie. *Id*. 125:21-126:5 ("I can assure you she and all her colleagues have been focused on" a potential adverse verdict.).

Likewise, opposing counsel injected his own personal belief as to the credibility of Mr. Haben and Ms. Paradise because it was Defendants' legal strategy to pretend as if they had no personal knowledge of matters even though that was the sworn testimony. *Id.* 100:13-19. First, opposing counsel attacked Mr. Haben's testimony. *Id.* ("And Haben, he says, 'I'm not a finance person' . . . [and] 'I did not write it'. That's their favorite thing. If it hurts, oh, three monkeys. Haven't seen it, haven't heard it, haven't spoken it. Right?"). Then, opposing counsel extended that attack to Ms. Paradise. *Id*. ("And we saw that a little bit today. I mean [Ms. Paradise] knew she was coming here more than a week ago.") Finally, he told the jury that they were not credible because of his opinion as to what believed to be Defendants' legal strategy. *Id*. ("And these are very, very skilled lawyers. They knew exactly what we were going to ask, and that's the best that you got today.").

Opposing counsel also inflamed the passions of the jury by providing his personal belief that Defendants' conduct was reprehensible because they were illicit monopolists and the jury should protect their "fellow citizens." *Id*. 105:20-106:20-107:9 ("[Defendants] have an 80-percent market share in this county," so "8 out of 10 people . . . are now paying almost" 20 times more than they used to pay. "But somehow, their position is we're the problem; Dr. Scherr is the problem."). However, there was no evidence of a monopoly, let alone an illicit monopoly or anticompetitive conduct vis-à-vis monopoly power. As such, this line of argument only served to inflame the passions of the jury.

Finally, opposing counsel inappropriately injected the jurors into the punitive damages

verdict. He told the jury, "if [they] talk with a whisper, I'm sorry, you have wasted a month and a half of your lives." *Id*. 107:14-15; *Lioce*, 124 Nev. at 8-10, 21 (ruling jury "wasted their time" arguments improper). It was highly inappropriate to ask the jury to measure the reprehensibility of Defendants' conduct giving rise to the liability verdict based on the time that the jury spent hearing the case.[13]

Because the Court erroneously permitted inappropriate or unfounded examination, a new trial is required. A new trial is also required because opposing counsel was able to inflame the jury's passions or otherwise engaged in misconduct during closing argument.

II.
BECAUSE THE COURT ERRANTLY ALLOWED DEFENDANTS' FIRST AMENDMENT RIGHTS TO BE VIOLATED, TEAMHEALTH PLAINTIFFS WERE ABLE TO FURTHER INFLAME THE PASSIONS OF THE JURY

Before trial, Defendants filed Motion *in Limine* No. 20 to prevent being held liable for engaging in First Amendment protected activity. In errantly denying that motion, the Court cautioned TeamHealth Plaintiffs that it would be vigilant in the admission of exhibits and questioning of witnesses because Defendants were engaged in matters of public opinion and political activity, such as lobbying efforts. 10/22/2021 Tr. 127:21-128:6. Not only did that protection turn out to be illusory, but unfounded exhibits were admitted into evidence. Further, TeamHealth Plaintiffs inflamed the passions of the jury or otherwise engaged in misconduct using these materials. Because of these errors, a new trial should be granted.

A. DEFENDANTS WERE HELD LIABLE FOR FIRST AMENDMENT ACTIVITY THAT SHOULD HAVE BEEN PRECLUDED BY THE *NOERR-PENNINGTON* DOCTRINE.

As explained in Defendants Motion *in Limine* No. 20 and at oral argument, the "*Noerr-Pennington* Doctrine makes clear that concerted private effort to influence government action is privileged and inadmissible as evidence or argument." Motion *in Limine* No. 20 at 4-6 (citing *Sosa*

[13] The prejudice of this misconduct can be seen in the excessiveness of the verdict. For example, Defendant HPN was reasonable for 119 of the 11,563 at-issue claims. PX 473. Despite the minimal amount of harm to TeamHealth Plaintiffs, the jury awarded them $12,000,000 against HPN. *Id*.; 12/7/21 Special Verdict Form at 2. Clearly, opposing counsels' misconduct caused the punitive damages verdict to be excessive.

v. DirectTV, Inc., 437 F.3d 923, 929 (9th Cir. 2006)); 10/22/2021 Tr. 109:24-117:19, 125:23-126:16. TeamHealth Plaintiffs admitted that Defendants' engagement with researches, such as at Yale or the Brookings Institute, and with the national press media, such as the New York Times, was part of Defendants' efforts to influence government action. Plfs' Opp. to Motion *in Limine* No. 20 at 6 ("these material [were] part of a long-term strategy to lobby Congress"). Yet, without a single allegation in their complaint that Defendants' activities were a sham or a single citation to legal authority in their opposition or at oral argument, TeamHealth Plaintiffs asserted that these activities incidental to Defendants' valid effort to influence government action were not protected by the First Amendment and, thus, could be used to prove liability. *Id*. at 6-7; Second Amend. Compl. Moreover, during oral argument, TeamHealth Plaintiffs' counsel errantly argued without support that the *Noerr-Pennington* doctrine is only applicable in antitrust suits. 10/22/2021 Tr. 119:20-120:3. TeamHealth Plaintiffs unsupported positions are all false.[14]

In Nevada, per the constitutional jurisprudence of the United States Supreme Court, Ninth Circuit, and federal District Court of Nevada, the *Noerr-Pennington* Doctrine extends "outside the antitrust field" to protect "those engaging in lobbying activities." *Sosa*, 437 F.3d at 929-30 (citing and discussing numerous Supreme Court decisions). In fact, the protection afforded by the doctrine applies to all statutory and common-law causes of action. *Id*. at 932 & n.6 ("There is simply no reason that a common-law . . . doctrine can any more permissibly abridge or chill the constitutional right of petition than can a statutory claim" (quoting *Video Int'l Prod. Inc. v. Warner-Amex Cable Comm., Inc.*, 858 F.2d 1075, 1084 (5th Cir. 1988))); *Theme Promotions, Inc. v. News Am. Marketing FSI*, 546 F.3d 991, 1007 (9th 2008) (same); *Garmong v. Tahoe Regional Planning Agency*, 2021 WL 412386, at *7 (D. Nev. Sept. 9, 2021) (slip op.) ("The doctrine 'bars any claim, federal or state, common law or statutory'" (quoting *Gen-Probe, Inc. v. Amoco Corp.*, 926 F. Supp. 948, 956 (S.D. Cal 1996))).

To provide the "breathing space" that must be given to the rights protected by the Petition

[14] Opposing counsel has an ethical duty to admit error. *See* NRPC 3.3(a)(1)-(2) ("A lawyer shall not knowingly: (1) Make a false statement of . . . law or fail to correct a false statement of . . . law . . . ; [or] (2) Fail to disclose to the tribunal legal authority in the controlling jurisdiction known to the lawyer to be directly adverse to the position . . . .").

Clause, *see Sosa*, 437 F.3d at 931-32, the "communications between private parties are sufficiently within the protections of the Petition Clause to trigger the *Noerr-Pennington* doctrine, so long as they are sufficiently related to petitioning activity." *Id*. at 935. For example, a public relations campaign and related private communications are "sufficiently related" activity because both are "incidental to a valid effort to influence governmental action." *Id*. at 934 (explaining that "*Noerr* itself" immunized the defendant's "public relations campaign" because it "was to influence the passage of favorable legislation" (citing *Eastern R.R. Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127, 140-43 (1961))); *Trang v. Bank of George*, 2022 WL 594832, at *2 (D. Nev. Feb. 28, 2022) (slip op.) ("immunity applies not only to direct petitioning activity, but also to conduct incidental to it").

The only way to pierce this constitutional protection is if a litigant alleges, and proves, that the activities, conduct, or communications were a sham. *Boone v. Redevelopment Agency of San Jose*, 841 F.2d 886, 895 (9th Cir. 1988) (holding plaintiffs seeking to establish the sham exception must "allege the existence of a publicity campaign" and defendant "was not genuinely seeking official action from the" government with specificity); *Evan Hotels, LLC v. Unite Here Local 30*, 433 F. Supp. 3d 1130, 1147 (S.D. Cal. 2020) ("a negative publicity campaign is protected by *Noerr-Pennington* unless it is a sham, not genuinely intended to influence government action" (citing *Boone*, 841 F.2d at 895)). TeamHealth Plaintiffs never did so. Nor could they. *Noerr*, 365 U.S. at 129, 144 (immunizing "highly successful" public relations campaign to influence legislation).

There is no doubt that Defendants' activities, conduct, and communications related to, *inter alia*, the Yale Study, the Brookings Report, and the New York Times article are incidental to their valid efforts to influence the passage of favorable legislation. *See* 11/2/2021 157:9-11 ("[ZAVITSANOS:] And no doubt about it . . . [Defendants] set out on a path to change the public narrative"). Indeed, TeamHealth Plaintiffs admitted that these efforts were related to legitimate petitioning activity. 10/22/2021 Tr. 120:5-8 ("They're trying to . . . get legislation" and "were able to secure that" legislation); *id*. at 121:15-16 ("the study was meant to influence public opinion"); 11/23/2021 Tr. 144:6-16 ("[Defendants got to you all [the jury] . . . through their . . . marketing" about the "huge problem with balance billing."); *id*. 145:20-21 ("this sounds like some kind of

political campaign"). Moreover, the trial's operative complaint contained no allegations, let alone specific allegations, that Defendants' petitioning activity was a sham. *See generally* Second Amend. Compl. (containing no allegations of a publicity campaign or that Defendants were not seeking official government action).

Nonetheless, TeamHealth Plaintiffs wanted to use those constitutionally protected efforts to punish Defendants for a "scheme." *Id*. at 120:23-121:4 ("THE COURT: And how would you use it, though? It's not relevant to the rate of pay. . . . MS. GALLAGHER: . . . We know they have a scheme to target us."); 10/22/2021 Tr. 121:11-123:3 ("THE COURT: I'm having a hard time understanding why it would be relevant. . . . MS. LUNDVALL: . . . the liability phase for the punitive damages is part of our case-in-chief."). *But see Sosa*, 437 F.3d at 934, 940-42 (barring liability for a "scheme" to be based on efforts incidental to petitioning activity, *e.g.*, a public relations campaign). As such, this Court should have granted Defendants' Motion *in limine* No. 20 and precluded all evidence incidental to Defendants' petitioning efforts. At a minimum, the Court should have, as it said it would, been "real careful about how anything comes in on this subject because we have lobbying." 10/22/2021 Tr. 127:21-2. During trial, however, there was no care taken and Defendants' activities that were incidental to their efforts to influence governmental action became central to TeamHealth Plaintiffs' strategy to obtain a liability verdict on all counts. *See, e.g.*, 11/8/2021 Tr. 94:6-15 (comparing the Yale study to a political ad that "looks objective until you find out that it's actually funded through a PAC."); 11/23/2021 Tr. 145:17-24 (arguing to the jury in closing that Defendants should be liable for their "political campaign").[15]

Because this Court should not have permitted the jury to hear anything about Defendants' efforts, incidental or direct, to influence governmental action, this Court must grant a new trial.

[15] TeamHealth Plaintiffs used, *inter alia*, the following exhibits to hold Defendants liable for engaging in protected First Amendment activities: PX 12; PX 13; PX 14; PX 32; PX 33; PX 37; PX 40; PX 55; PX 56; PX 63; PX 79; PX 85; PX 100; PX 239; PX 509; PX 528. Some of these documents were also impermissibly shown to the jury during opening statement. *Infra* Course of, or Lead-Up to, Trial Errors Section III.C.1. Moreover, some of these documents were shown to the jury during TeamHealth Plaintiffs' lability phase closing argument.

B. NUMEROUS DOCUMENTS PROTECTED BY THE FIRST AMENDMENT WERE ADMITTED INTO EVIDENCE WITHOUT PROPER FOUNDATION.

Putting aside whether TeamHealth Plaintiffs should have even been allowed to attempt to admit documents incidental to Defendants' protected First Amendment activities, those documents were, by and large, admitted without proper foundation. This error was due, in part, to TeamHealth Plaintiffs' argument that documents incidental to Defendants' First Amendment protected activities should be admitted because "the jury is permitted to infer that [a witness] is not being completely truthful when [the witness] says he [or she] didn't know about" the document. 11/8/2021 Tr. 78:3-83:24 ("the test on . . . foundation for a document is not whether the witness says they're familiar with it or whether his [or her] name is on it. . . . It's . . . a very slight standard. And it's akin to authentication"). That is wrong.

As noted below, a document must be admitted through an appropriate foundational witness. *Infra* Course of, or Lead-Up to, Trial Errors Section III.C.2 (detailing relevant law). That witness must have personal knowledge of a document, meaning that the witness can testify "as to how, when and in what manner" the document was created, was a custodian of the record(s), or understands the record-keeping system involved. *Id*. While the Court at times recognized the contours of proper foundation and stopped questioning, 11/8/2021 Tr. 102:14-20 ("Why are there a bunch of folks from United talking to a Yale professor about what he should put in his paper? . . . COURT: He hasn't had any personal knowledge of that."), it still admitted unfounded exhibits concerning Defendants' First Amendment protected activities.

While admitted documents, TeamHealth Plaintiffs' counsel provided his personal belief that Defendants were engaged in protected First Amendment activity in an effort to inflame the jury: if Defendants "blitzed enough media, the narrative would be viewed through their lens, rather than the cathedral of truth." 11/2/2021 Tr. 157:9-19. Against the backdrop of that further misconduct by opposing counsel, this Court admitted PX 55 without proper foundation. 11/3/2021 Tr. 75:5. In doing so, the Court permitted opposing counsel to ask repetitive questions over objection, *id.* 75:1-7, to solicit testimony about whether the document mentioned the Outlier Cost Management program, whether it was produced by Defendants, and whether Mr. Haben was "in charge of the

OCM program." *Id.* 71:23-75:19. However, Mr. Haben testified that he was not sure if the document dealt with the Outlier Cost Management program because he did not write it the exhibit. *Id.* 73:21-74:1. There was no testimony or other evidence linking Mr. Haben this document, including why or how it was made. Additionally, there was no evidence or testimony that Mr. Haben was familiar with Defendants' record-keeping database to provide foundation via the hearsay exception for business records. As such, the Court should not have admitted the exhibit. Furthermore, the jury was permitted to evaluate PX 40 even though it was never fully admitted into evidence. 11/8/2021 Tr. 86:19-87:2.

Because the jury was permitted to evaluate evidence that should not have been introduced into the case, a new trial is required.

C. INFLAMING THE PASSION OF THE JURY THROUGH USE OF FIRST AMENDMENT PROTECTED ACTIVITY WAS CENTRAL TO TEAMHEALTH PLAINTIFFS' TRIAL STRATEGY

Assuming that the documents incidental to Defendants' First Amendment protected activities were properly admitted, a new trial is required because of TeamHealth Plaintiffs' counsels' examination misconduct. Their examinations were littered with inappropriate statements to inflame the passions of the jury, to ridicule or belittle witnesses, or to provide personal opinion as to justness of their clients' cause, the credibility of a witness, or the culpability of Defendants. *Infra* I.B. This misconduct included, *inter alia*, the following:

- Opposing counsel testified to the justness of his clients' cause and the culpability of Defendants and otherwise inflamed the passions of the jury by telling the jury that Defendants "[ha]ve been very successful" in influencing public opinion "because the Wall Street Journal, The New York Times, the Washington Post, CNBC. I mean, I think we got the most important. I mean, you've been successful in putting the bullseye on the back of Team Health over the last five years to justify these targets of which you're going to get 35 percent." 11/2/2021 Tr. 158:12-23; *see also* 11/3/2021 Tr. 109:3-11 ("So we're going to talk about 2014 to 2019. Is it true, Mr. Haben, that y'all attempted to -- that these Instagrammers, y'all attempted to influence through a very carefully planned strategy the public during this five-year period by using a variety of tools designed to get out to the media, so that as you

were cutting rates, public sentiment would be on the side of the insurers who were carrying the healthcare reform flag and not the doctors"); *id.* 116:25-117:5 ("Now the plan was to use this word egregious so often that people would start equating it with emergency room doctors. That was the messaging, the influence y'all were trying to get out to the world, so that you could then justify cutting the rates."); *id.* 78:13-19 ("you're telling the media we got runaway bill charges. It's a problem. People are vulnerable in the emergency room. Charges are escalating. There's some bad apples out there").

- Opposing counsel testified to the justness of his clients' cause and the culpability of Defendants and otherwise inflamed the passions of the jury by telling the jury that Defendants "develop[ed] extensive messaging, including media statement, general talking points, questions and answers, and other materials to support" their tactics that would cause the media to "make [Defendants] look good and make the doctors look like they're egregious billers." 11/3/2021 Tr. 123:3-9.
- Opposing counsel injected his belief as to why his clients' cause of action was just based on the Yale documents not being public until they brought a lawsuit. 11/8/2021 Tr. 114:14-18 ("And these [Yale] documents we just looked at sir, these were all under wraps for keeping secret until just a few months ago."); *id.* 77:16-21. ("Well, is it true, sir, before we get into the documents on the Yale study, that until just a few months ago, nobody knew that the Yale study had been supported and funded by United?"); *see also id.* 38:20-23 ("When you began this campaign, you knew the public would not accept the idea that all out-of-network emergency room doctors are bad. And so, you began taking baby steps").
- Regarding PX 37, opposing counsel inflamed the passion of the jury and provided his personal belief that Defendants were not credible by testifying that United being referred to as a "large carrier" and that Defendants "'support is expected to remain behind the scenes' . . . mean[t] United Geppetto, the person controlling the puppet, nobody knows he's behind the curtain." 11/8/2021 Tr. 91:24-93:7.
- Regarding PX 37, opposing counsel inflamed the passion of the jury when he was allowed to solicit unfounded and improper expert testimony from Mr. Haben regarding market

perception, which only an expert in marketing could provide. 11/8/2021 Tr. 93:18-24 ("Because you know, Mr. Haben, that if United is associated with this piece, the force that it's going to carry with the public is not going to have the same weight as if it's an objective piece put out by a professor at world-class university, right?").

- Regarding PX 55, opposing counsel testified that the exhibits contents were a lie to provide his personal belief that Defendants were culpable. 11/3/2021 Tr. 77:23-78:7 ("And what you're telling the media is that you're actually going to collaborate with the doctors to put a cap on the charges billed . . . . And that, Mr. Haben, 100 percent is a lie. You did not consult one doctor, other than your in-house medical director to come up with this cap.").
- Regarding PX 79, opposing counsel testified as to the culpability of Defendants by claiming that "[n]ice splash" demonstrated Defendants' "vindicative" intent when dealing with "TeamHealth." 11/8/2021 Tr. 107:4-19; *id*. 109:9-14 ("As this Yale study is leaving its mark, you now begin talking about putting a cap on how much emergency room doctors can charge as a way to generate shared savings fees with your ASO clients.").
- Regarding PX 509, opposing counsel provided his personal opinion that Defendants were culpable by asserting that Defendants were gaming the system by paying off researchers. 11/8/2021 Tr. 112:21-113:7 ("Zack Cooper's not an umpire. He's on the team . . . . you're going to use him to bring our story to life, to speak on this healthcare trend.")
- Opposing counsel inflamed the jury by providing his own personal belief that Defendants "didn't want to bash all doctors . . . just a handful" when Defendants engaged in media outreach about providers causing runaway healthcare costs. 11/8/2021 Tr. 37:20-38:4.
- Opposing counsel testified that Defendants were "Geppetto, the person controlling the puppet," *i.e.*, the Yale researcher. 11/8/2021 Tr. 91:24-93:7.
- In closing argument, opposing counsel injected his personal belief as to the justness of his clients' cause and culpability of Defendants and otherwise inflamed the jury's passions by saying Defendants protected First Amendment activities were "nonsense." 11/23/2021 Tr. 144:6-16 ("[L]et me tell you something, they got to you all [the jury]" with "this nonsense [of] educating the public" with their "marketing" that the Country "had this huge problem

with balance billing."). This also had the dual effect of asking the jury to remedy a social ill and injecting the jury into the case by making their verdict vindicate society's and their own manipulation at the hands of Defendants. *Id*. ("they got to you all").

- Also during closing arguments, opposing counsel inflamed the passions of the jury by telling the jury that Nevada's quality of care is was harmed as a result of Defendants' protected First Amendment activities. 11/23/2021 Tr. 155:20-156:7. Opposing counsel told the jury that Defendants' "seed[s]," *i.e.*, their First Amendment activities, "had turned into . . . [the giant sequoias] outside of San Francisco. *Id*.; *id.* 145:10-16. Then, he further inflamed: "Congratulations, Nevada. Here's your pat on the back. You're saving the healthcare industry. We're getting the healthcare crisis under control. Thank you, Nevada." *Id.* 155:20-156:7. Similarly, during closing argument in the punitive damages phase, opposing counsel used Defendants' protected First Amendment activities to inflame the passions of the jury. 12/7/2021 Tr. 98:19-23 ("[Defendants] have spent an enormous amount of resources in brainwashing not only the people of this state, but everyone. . . . You all saw this in the exhibit where they were literally talking about seeding stories in the local media."). These closing arguments had the effect of asking the jury to remedy a social ill. And, no juror is going to rule against remedying a harm that they believe concerns themselves, especially when they are lead to believe they have been manipulated or brainwashed.

* * *

Because of the aforementioned misconduct, a new trial is required. Additionally, this misconduct makes clear that the use of Defendants' protected First Amendment Activities was central to TeamHealth Plaintiffs' trial strategy. Thus, the jury's verdict is holds Defendants liable for First Amendment activities that should have never been presented. Therefore, a new trial is required.

III.
IRREGULARITY IN THE PROCEEDINGS, ABUSE OF DISCRETION, AND ERRORS OF LAW THAT REQUIRE A NEW TRIAL

This case was highly unusual. From just before trial began through the verdict, Defendants' ability to mount of defense was impeded. TeamHealth Plaintiffs were allowed to change their

theories of recovery whenever they saw fit, including just before trial began and just before the liability phase was submitted to the jury. Defendants were not allowed to exercise their peremptory challenges pursuant to the method required by law so that their right to a fair and impartial jury is fully protected. The Court admitted many documents without proper foundation, so the jurors were allowed to render a verdict based on material that they should not have seen. And, Defendants were subjected to highly unusual and prejudicial use of deposition testimony. Because of these errors and the prejudice, a new trial is required.

A. BECAUSE TEAMHEALTH PLAINTIFFS' WERE PERMITTED TO CHANGE THEIR PUNITIVE DAMAGES THEORY WHENEVER THEY SAW FIT, DEFENDANTS WERE DENIED A FAIR TRIAL.

When TeamHealth Plaintiffs initially filed their complaint, they requested punitive damages on two theories. The first was based on Defendants' malicious, oppressive or fraudulent conduct that constituted a tortious breach of the covenant of good faith and fair dealing implied into an implied-in-fact contract. Original Complaint ¶ 55 ("malice, oppression and/or fraud . . . just[ies] an award of punitive . . . damages"). The second was based on Defendants' "bad faith" conduct that constituted a violation of the Unfair Claims Practices Act. *Id*. ¶ 74. Those were the exact same theories alleged in their First Amended Complaint. First Amend. Compl. ¶¶ 214, 233. Then, in response to Defendants' Partial Motion for Summary Judgment, TeamHealth Plaintiffs filed the operative trial complaint, the Second Amendment Complaint. *See* Defs' Mot. For Partial Summ. J.; Second Amend. Compl. Thereafter, only the second punitive damages theory remained. Second Amend. Compl. ¶ 96.

None of this was irregular. However, it was irregular and an abuse of discretion for this Court to permit TeamHealth Plaintiffs to file improper sur-reply to Defendants' Motion for Partial Summary Judgment on the eve of oral argument. Plfs' Mot. for Leave to File Supp. in Opp. to Summ. J. Likewise, it was irregular, an abuse of discretion, and an error of law to allow TeamHealth Plaintiffs to amend the joint pre-trial memorandum so that they could present an additional theory of punitive damages to the jury that was ***never*** included in ***any*** complaint. *Compare* Plfs' Mot. to Modify Joint Pre-Trial Order, *with* Original Complaint ¶¶ 57-67, First Amend. Compl. ¶¶ 216-226, *and* Second Amend. Compl. ¶¶ 80-89 (all failing to allege punitive damages vis-à-vis unjust

enrichment cause of action). Indeed, when "the prayer for relief associated" with the specific cause of action and a plaintiff's "pre-trial statements" do not mention punitive damages, a defendant rightfully believes that punitive damages are not sought for that cause of action. *Sprouse v. Wentz*, 105 Nev. 597, 604, 781 P.2d 1136, 1140 (1989). To allow a plaintiff to recover punitive damages based on such a procedural history would "deny [defendants] the opportunity to defend against a substantial punitive damages award." *Id.* These irregularities and abuses of discretion deprived Defendants of a fair trial. Thus, a new trial is required.

1. Defendants' Trial Preparations were Unfairly Hampered When, Without Amending the Operative Complaint, TeamHealth Plaintiffs Expand Their Punitive Damages Theory One Week Before Trial.

Defendants' Motion for Partial Summary Judgment argued that TeamHealth Plaintiffs could not recover punitive damages at trial because there was no evidence to support that relief. Defs' Mot. Summ. J. at 42:23-33:3. In their Opposition, TeamHealth Plaintiffs went beyond their theory to recover punitive damages—*i.e.*, Defendants' "bad faith" conduct that constituted unfair insurance practices—and asserted that they were pursuing punitive damages based on oppression and fraud. Defs' Opp. to Plfs' Mot. for Leave to File Sur-Reply at 6 n.6. Then, after reviewing Defendants' Reply in support of Partial Summary Judgment, TeamHealth Plaintiffs realized that their Opposition was severely deficient. *See* Plfs' 10/17/2021 Sur-Reply.

Instead of falling on their sword, they filed improper Sur-Reply on the eve of oral argument. *See id*. And once again, their punitive damages theory changed. Defs' Opp. to Plfs' Mot. for Leave to File Sur-Reply at 4, 8. Now, a jury could award punitive damages based on a finding of malice. Defs' Opp. to Plfs' Mot. for Leave to File Sur-Reply at 4, 8. Additionally, TeamHealth Plaintiffs presented the Court with new evidence that it was relying upon, including national negotiations between the parties' affiliates and alleged harm occurring outside the state of Nevada.

Because trial was only one week away, trial preparation was in full swing. So, Defendants requested that TeamHealth Plaintiffs improper sur-reply be rejected. Defs' Opp. to Plfs' Mot. for Leave to File Sur-Reply at 4-6. As a result, Defendants were hampered in their trial preparation efforts by having to readjust their trial preparation to the moving target that was TeamHealth Plaintiffs' punitive damages theory while their finite resources were diverted responding to improper

sur-reply. The abuse of discretion in allowing the improper sur-reply resulted in irregular, prejudicial proceedings and unfair surprise that Defendants could not prevent with ordinary prudence. As such, a new trial is necessary to provide a fair trial.

But the error did not end there, because TeamHealth Plaintiffs were allowed to amend the joint pre-trial memorandum to add a brand new theory to recover punitive damages on the eve of jury deliberations.

2. Defendants Were Denied a Fair Trial When This Court Allowed TeamHealth Plaintiffs to Change Their Punitive Damages Theory by Modifying the Joint Pre-Trial Memorandum Just Before Jury Deliberations.

As noted above, the operative trial complaint only alleged one theory of punitive damages recovery: Defendants engaged in "bad faith" conduct that constituted a violation of the Unfair Claims Practices Act. Second Amend. Compl. ¶ 96. TeamHealth Plaintiffs abandoned their other theory based on alleged malicious, oppressive or fraudulent conduct that constituted a tortious breach of the covenant of good faith and fair dealing implied into an implied-in-fact contract. First Amend. Compl. ¶ 214. Accordingly, that sole theory of punitive damages recovery guided the parties' joint pre-trial memorandum meet and conferral process. As a result, TeamHealth Plaintiffs perfected their theory of recovery when they stipulated that they were only seeking punitive damages pursuant to the allegations associated with their Unfair Claims Practices Act cause of action. Joint Pre-Trial Memo. at 5-6; *Sprouse*, 105 Nev. at 604, 781 P.2d at 1140 ("[Defendant] rightfully believed from the pleadings and the pre-trial statements that [plaintiff] sought punitive damages based only on" one cause of action).

The meet and conferral process occurred against the backdrop of TeamHealth Plaintiffs' improper tactics in opposing summary judgment, including an ever-changing punitive damages theory that did not comport with the operative complaint's allegations. So, Defendants were cognizant that TeamHealth Plaintiffs may attempt to swindle them out of a clear target to prepare for trial by failing to comply with EDCR 2.67(b)(2). That almost occurred.

On October 4, 2021, TeamHealth Plaintiffs provided Defendants with their portion of the stipulated pretrial memorandum, which informed Defendants that they would only be seeking a

punitive damages award based only on their allegation of bad faith contained in their Unfair Claims Practices Act cause of action. Defs' Opp. to Modify Joint Pretrial Memorandum at 3 (citing exhibit 1). At the October 20, 2021 pretrial hearing, TeamHealth Plaintiffs' counsel represented the parties' discussions regarding the scheduling deadline for the stipulated pretrial memorandum: that the parties are in agreement to submit the stipulation on October 26, after jury selection starts. 10/20/2021 Tr. 99:19-25. TeamHealth Plaintiffs' counsel also asked whether the Court would permit that filing deadline, which the Court ordered was allowable pursuant to agreement by the parties. *Id*. 100:1-5. Therefore, the stipulated pretrial memorandum was scheduled to be submitted on October 26 via stipulated order. On October 26, 2021, TeamHealth Plaintiffs amended their portion to remove all references to their causes of action or the categories of damages that they request for each cause of action. Defs' Opp. to Modify Joint Pretrial Memorandum at 3 (citing exhibit 1).

Defendants responded by informing TeamHealth Plaintiffs that their revisions did not comply with EDCR 2.67(b)(2), which requires "[a] list of all claims for relief designated **by reference to each claim or paragraph of a pleading** and a **description of the claimant's theory of recovery** with each **category of damage** requested." *Id*. (quoting exhibit 1 (bolding in exhibit)) (quoting EDCR 2.67(b)(2)). Defendants were insistent on compliance with the rule and would not have signed onto a non-compliant pretrial memorandum. Based on the demand, TeamHealth Plaintiffs reverted back to their October 4 recitation of their causes of action and the categories of damages that they were pursuing for each cause, including that they were only seeking a punitive damages award based on Unfair Claims Practices Act cause of action. *Id*. Defendants then relied on TeamHealth Plaintiffs' statement of their case in creating their trial defense strategy and trying their case.

Then, two days before closing argument, TeamHealth Plaintiffs stated that they wanted to seek punitive damages based on their unjust enrichment cause of action. 11/21/2021 Tr. 122:9-123:25. This was a brand new theory that was ***never*** part of the case. It was never alleged in any complaint or articulated in TeamHealth Plaintiffs' pre-trial statements. Thus, Defendants protested the unfairness and prejudice of that modification. 11/21/2021 Tr. 122:15-123:21; *Sprouse*, 105 Nev. at 604, 781 P.2d at 1140 ("[Defendant] rightfully believed from the pleadings and the pre-trial

statements that [plaintiff] sought punitive damages based only on" one cause of action). However, after pre-judging the issue, the Court permitted TeamHealth Plaintiffs to move for modification, which motion was filed the day before closing argument. 11/21/2021 Tr. 123:16-25; Plfs' Mot. to Modify Pre-Trial Order. So, while Defendants needed to prepare for closing argument, it had to divert their resources to oppose the motion to modify. That 15-page opposition was filed on November 22, 2021 at 11:57pm and is incorporated fully herein. Defs' Opp. to Modify Joint Pretrial Memorandum at 1.

In short, Defendants opposed modification because Plaintiffs filed their motion the day before closing argument and the issue would not be resolved until the day of closing argument. *Id.* at 3. That left Defendants unable to fully prepare for closing argument because they did not know if an issue that was not tried could be argued. Defendants also argued that TeamHealth Plaintiffs did not: (1) address their high burden for modification—that modification is imperative to prevent manifest injustice; (2) provide good cause for their request to amend the scheduling order governing the stipulated pretrial memorandum; (3) did not demonstrate that they were diligent in pursing this theory of damages to justify adding it after Defendants have presented their limited defense;[16] and (4) demonstrate that Defendants consented to the brand new punitive damages theory. *Id*. at 3-15. However, the Court granted TeamHealth Plaintiffs motion to modify and subjected Defendants to the brand new punitive damages theory just before closing arguments were delivered. 11/23/2021 Tr. 115:25-116:10. For the reasons stated in Defendants' opposition to the motion to modify, this was an irregularity in the proceedings, an abuse of discretion, and an error of law that subjected Defendants to trial by ambush. *See also Sprouse*, 105 Nev. at 604, 781 P.2d at 1140. Thus, a new trial is required.

B. Because the Jury was Impaneled Using an Irregular Peremptory Challenge Process, Defendants Were Denied a Fair Trial.

The "basic purpose of peremptory challenges" is "to allow parties to remove potential jurors whom they suspect, but cannot prove, may exhibit a particular bias," *Diomampo v. State*, 124 Nev.

[16] Defendants were unable to present their desired case because of TeamHealth Plaintiffs' trial strategy that involved four days of voir dire and questioning one witness for two weeks.

414, 426, 185 P.3d 1031, 1039 (2008), making them the "'means to the constitutional end of an impartial jury and a fair trial.'" *Georgia v. McCollum*, 505 U.S. 42, 57 (1992). Defendants were denied the full opportunity to exercise their peremptory challenges and, thus, did not receive the protections afforded to them by the Nevada Legislature. A new trial is required.

On October 31, 2021, Defendants filed a trial brief regarding the peremptory challenge process.[17] That brief was necessitated by off-the-record discussions that the parties and the Court had after voir dire on October 28, 2021. Defs' Trial Brief Regarding Peremptory Challenges at 1. TeamHealth Plaintiffs proposed, and the Court eventually accepted, a novel approach to how the parties may exercise their challenges. *Id*. Namely, that the parties must exercise their challenges in the order that the jury was drawn and are deemed to have waived any challenge to a prospective juror if a party has already challenged a subsequently drawn juror. *Id*. (explaining that by challenging juror no. 5, a party cannot then challenge jurors nos. 1-4).

TeamHealth Plaintiffs argued that permitting a juror to be challenged after a challenge to a subsequently drawn juror would constitute a "back-strike." 11/1/2021 Tr. 142:13-16 ("[TeamHealth Plaintiffs] strike first. The defense then strikes. We strike again, but . . . we can't back-strike. We can only go forward, not backward."). Defendants explained to the Court that TeamHealth Plaintiffs' back strike description was wrong. *Id.* 146:8-11. Correctly understood: "a back strike is defined . . . as exercising a strike against the panel after you have been through the whole strike process. Where you hold the strike and use it after the entire jury panel has been picked." *Id*. That entails not exercising a peremptory challenge after the opposing party exercises its challenge, so that they opposing party exercises two challenges in a row. *See* NRS 16.030(4) (requiring "alternat[ing] strikes"). But that was not what Defendants were asking to do. 11/1/2021 Tr. 146:10-11. Instead, Defendants wanted to alternate strikes with TeamHealth Plaintiffs and exercise its challenges against any name from the list of persons on the panel, as permitted and required by Nevada law. *Id.* 143:24-144:4; NRS 16.030(4). However, the Court erroneously agreed with TeamHealth Plaintiffs and their approach was used. *See* 11/1/2021 Tr. 145:5-7 (overruling

[17] That brief is fully incorporated herein.

Defendants' objection because "this court [doe]s not allow any back strikes").

The approach to peremptory challenges and empaneling the jury did not conform to the approach required by NRS 16.030(4) and NRS 16.040(1). Under those statutes, the parties "***shall*** exercise its peremptory challenges . . .by alternat[ing] strikes" against ***any*** "***name[] from the list of persons on the panel***." NRS 16.030(4) (emphasis added); NRS 16.040(1) ("Either party may challenge ***the jurors***."). The statute does not bar a litigant from challenge a juror just because a prior challenge was first made to a later drawn juror. Indeed, NRS 16.030(4) identifies when "the order in which [the jurors] names were drawn" has impact on the process. It is limited to determining which "persons remaining on the panel" are jurors or alternates "***[a]fter the peremptory challenges have been exercised***." *Id.* (emphasis added). In sum, the Legislature clearly indicated when the order in which the jurors were drawn matters. *State v. McClear*, 11 Nev. 39, 53 (1876) (holding "peremptory challenges ha[ve] always been regulated by statute . . . [and] is a question of policy . . . which may always be decided by the legislature").

Moreover, that clear intent is exemplified by the materially different approach that the Legislature requires when impaneling a jury in a criminal case. In NRS 175.051, the Legislature expressly mandated that a peremptory challenge is waived if it is "not exercised in its proper order." NRS 175.051 ("The prosecuting attorney and the defendant shall exercise their challenges alternatively, in that order. ***Any challenge not exercised in its proper order is waived***." (emphasis added)). The words "proper order" and "waived" are not used in NRS 16.030(4) or NRS 16.040(1). As such, they do not require that a party exercise its peremptory challenges based on the order the jurors were drawn. Instead, the challenges exercised against any "name[] from the list of persons on the panel" without fear of wavier. Therefore, the Court was required to allow Defendants to challenge any "name[] from the list of persons on the panel." NRCP 47(b) ("The court must allow peremptory challenges . . . as provided in NRS Chapter 16.").

Finally, the exercise of a peremptory challenge on any "name[] from the list of persons on the panel" has been the practice in Nevada since at least the admission of the State. *See, e.g.*, *State v. Pritchard*, 15 Nev. 74 (1880). In *Pritchard*, the Nevada Supreme Court held that the ability of a litigant to challenge "any juror peremptorily *is absolute* at any time before the jury is sworn, and

that *no circumstances can bring that right within the discretion of the court*, so long as it is confined to the number of peremptory challenges allowed by law." *Id*. at 92-93 (emphasis in original). Because the Legislature provided civil litigants with the ability to challenge any "name[] from the list of persons on the panel" without fear of wavier if a challenge is not exercised in a "proper order," Defendants were entitled to challenge any jury at any time before the panel was sworn. However, that is not what occurred. To remedy the individual or cumulative effect of this error, a new trial is required.

C. THE IMPROPER ADMISSION OF EVIDENCE DURING THE LIABILITY PHASE OF TRIAL REQUIRES A NEW TRIAL.

1. The Court Improperly Pre-Admitted or Conditionally Admitted Numerous Exhibits.

The day before opening statements, TeamHealth Plaintiffs asked this Court to admit 115 documents so that they could use those materials during their opening statements. *See* 11/1/2021 Tr. 184:9-186:6. Despite numerous issues, this Court granted that request without a hearing to determine admissibility.

First, TeamHealth Plaintiffs did not follow the proper procedure for obtaining pre-trial rulings regarding the admissibility of documents. Pursuant to the pre-trial scheduling order, the deadline to file motions *in limine* was September 21, 2021. As such, TeamHealth Plaintiffs request for the admission of 115 documents on November 1, 2021 was improper and prejudiced Defendants. 11/1/2021 Tr. 192:24-193:14 ("Your Honor would have had a chance to go into the details, could have hear argument on it, and issued rulings . . . well before 4:20 on the afternoon before opening statements."). Moreover, that request blindsided Defendants. 11/1/2021 Tr. 186:17-25. The Court initially recognized Defendants' plight and told the parties that the issue would be addressed in the morning to not put Defendants on the spot. 11/1/2021 Tr. 184:25-185:8 ("[Defendants] need to have a chance to look at it. We can do this in the morning. [defense counsel]: I'm happy to address it then, Your Honor."); *id.* 197:19-23. However, TeamHealth Plaintiffs steamrolled ahead, 11/1/2021 Tr. 187:1-10, and the Court became predisposed to ruling in their favor, 11/1/2021 Tr. 199:3-9 ("it makes perfect sense to conditionally admit them and let the Plaintiffs use them in opening . . . [but] we can take this up tomorrow"). The following day, that tentative ruling become final because the

Court did not "want to prolong this argument." 11/2/2021 Tr. 6:20-22.

Second, the Court was required to hold a hearing to resolve all questions of admissibility based upon an individualized analysis of the documents before admitting any documents. NRS 47.080. The primary purpose of an NRS 47.080 hearing is to ascertain whether the disputed exhibits could be admitted for a proper purpose. *Park v. Sierra Pac. Power Co*., 78 Nev. 297, 300 (1962)

Defendants requested that hearing and protection before the Court issued its tentative ruling. 11/1/2021 Tr. 194:3-195:5; Defs' 11/1/2021 Trial Brief re Pre-Admitting Exhibits at 4 ("wholesale pre-admission of the [disputed] exhibits without addressing objections to them individually would be improper for numerous reasons," including because every "document that is related to an out-of-network program is [not] ipso facto evidence. [Admissibility] depends on why it's being offered to prove what, for what purpose, and what other considerations relate to what the document contains in it, including hearsay and a host of other things.").[18] As such, TeamHealth Plaintiffs, as the offering party, should have been required to "*state the proper purpose*" of each objected to document before the documents were admitted. *See Park*, 78 Nev. at 300 (emphasis in original); *see also Rodriguez v. State*, 128 Nev. 155, 162, 273 P.3d 845, 849 (2012) ("proponent of the evidence must explain the purpose for which the [material] is being offered and provide sufficient direct or circumstantial corroborating evidence . . . to authenticate"). But, that detail was never provided. *See* 11/1/2021 Defs' Trial Brief re Pre-Admitting Exhibits at 4 ("TeamHealth Plaintiffs have provided no detail on what they are offering the exhibits to show.").

Additionally, aside from determining whether there was a potential proper purpose for the admission of the documents, the hearing was needed because the documents were subject to numerous unresolved objections. 11/1/2021 Trial Brief re Pre-Admitting Exhibits at 4 (explaining "there [wa]s no indication that a proper foundation can be laid for the evidence at trial," there were

[18] Because NRS 47.080 states that the Court should hold the hearing outside to presence of the jury to the extent practicable, Defendants informed the Court that the hearing "would require further delay in the trial schedule, a result that should be avoided at all cost." *See* 11/1/2021 Defs' Trial Brief re Pre-Admitting Exhibits at 6. That is, TeamHealth Plaintiffs' delay should not have been a reason for the Court to admit the disputed exhibits for use in opening statements. *See id*. Thus, Defendants requested that the disputed exhibits not be admitted due to the manufactured impracticability of that hearing by TeamHealth Plaintiffs.

rule of completeness issues, there was a lack of exhibit list disclosure, and there were "hearsay, undue prejudice, or relevance" objections). Those issues were not resolved before the documents were admitted to be used against Defendants because the required hearing never occurred. 11/2/2021 Tr. 5:23-6:21 ("Based on the argument we heard yesterday, . . . the Court . . . decided it wasn't going to engage in an individualized document by document review of objections. It was going to admit whatever [TeamHealth Plaintiffs] were . . . proposing."). Instead, the Court resolved the dispute based on a discussion "about a list [of documents] that no one has in front of them." 11/1/2021 Tr. 194:17-25. Thus, the Court deprived Defendants of the required hearing that they requested and enabled TeamHealth Plaintiffs to adversely use numerous exhibits against Defendants in opening statement.

Third, as explained in Defendants' November 1, 2021 trial brief regarding the pre-admission of exhibits, the admission of exhibits before trial so that TeamHealth Plaintiffs could use those documents in opening statement would not be harmless error and could be grounds for a new trial. *See* 11/1/2021 Trial Brief re Pre-Admitting Exhibits at 4-5. "[I]mproper advocacy that places prejudicial and inadmissible evidence before the jury can create an unacceptable risk of biased jury deliberations and also require mistrial as a matter of 'manifest necessity.'" *Glover v. Eight Judicial Dist. Court of Nev.*, 220 P.3d 684, 692 (Nev. 2009); *cf. Guerrero v. Smith*, 864 S.W.2d 797, 799 (Tex. Ct. App. 1993) (ruling that counsel are not permitted to, in opening statement, "detail to the jury the evidence which he intends to offer, nor to read or display the documents and photographs he proposes to offer" because "[t]his practice misleads and confuses the jurors as between counsel's mere expectations and evidence that is actually admitted"). TeamHealth Plaintiffs did not propose making "isolated remarks" on a piece of inadmissible evidence. *See Ledbetter v. State*, 122 Nev. 252, 264-65, 129 P.3d 671, 680 (2006). They proposed showing, and did show, a large swath of documents to jurors, the admissibility to which the Defendants disputed and still dispute. *Id*.

For example, PX 25 was shown to the jury in opening statement by TeamHealth Plaintiffs and Defendants even though it was "fully" admitted without proper foundation. *See infra* Course of, or Lead-Up to, Trial Errors Section IV.C.2. Similarly, even though PX 37, PX 79, PX 100, PX 509, and PX 528 could not be used against Defendants because they were protected by the First

Amendment, TeamHealth Plaintiffs were allowed to show to the jury these materials during opening statement because they were conditionally admitted. *See supra* Course of, or Lead-Up to, Trial Errors Section II.A. Making matters worse, when Defendants objected to the full admission of PX 25 during trial, the Court admitted it because it had already been conditionally admitted. *E.g.*, 11/3/2021 Tr. 41:6-21 (overruling Defendants objection to the admission of PX 25 because "[i]t was conditionally admitted yesterday").

Because TeamHealth Plaintiffs did not adhere to proper procedure and the Court admitted numerous exhibits without conducting an individualized analysis of the disputed documents pursuant to NRS 47.080, a shadow was caste upon the trial from the outset. This Court must grant a new trial to remedy this error.

2. The Court Improperly Admitted Numerous Exhibits that Lacked Foundation.

As noted in above, *supra* Course of, or Lead-Up to, Trial Errors Section II.B., and detailed more fully here, the Court admitted numerous exhibits without proper foundation being laid. A new trial is required because the jury was able to evaluate documents they should have never seen.

TeamHealth Plaintiffs advanced an array of erroneous arguments to abrogate the requirements of foundation. First, they asserted that there is a very low foundation threshold for the admission of evidence. 11/1/2021 Tr. 188:5-21. However, the caselaw cited below makes clear that the threshold is not so low as to have no meaning at all, as TeamHealth Plaintiffs desire. Second, TeamHealth Plaintiffs argued that "the jury is permitted to infer that [the witness] is not being completely truthful when" the witness testifies that he or she does not have personal knowledge of the document. However, the Court, and not the jury, is the gatekeeper of whether evidence is admissible. *See Ford v. State*, 122 Nev. 796, 806 (Nev. 2006) .

Third, they argued that any document concerning out-of-network programs is admissible because Mr. Haben and/or Ms. Paradise were responsible for those programs. *Id*. 188:22-189:4. In doing so, they accused Defendants of "trying to conflate whether a witness has foundation to speak to a document with the foundation for the document itself." *Id.* 189:6-8. However, it is TeamHealth Plaintiffs that conflated the standards and confused the Court. While a witness may be able to testify

as to the contents of a document, the document must still be admitted through a proper witness that can establish that the document is what it purports to be. *See* NRS 50.025 ("A witness may not testify to a matter unless . . . the witness has personal knowledge of the matter."); NRS 52.015 ("The requirement of authentication or identification as a condition precedent by . . . a finding that the matter in question is what its proponent claims."); NRS 52.025 ("The testimony of a witness is sufficient for authentication or identification if the witness has personal knowledge that the matter is what it is claimed to be."). For example, the CEO of any company is responsible for all things at the company. However, the CEO cannot lay foundation for every company document because having responsibility over something does not make the person omniscient regarding that thing.

The threshold for foundation is not so low as to have no meaning at all. Proper foundation requires that a document may be admitted when an ***appropriate witness*** identifies and authenticates the document. *Frank v. State*, 94 Nev. 610, 613, 584 P.2d 678, 679 (1978). To be an appropriate witness pursuant to NRS 52.025, the individual must have "personal knowledge of the document at issue" which includes being "able to testify about the circumstances of the document," *i.e.*, the "how, when and in what manner" the document was created. *Frias v. Valle*, 101 Nev. 219, 221-22, 698 P.2d 875, 877 (1985); *Select Portfolio Servicing, Inc. v. Dunmire*, 456 P.3d 255, 2020 WL 466816 (Nev. Jan. 27, 2020) (holding no foundation to admit exhibit when witness "was not the custodian," "had no personal knowledge of the record, and could not testify . . . as to how the record was made"); *Shanks v. First 100, LLC*, 134 Nev. 1010, 2018 WL 6133885, at *1-2 (Nev. Ct. App. Nov. 23, 2018) (citing *Mishler v. McNally*, 102 Nev. 625, 628, 730 P.2d 432, 435 (1986) ("determining that a memo was not authenticated per NRS 52.015 and inadmissible because it was an unsigned copy with no date of receipt and the custodian of records could not say when the hospital received it")); *Sanders v. Sears-Page*, 131 Nev. 500, 516, 354 P.3d 201, 211 (Nev. Ct. App. 2015) ("concluding that a medical record was not authenticated where the testifying doctor 'did not author the document, was not the custodian of the record, and [merely] testified [that] the document looked like a typical medical record'")).

Similarly, an appropriate foundational witness is required for the admission of business records. *See* NRS 51.135 (business records hearsay exception). To be a foundational witness under

NRS 51.135, the person must either be the custodian of the specific record(s) or an "other qualified person," *i.e.*, the person "understands the record-keeping system involved." *Thomas v. State*, 114 Nev. 1127, 1147-48 (1998) (requiring other qualified person to know that the type of document is "kept in the ordinary course of business and the procedures involved" to create the document); *see also United States v. Komasa*, 767 F.3d 151, 156 (2d Cir. 2014) (requiring testimony that the document was "kept in the course of regularly conducted business activity and also that it was the regular practice of that business activity to make the [record]"); *Kasper Global Collection & Brokers v. Global Cabinets & Furniture Manu. Inc.*, 952 F. Supp. 2d 542, 572 (S.D.N.Y. 2013) (requiring other qualified person to know "how the records were created"). A witness may be an "other qualified person" based on his or her position within the company, but only if the position makes the witness "intimately familiar with the company's" record-keeping system or database. *See Bayview Loan Servicing v. Sterling at Silver Springs Homeowners Ass'n*, 2020 WL 1275611, at *4-5 (D. Nev. Mar. 17, 2020).

The following exhibits, *inter alia*, were admitted through a witness that could not testify to the "how, when and in what manner" the document was created, were not custodians of the document, did not provide any testimony that they understood the record-keeping system(s) involved, and did not have a position within any of the Defendant entities that made them "intimately familiar with" the record-keeping system(s) involved:

- PX 25. This exhibit was admitted through Mr. Haben. 11/3/2021 Tr. 41:22. The only testimony that Mr. Haben provided regarding PX 25 was he believed it identified out-of-network programs under his department's responsibility. *Id*. 41:6-15. However, there was no testimony or other evidence provided that Mr. Haben knew how, when, or why the document was created or that he had ever seen it before. There was also no testimony that Mr. Haben was familiar with Defendants' record-keeping database or that he was the custodian of record. Therefore, there was no foundation for the document to be admitted. This document was highly prejudicial because opposing counsel told the jury that it was "one of the most important documents in the case." 11/23/2021 Tr. 142:5-6.
- PX 53. This exhibit was admitted through Mr. Haben because of testimony that it contained

information about ENRP; that he recognized a few, but not all, of the names in the document that a person; that one of the recognized names was Sara Peterson but that he could not recall if she was on his team when the document was created because she was only periodically a member of his team; that Mr. Haben had no reason to dispute that it was a document of Defendants; and that some of the subject matter in the document fell under his department. 11/12/2021 Tr. 117:2-119:11

- PX 55. *Supra* Course of, or Lead-Up to, Trial Errors Section II.B. (detailing lack of foundation for PX 55).
- PX 67. This exhibit was admitted through Mr. Haben. 11/8/2021 Tr. 117:5-128:2. Even though Mr. Haben testified that he had no personal knowledge about the document, the Court admitted the exhibit after hearing testimony that it dealt with Tina Brown-Stevenson's development of new out-of-network initiatives; that the document was under the purview of Ms. Brown-Stevenson's group, not Mr. Haben's group, because Ms. Brown-Stevenson is responsible for initiatives; that in a very broad sense there was overlap between his and Ms. Brown-Stevenson's jobs because he managed the programs once put into the market; that the document referenced the Outlier Cost Management program, which Mr. Haben was responsible for managing; that the document sounds similar to other docs they have looked. *Id.* However, Mr. Haben did not give any testimony connecting himself to the creation of the document.
- PX 92. This exhibit was admitted through Mr. Haben. Mr. Haben testified that he was not part of the business meeting depicted in the document and was not part of that group. *Id.* 129:12-19. He also testified that the figures contained in the exhibit did not come from his department. *Id.* 131:10-15. While the Court recognized that the information would have come from a different group, it admitted the exhibit because it described out-of-network programs. *Id.* 150:17-152:17. Additionally, this document was admitted even though Mr. Haben had never seen it before, so he could not testify to how, when, or why it was created. 11/3/2021 Tr. 128:25-129:2. There was also no evidence that Mr. Haben was familiar with Defendants' record-keeping system that stored this document.

- PX 273. This was a 190+ page E&I presentation. 11/9/2021 Tr. 109:14-16. Mr. Haben testified that while it has a "United logo on it," he is "not familiar with the document" and "[does]n't know what it is." *Id.* 109:17-22. The Court admitted the exhibit because page 56 contains a percentage increase of premiums in the 2014-19 time period even though Mr. testified that he did not "know what the document is," after being shown page 56, because he "didn't write it." *Id.* 109:23-110:6. Mr. Haben was not the custodian of record and there was no testimony that he was familiar with Defendants' record-keeping system that stored the document.
- PX 354. To establish foundation, TeamHealth Plaintiffs asked Mr. Haben about a future out-of-network program, if he remembers testifying about the document at his deposition, and whether the document deals with out-of-network programs that fell under his responsibilities. 11/8 Tr. 14:24-17:4. However, there was no indication that Mr. Haben could explain how, when, or why the document was created. *Id*. There was also no evidence that Mr. Haben had seen the document before, except for at his deposition when he also testified that he had never seen it before. *Id*. Mr. Haben was not the custodian of record and there was not evidence that he was familiar with the record-keeping system that stored the document.
- PX 361. This document was admitted after Daniel Schumacher's deposition was played for the jury. 11/16/2021 Tr. 48:11-22. The Court admitted the exhibit even thought there was no evidence that Mr. Schumacher wrote it or received it. *Id*.
- PX 413. This was a MultiPlan document regarding how Data iSight purportedly worked. 11/9 Tr. 98:19-101:10. The exhibit was admitted through Mr. Haben even though he did not recognize it, but that Defendants used Data iSight to administer at-issue claims. *Id.* This document was not produced by Defendants and there was no evidence that Mr. Haben knew how, when, or why the document was created. *Id*. Mr. Haben was not a custodian of the record.
- PX 426. A document regarding the October 2019 Summit of the West Region, which named Dan Rosenthal. 11/9/2021 Tr. 192:3-9. Mr. Rosenthal was not Mr. Haben's boss at that

time, because Mr. Haben never worked for the "West region." *See id.* 192:11-14. In response to whether this exhibit was another financial performance report just like PX 462, Haben testified that he did not know what the document was and had "never seen it before." *See id.* 192:15-17. Additionally, Mr. Haben was unsure whether every person listed on page 8 was employed either by Defendants or by an affiliate, but some were. *Id.* 193:19-194:10. While Mr. Haben had no "reason to doubt that this is a United document," he had no idea whether the document appeared to be what it contained because he had never seen it before. *Id*. 194:7-15. Mr. Haben was not a custodian of this record and there was no evidence that he was familiar with the record-keeping database that stored the document.

- PX 462. This document purportedly contained information about the "financial performance in the West Region, which includes Nevada." 11/9/2021 Tr. 186:4-5. However, Mr. Haben testified that he did not know if the document was what it purported to be because he did not write it and was not otherwise familiar with it. *Id*. 186:4-6. There was no testimony that Mr. Haben knew how, when, or why the document was created. *Id.* 186:4-189:25. He was also not a custodian of this record and there was no testimony that he was familiar with the record-keeping database that stored this document. Nonetheless, the Court admitted the document because he knew some of the people named in the document. *Id*. 188:24-7.
- PX 470. The Court admitted this document even though Mr. Haben testified that even though it has a Defendants' Bates number, he was "not sure what [it] [wa]s," that he had "never seen [a document like it] before," that he did not know if the document is what "it purports to be," that he did not know if the document was "fraudulent," and that there is an appeal process governing all claims reimbursed by Defendants. 11/9/2021 Tr. 40:19-42:10. Mr. Haben did not provide any testimony that he was familiar with the appeal process. *Id*. Also, Mr. Haben did not provide any testimony that her knew how, when, or why the document was created. *Id*. Further, he was not a custodian and there was no evidence that he was familiar with the record-keeping database the stored the document. *Id*.
- PX 478. The Court admitted this exhibit even though Mr. Haben testified that he did not know who created the document. 11/9/2021 Tr. 169:4-16. He also testified that he could

not determine if anything was inconsistent with the purpose of the program depicted in the document because he was not familiar with the document and had not read all of it while on the stand. *Id*. 169:22-170:7. The Court believed there was sufficient foundation because the document said the word "Naviguard," Mr. Haben was in charge of that program, the limited portions of the document that Mr. Haben was directed to were not inconsistent with his understanding of Naviguard, and, even though not part of Mr. Haben's team, some, but not all, of the people named in the document were employed by affiliates of Defendants. *Id*. 171:5-15.

* * *

Because the jury was allowed to consider evidence that was not properly admitted into evidence, the verdict cannot stand. As such, a new trial is necessary to produce a fair result.

D. THE IMPROPER ADMISSION OF EVIDENCE DURING THE PUNITIVE DAMAGES PHASE REQUIRES A NEW TRIAL.

On December 5, 2021, Defendants filed Motion *in limine* No. 40 to preclude the admission of irrelevant financial documents and evidence of Defendants' historical conduct that was not admitted during the lability phase of trial.[19] The Court declined to consider that motion because it was not accompanied by an order shortening time. 12/6/2021 Tr. 46:17-18. However, TeamHealth Plaintiffs waived the need to brief the issue and had no objection to having the Court hear the issue without an order shortening time. *Id*. 40:16-42:6 ("I don't want to do anymore briefing, . . . [so] to the extent that counsel would like this heard now, we have no objection to that, . . . we're ready to go."). While it was a procedural error for the Court to refuse to rule on the motion, it was a substantive error for TeamHealth Plaintiffs to use irrelevant financial information and evidence of historical conduct that was not admitted during the punitive damages phase.

1. A New Trial is Required Because Irrelevant Financial Information was Admitted.

TeamHealth Plaintiffs successfully admitted PX 519 and 1001-04 into evidence. These documents were inadmissible because they (1) were not properly requested during discovery, (2)

[19] That motion is incorporated in full herein.

were irrelevant, (3) lacked foundation, or (4) related to the wealth of non-parties.

First. Before the punitive damages phase begun, Defendants explained to the Court that the financial evidence that TeamHealth Plaintiffs wanted to admit was never requested during discovery. 12/6/2021 Tr. 42:22-43:8. Instead, during the week of November 29, 2021, TeamHealth Plaintiffs requested by email that Defendants produce "certified financial statements for the last three or four years." *See id*. Confronted with the reality of their own misgivings, TeamHealth Plaintiffs asserted that request for production number 34 was "a very specific request for production to get" the desired financial documents. 12/6/2021 Tr. 41:3-4; 12/7/2021 Tr. 51:24-52:11.

That discovery request, however, was limited to "any and all documents and communications regarding the impact, if any, that reimbursement rates paid by you to non-participating providers had on profits you earned and/or premiums you charged with respect to one or more of your commercial health plans offered in the State of Nevada from 2016 to the present." 12/7/2021 Tr. 52:4-9. The certified financial statements, simply, were not responsive to that request. They did not regard, or show, any impact to Defendants' profits due to the reimbursement rates that they paid to out-of-network providers because there was no way to discern any impact that out-of-network reimbursement had on any financial figure contained in the certified financial statements. PX 1001-04. Indeed, there was no mention of out-of-network reimbursement in any of the documents. *Id*. And, only two of the certified financial statements, PX 1003 and 1004, pertained to Nevada. Thus, these documents should not have been admitted because Defendants should not have been required to produce these documents.

Second. In Motion *in Limine* No. 40 and at oral argument, Defendants made clear that they were not going to argue that their financial conditions "should mitigate the punitive damages award." Defs. Mot. *in Limine* No. 40 at 12; 126/6/2021 Tr. 37:19-38:2. Therefore, evidence regarding Defendants' financial conditions were irrelevant and the only purpose of that evidence "would be to exploit the jury's emotions and biases to award a large sum" of punitive damages. *Id.* (citing Nev. Civ. J.I. 12 PD.2 (modified) ("Your award cannot be more than otherwise warranted by the evidence in this case merely because of the wealth of the defendant."); *State Farm Ins. Co. v. Campbell*, 538 U.S. 408 (2003); (the wealth of the defendant cannot justify an otherwise

unconstitutional punitive damages award); *BMW of North America v. Gore*, 517 U.S. 599, 585 (1996) ("[T]he fact that BMW is a large corporation rather than an impecunious individual does not diminish its entitlement to fair notice of the demands that the several states impose on the conduct of its business"); *see also Bongiovi v. Sullivan*, 122 Nev. 556, 582-83, 138 P.3d 433, 452 (2006) (adopting federal guideposts set forth in *Campbell* and *Gore*)). As such, no document pertaining to Defendants' financial wealth should have been admitted. However, the Court disagreed.

Third. The Court also erred in admitting PX 1001-04 and PX 519 into evidence because there was no foundation. *Supra* Course of, or Lead-Up to, Trial Errors Section III.C.2 (detailing who is an appropriate witness to lay foundation). Ms. Paradise was the only witness affiliated with Defendants called to testify about during the punitive damages phase of trial. However, she was not authorized to represent every single employee, executive, of entity related to Defendants. 12/7/2021 Tr. 41:18-24. She was limited to giving testimony regarding her specific role within United Health Services. *Id*. That role did not make her privy to how Defendants' finances are accounted. In fact, while she has seen some "financial information" depending on how that term is used, Ms. Paradise has "[n]ever seen a balance statement in [her] time . . . at United." *Id*. 9:18-19; *id.* 6:21-22. And, she had never seen PX 519 or PX 1001-04 before she took the stand on December 7, 2021. *Id*. 43:15-17; *see also* 44:16-20 (testifying that she is not "the person to talk to" regarding Defendants financial statements or legal entity consolidation) *Id*. There was also no testimony that Ms. Paradise had any knowledge of how those exhibits were created or whether she was familiar, let alone intimately familiar, with Defendants' record-keeping database. *Supra* Course of, or Lead-Up to, Trial Errors Section III.C.2 (detailing how business record hearsay exception can be satisfied). As such, she was not an appropriate foundational witness to admit these documents. Nonetheless, the Court overruled Defendants' foundation objections to PX 519 and 1001-04.

Fourth. The Court admitted PX 519 even though it is a U.S. Securities and Exchange Commission Form 10-K filed by UHG. UHG was not a party at trial and there is no caselaw or justification for allowing the jury to assess punitive damages based on the net worth of a parent holding company. 11/7/2021 Tr. 50:6-15. Moreover, UHG's 10-K represents the financial condition of more than just Defendants. So, assuming that financial information could have been admitted,

PX 519 was improperly admitted because the jury obtain a false representation of Defendants' state of affairs.

* * *

Because the Court admitted material that was not requested in discovery, was irrelevant, lack foundation, or related to non-parties, a new trial is required.

2. A New Trial is Required Because the Reprehensibility of Defendants' Conduct was Assessed Based on Material that Did Not Give Rise to Liability.

In addition to PX 519 and 1001-04, TeamHealth Plaintiffs successfully admitted PX 89 during the punitive damages phase. That exhibit concerned the April 2017 review of UnitedHealth Network's West Region. The exhibit should have been precluded (1) for the reasons stated in Motion *in Limine* No. 40 and (2) there was no foundation. Additionally, TeamHealth Plaintiffs used PX 89 to inflame the passions of the jury.

First. In Motion *in Limine* No. 40 and at oral argument, Defendants explained that the punitive damages phase presents a narrow issue for the jury to decide: what amount of punitive damages is appropriate based on the jury's liability verdict. *Id*. at 9; 12/6/2021 Tr. 37:5-18, 39:9-40:12, 44:22-45:12. So, the reprehensibility of Defendants' conduct in this case is not determined by relitigating the conduct with new evidence. Defs' Mot. *in Limine* No. 40 at 9-10.

Pursuant to Nevada law, jurors are instructed that they are only determining the amount of punitive damages and not weighing the evidence anew to redetermine whether Defendants' conduct warrants punitive damages. *See Wyeth v. Rowatt*, 126 Nev. 446, 476, 244 P.3d 765, 785 (2010) ("By statute, Nevada requires that the liability determination for punitive damages against a defendant be bifurcated from the assessment of the amount of punitive damages, if any, to be awarded.") (citing NRS 42.005(3)); *see also Notrica v. State Compensation Ins. Fund*, 70 Cal. App. 4th 911, 947, 83 Cal. Rptr. 2d 89, 113 (1999) (quoting *Medo v. Superior Court*, 205 Cal. App. 3d 64, 68, 251 Cal. Rptr. 924 (1988) ("[P]unitive damages 'must be tied to oppression, fraud or malice ***in the conduct which gave rise to liability in the case***.'") (emphasis in *Medo*)).

Moreover, the jury's award must bear a reasonable relationship and be proportionate to the harm caused to a plaintiff—*i.e.*, the compensatory damages—meaning a jury's punitive damages

award must be based solely on the conduct that by clear and convincing evidence was shown to constitute fraud, oppression, or malice. *E.g.*, 12PD.2: Amount; *Campbell*, 538 U.S. at 425; *Gore*, 517 U.S. at 580-81; *see Pioneer Chlor Alkali Co. v. Nat'l Union Fire Ins. Co*., 863 F. Supp. 1237, 1250–51 (D. Nev. 1994). Thus, the already admitted evidence defines the boundaries that a jury may consider when evaluating the reprehensibility of a defendant's conduct. *See In re W.N. Connell & Marjorie T. Connell Living Tr.*, Dated May 18, 1972, 437 P.3d 1057, 2019 WL 1450277, at *4 (Nev. March 29, 2019) (reversing district court that held two separate hearings on punitive damages but ultimately "determined that punitive damages were warranted and the amount of those damages at the same time"). As such, additional evidence of Defendants' historical should not have been admitted. Instead of enforcing the required boundaries, the Court admitted PX 89. Thus, a new trial is required.

Second. The Court admitted PX 89 without proper foundation. That exhibit concerned the April 2017 review of UnitedHealth Network's West Region. 11/7/2021 Tr. 21-24. Ms. Paradise testified that she is "not involved in the network review," did not recall the April 2017 West Region review, and did not manage the West Region because she has a national role. *Id*. 22:2-15. There was no testimony that she had ever seen, received, or written PX 89 or had a role in its development. *Id*. 22:19-21. And, Ms. Paradise was not a custodian for PX 89 and did not provide any testimony that she was familiar with Defendants record-keeping database. As such, she could not provide proper foundation for PX 89 to be admitted. *Supra* III.C.2. Because the Court errantly admitted this exhibit, a new trial is required.[20]

Third. TeamHealth Plaintiffs used PX 89 to inflame the passions of the jury. During closing argument, they argued that Defendants conduct was reprehensible because "Sierra United" had an 80% market share in Clark County so they must be illicit monopolists. *Id*. 22:25-26:3, 105:20-

[20] As noted above, the newly introduced evidence opened the door to Defendants being able to introduce evidence regarding their state-of-mind that was responsive to the question of reprehensibility. *Supra* Discovery Errors Section. Those evidentiary topics included: (1) the contractual relationship between the parties before TeamHealth Plaintiffs terminated their agreements with Defendants; (2) in-network rates; and (3) Mr. Bristow's understanding of the reimbursement rates that TeamHealth Plaintiffs accepted in Nevada and in other states from Defendants biggest competitor, Blue Cross Blue Shield. 12/7/2021 Tr. 71:9-79:19.

106:3. Despite there being no evidence in the case about the distinct legal concepts of market power or monopoly, especially an illicit monopoly, the Court found that TeamHealth Plaintiffs did nothing improper. *Id*. 22:22, 106:6-7. As such, a new trial is required.

E. THE USE OF DEPOSITION TESTIMONY IN THIS CASE WAS FRAUGHT WITH IRREGULARITY, ABUSE OF DISCRETION, AND UNFAIR SURPRISE.

1. TeamHealth Plaintiffs' Inappropriately Designated Multiple Weeks' Worth of Deposition Testimony To Ambush Defendants and Impede Their Trial Preparations.

Nevada Rule of Civil Procedure 16.1(a)(3)(A)(ii) requires litigants to designate the portions of deposition transcript that they "expect[] to present" to the jury. As discussed further in the Course of, or Lead-Up to, Trial Errors Sections IV.A-B, *infra*, TeamHealth Plaintiffs circumvented NRCP 16.1's disclosure rules to try their case by ambush. Part of that strategy included the improper designation of deposition testimony that they could not feasibly have expected to present.

On October 19, 2021, TeamHealth Plaintiffs told this Court that they expected to present their case in seven trial days. 10/19/2021 Tr. 216:5-6. Then, after mid-night on October 28, 2021, they filed their "final" deposition designations. 11/9/2021 Tr. 200:19-201:5. Those final deposition designations covered 24 different witnesses and spanned thousands of line items of testimony from 32 different transcripts. *See* 11/9/2021 Tr. 200:19-25; 11/4/2021 Plfs' Notice of Depo. Designations. In many instances they designed nearly the whole transcript. To get through it all would take far more than seven trial days. Simply, it was an overwhelming amount of designations that TeamHealth Plaintiffs did not feasibly expect to present to the jury. *See* 11/8/2021 Tr. 7:16-21 ("[A]s I represented to Your Honor and opposing counsel, I have three days of cross for Mr. Haben, [the first witness], that's what I represented to the Court . . . . Once Mr. Haben is off the stand, the pace of this case is going to pick up substantially, and I mean substantially."); *see also* JPTO at 11 (listing seven friendly witnesses that they did not designate any deposition testimony for but "expect[ed] to present" to the jury).[21]

[21] TeamHealth Plaintiffs may attempt to argue that their dereliction of NRCP 16.1(a)(3)(A)(ii) should be excused because an avalanche of deposition testimony needed to be disclosed to preserve their ability to call witnesses if they were not going to be at trial. *See* 11/9/2021 Tr. 202:17-20. But, "[a] claim of misconduct cannot be defended with an argument that the misconduct was

Indeed, in the midst of trial, on the night of November 8, 2021, TeamHealth Plaintiffs slashed their designations, ambushing Defendants with their intended case. *Id*. 201:21-25 ("Last night, [Defendants] received [an update to TeamHealth Plaintiffs'] final designations, which deleted 166 lines items . . . and added 23 line items of designations for . . . one witness."). This bait and switch had dual impact on Defendants trial preparations. First, Defendants spent a substantial amount of trial preparation resources countering and objecting to those improper designations that could have been utilized elsewhere. 11/9/2021 Tr. 200:25-2. Second, Defendants were forced to prepare for trial as if all of that testimony would be presented to the jury.

Because this irregular process and misconduct by TeamHealth Plaintiffs created surprise that Defendants' ordinary prudence could not have guarded against, a new trial is required. The cumulative effect of this error also mandates a new trial.

2. Deposition Testimony Was Presented to the Jury In Violation of Nevada Law and Prejudiced Defendants.

Nevada Rule of Civil Procedure 32(a)(6) mandates that "[i]f a party offers in evidence only part of a deposition, an adverse party may require the offeror to introduce other parts that in fairness should be considered with the part introduced." *See also* NRS 50.115(1)(a) (requiring all courts to "exercise reasonable control over the mode and order of interrogating witnesses and presenting evidence" so that "the interrogation and presentation" is "effective for the ascertainment of the truth"). Instead of following this mandate, the Court allowed TeamHealth Plaintiffs, but not Defendants, to present deposition testimony in whatever manner they saw fit.

On November 1, 2021, the day before the trial began, TeamHealth Plaintiffs informed the Court that they wanted to call witnesses that would only be testifying through deposition video just as they would present a live witness. 11/1/2021 Tr. 170:20-23. That is, they would play their portion of the designated video and then Defendants would play their counter-designations. *Id*. Specifically, TeamHealth Plaintiffs wanted to do so in order to prejudice Defendants by landing punches out of

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unintentional. Either deliberate or unintentional misconduct can require a new trial." *Lioce*, 124 Nev. at 25, 174 Nev. at 986. TeamHealth Plaintiffs had an obligation to discern and designate the testimony that they ***expected to present*** to the jury in seven trial days so that Defendants could fairly prepare for trial. They willfully disregarded that duty to try their case by ambush.

context. *Id*. 170:24-171:8 ("We very well may want to . . . , for a video deposition, . . . play only one question and one answer because we want to make that impact" and they did not want "the limited excerpt . . . [to] get[] buried" in relevant context). And, TeamHealth Plaintiffs did not want "to get penalized because the clip is very long." *Id*. 171:5-6. So, they requested that they get to present witness by deposition just as if the witness were live. And the Court agreed, wanting TeamHealth Plaintiffs to be able to "control how they put their case on." *Id*. 172:1-7 ("I want to be the master of what we present to the jury. . . . THE COURT: Now, I tend to agree").

In abdicating its responsibility to exercise reasonable control over the mode and order of interrogating witnesses, the Court allowed NRCP 32(a)(6)'s mandate to be violated, failed to recognize that presenting a witness by deposition is inherently different than live testimony, and precluded Defendants from remedying the prejudice that it would suffer. Furthermore, when Defendants wanted to have control over how they put their case on by presenting deposition testimony in the manner they wanted, the Court said no.

First, as noted above, NRCP 32(a)(6) is clear that deposition testimony cannot be introduced by an offeror without all other parts that should in fairness be presented at the same time. The purpose of this rule is to "preclude the selective use of deposition testimony that might convey a misleading impression." *Farr Man Coffee Inc. v. Chester*, 1993 WL 248799, at *19 (S.D.N.Y. June 28, 1993); Advisory Committee Notes, NRCP 32 (noting Rule 32 conforms to FRCP 32). TeamHealth Plaintiffs knew this to be true, too. To be sure, when defense counsel used prior trial testimony similar to how deposition testimony is presented, TeamHealth Plaintiffs demanded simultaneous presentment of that additional, contextual testimony. 11/10/2021 Tr. 194:13-20 ("Your honor, under optional completion, can we read the rest of the Q and A on that page, please? . . . Including the Court's instruction."). Likewise, when defense counsel was questioning a witness by reading from a document, TeamHealth Plaintiffs demanded that additional, contextual information be presented simultaneously. *Id*. 129:17-130:2; *Trepel v. Roadway Exp., Inc.*, 194 F.3d 708, 718 (6th Cir. 1999)

(noting that rules of completeness governing deposition testimony, Rule 32, and written evidence, FRE 106, serve the same purpose); *Perez v. State*, 127 Nev. 1166, 2011 WL 4527520 (Sept. 29,

2011) (noting that Nevada codified FRE 106 as NRS 47.120(1)). While the Court granted TeamHealth Plaintiffs requests, 11/10/2021 Tr. 129:17-130:2, 194:13-20, it refused to give equal treatment to Defendants.

Second, the Court failed to recognize that presenting a witness by deposition is inherently different than doing so live. Deposition testimony cannot replicate live testimony because the deposition testimony was recorded in a different location, at a different time, and by different lawyers. 11/1/2021 Tr. 172:10-173:3. Deposition testimony can also not replicate live testimony because when it is broken up clarity and understanding are lost. *Id*. The jury will hear a question and answer but will not hear testimony that naturally follow, thereby defeating the ascertainment of truth and leading to a mislead jury. So, Defendants were prejudiced by the jury not being able to make the connections that should have been made.

Third, when the Court adopted TeamHealth Plaintiffs' approach, it precluded Defendants from contextualizing what was already shown to the jury. In convincing the Court that the deposition testimony should be presented the same was as live witnesses, TeamHealth Plaintiffs assured the Court that "we will avoid duplication. There's not going to be duplication." *Id*. 171:13-17. TeamHealth Plaintiffs were not authorized to speak for Defendants on this issue. However, without hearing from Defendants, the Court informed the parties that duplication would not be permissible because "[t]he best lawyers don't have to say everything three times. That's all I'm going to say." *Id*. 171:19-20. Effectively, the Court precluded Defendants from any chance of contextualizing the deposition testimony to allow the jury to not be misled and ascertain the truth.

Therefore, a new trial is required to remedy the prejudice that Defendants suffered from the Court's errors of law that allowed TeamHealth Plaintiffs' irregular presentment of deposition testimony.

3. TeamHealth Plaintiffs Were Permitted to Impeach Defendants' Witnesses With Deposition Testimony in Violation of Nevada Law.

Similar to TeamHealth Plaintiffs' irregular method of presenting incomplete deposition testimony to the jury, this Court allowed TeamHealth Plaintiffs to use incomplete deposition testimony as an impeachment tool. This again was a violation of NRCP 32(a)(6) because a part of

deposition testimony was introduced without the other parts that in fairness should be been introduced.

When TeamHealth Plaintiffs wanted to undermine the fact that they were egregious billers, they asked Mr. Haben whether self-insured employers, Defendants' clients, were going bankrupt because of out-of-network emergency room charges. 11/08/2021 Tr. 24:17-25:3. Because TeamHealth Plaintiffs did not like Mr. Haben's answer, they turned to his deposition testimony. In doing so, they quoted a portion of it, then said, "I'm going to skip the rest of that sentence," and then read another portion. *Id*. 25:12-17. Defendants objected on rule of completeness grounds. *Id*. 25:18-20 ("[I]f he's going to read the witness' testimony, he needs to read the entire piece. He's cutting pieces of it up."). In response, TeamHealth Plaintiffs claimed that a motion *in limine* ruling permitted them to skip the undesired deposition testimony regarding Nevada's balancing billing laws that were enacted to prevent financial ruin. *Id*. 25:21-22, 52:9-15. TeamHealth Plaintiffs also tried to assert that the new balance billing laws had nothing to do with emergency room provider billing practice and whether those practices were causing financial strain. *Id.* 52:18-23. However, there is no denying that the Nevada Legislature enacted those laws to curb the business practices utilized by private equity backed hospital staffing companies, such as the TeamHealth Plaintiffs, that cause financial hardship. So, the deposition testimony that TeamHealth Plaintiffs decided to "skip" was very relevant to their financial hardship line of examination.

Instead of convening a bench conference, the Court reprimanded defense counsel in front of the jury and permitted the improper questioning. *See id*. 25:25-26:9. Then, during the next break's record making exercise, Defendants requested TeamHealth Plaintiffs cite the specific *in limine* ruling that they believed covered the issue. *Id.* 51:19-24, 53:4-10. However, because there was no *in limine* ruling on point, all TeamHealth Plaintiffs could do is make up the belief that the issue was covered. *See id*. 52:23-25. Without checking whether there was such a ruling, the Court accepted TeamHealth Plaintiffs false representation. *Id*. 53:3 ("Good enough.").

Therefore, a new trial is required to remedy the complete failure to enforce NRCP 32(a)(6) against TeamHealth Plaintiffs to Defendants' detriment.

IV.

DEFENDANTS WERE DENIED A FAIR TRIAL BECAUSE THIS COURT PERMITTED DAVID LEATHERS TO TESTIFY DESPITE TEAMHEALTH PLAINTIFFS' IMPERMISSIBLE TRIAL BY AMBUSH TACTICS

Pursuant to NRCP 16.1(a)(2), each party must "provide a written disclosure of their experts and the contents of those experts' testimonies, including information each expert considered in forming an opinion, well in advance of trial." *Sanders v. Sears-Page*, 131 Nev. 500, 516, 354 P.3d 201, 211 (Nev. Ct. App. 2015). To satisfy that disclosure requirement each "***report must contain a complete statement of all opinions*** the witness will express, and the basis and reasons for them." NRCP 16.1(a)(2)(B)(i) (emphasis added). Additionally, a party must timely supplement a Rule 16.1 disclosure when the "party learns that in some material respect the information disclosed is incomplete or incorrect and if the additional or corrective information has not otherwise been made known to the other parties during the discovery process or in writing." NRCP 26(e); NRCP 16.1(a)(2)(F)(i) (requiring supplement by the time proscribed in Rule 26(e)). This "duty extends both to information contained in the report and to information provided through a deposition of the expert. Any additions or other changes to this information must be disclosed by the time pre-trial disclosures are due." NRCP 26(e). These rules "serve[] to place all parties on an even playing field and to prevent trial by ambush or unfair surprise." *See Sanders*, 131 Nev. at 517. As such, a court can only relieve a party of its disclosure duty for good cause, which is generally only "established when it is shown that the circumstances causing the failure to act are beyond the [party's] control." *Id*. at 518 (quoting *Moseley v. Eight Judicial Dist. Court*, 124 Nev. 654, 668 n.66, 188 P.3d 1136, 1146 n.66 (2008)).

TeamHealth Plaintiffs violated this clear mandate when they chose to rely on David Leathers as their trial expert. On September 9, 2021—nine days after the deadline for expert rebuttal reports, *i.e.*, forty days after the deadline for affirmative reports, and less than two-months before trial—TeamHealth Plaintiffs disclosed a brand new affirmative damages report authored by Mr. Leathers. Defs' Mot. to Strike Plfs' Supp. Expert Report at 4. Then, the night before Mr. Leathers' deposition, on September 15, 2021, TeamHealth Plaintiffs disclosed additional work product that underpinned the basis of Mr. Leathers new opinions. 10/19/2021 Tr. 106:14-23, 112:25-113:13. Without a

showing of good cause to relieve TeamHealth Plaintiffs of their disclosure obligations, this Court excused TeamHealth Plaintiffs' improper trial by ambush tactics. *See* Plfs' Opp. to Defs' Mot. to Strike Plfs' Supp. Expert Report; 10/19/2021 Tr. 103:24-123:19; 11/1/2021 Order Denying Defs' Mot. to Strike Leathers' Supp. Report.

Having realized that their tactics would not be condemned, TeamHealth Plaintiffs disclosed that they added more new opinions to Mr. Leathers' report less than two day before he testified at trial. 11/16/2021 Tr. 255:6-257:13; 11/17/2021 Tr. 281:11-300:2. Again, without a showing of good cause to relieve TeamHealth Plaintiffs of their disclosure obligations, this Court allowed Defendants to be ambushed. *See* Plfs' Opp. to Defs' Mot. to Strike Plfs' Supp. Expert Report; 10/19/2021 Tr. 103:24-123:19.

A. A NEW TRIAL IS REQUIRED DUE TO THE TEAMHEALTH PLAINTIFFS' EXPERT BEING ABLE TO PROVIDE DAMAGES OPINION CONTAINED IN AN UNTIMELY EXPERT REPORT

Defendants moved to strike Mr. Leathers' untimely rebuttal report before trial and incorporates those arguments in full. TeamHealth Plaintiffs retained two experts in this case: Scott Phillips and Mr. Leathers. *See* Defs' Mot. to Strike Plfs' Supp. Expert Report at 4. Before the close of expert discovery, TeamHealth Plaintiffs submitted one expert report authored by Mr. Leathers. *Id*. The scope of that affirmative report was to "estimate the amount of damages, if any, sustained by the [TeamHealth] Plaintiffs as a result of [Defendants'] alleged violations of the Nevada Racketeering statute." *Id*. (quoting Leathers' Affirmative Report"). TeamHealth Plaintiffs did not offer a rebuttal report from Mr. Leathers in response to Defendants' expert report. *Id*. Instead, they submitted a rebuttal report authored by Mr. Phillips. *Id*.

Then, after the deadline for rebuttal expert reports and less than two-months before the start of trial, TeamHealth Plaintiffs submitted a second, affirmative report from Mr. Leathers. *See id*. To disguise that this new affirmative report, TeamHealth Plaintiffs dubbed it a "supplemental report" filed pursuant to NRCP 16.1(a)(2). *See id*. However, the scope of the new report was expressly not limited to Nevada RICO damages and contained new, previously undisclosed opinions. *See id*. And, Mr. Leathers testified that the purpose of his new report was to rebut the opinions of Defendants' expert, Bruce Deal. *Id*. Because Mr. Leathers and TeamHealth Plaintiffs, eventually, admitted that

the new report was not a supplement and untimely, it should have been struck and Mr. Leathers precluded from opining on any issues not contained in his original report.

TeamHealth Plaintiffs' sole basis in opposing that requested relief was that their trial by ambush tactics did not prejudice Defendants. *Id*. at 107:18:22. However, the question of prejudice should not have been reached because TeamHealth Plaintiffs did not establish good cause to relieve their failure to satisfy their duty to disclose. *Id.* at 107:23-108:10 (explaining that TeamHealth Plaintiffs did not file a motion for relief or ever provide a reason for their violation of their disclosure requirements); *see also Sanders*, 131 Nev. at 518. Nor could they, because the circumstances causing TeamHealth Plaintiffs' failure to act were completely within their own control. *Sanders*, 131 Nev. at 518 (citing *Moseley*, 124 Nev. at 668 n.66). Moreover, they never attempted to show that they exercised due diligence or had a reasonable basis for not complying with the expert report deadlines. *See* 10/19/2021 Tr. 108:18-111:1 (citing *Moseley*). Instead, they told the Court that the case was too complex for them to handle and they mismanaged their responsibilities. *See id*. 114:24-115:25 ("[H]ere is the cold-hearted reality. We have assigned lots of different portions of preparing for this trial to the group that's here before you. I have principle responsibility on the experts. . . . [T]here was a lot going on that I was trying to handle . . . . And so in . . . studying th[e] complaint . . . it occurs to me that I should have Mr. Leathers work up" his new opinion. But, "Mr. Blalack is correct."); *id.* at 118:16-18 ("THE COURT: And why did you not file a motion for leave? . . . MR. LEYENDECKER: Pure oversight on my part. I have no legitimate explanation for why I didn't. I'm aware of that process."). That is not good cause that enables a court to circumvent a litigant's right to a fair trial.

But even assuming those findings could be skipped, Defendants were prejudiced. If TeamHealth Plaintiffs had complied with Rule 16.1(a)(2), then Defendants, including their experts, would have had 15-days to review, dissect, and develop lines of examination and impeachment before deposing Mr. Leathers. *Id*. 112:12-16. Instead, Defendants had six days. *Id*. 112:17-18. Moreover, on September 14, 2021, the night before Mr. Leathers deposition, TeamHealth Plaintiffs disclosed two spreadsheets underpinning the basis of Mr. Leathers new opinions. 10/19/2021 Tr. 106:14-23, 112:25-113:13. One spreadsheet was an update of analysis contained in the new report

and the other was brand new analysis reflecting a new methodology to calculate the out-of-network rate. *Id*. This was new work that Mr. Leathers performed since he finished his supplemental report. *Id.* 113:9-14:8. As such, Defendants were prejudiced in that they were ambushed with an untimely expert report and by being deprived of a meaningful opportunity to depose Mr. Leathers. *See id* 106:14-23, 111:25-114:14. Therefore, the new report should have been struck and Mr. Leathers should not have been allowed to offer opinions unrelated to the calculation of damages under the Nevada RICO statute.

Even though this Court agreed that Defendants were prejudiced, it denied the motion to strike because it errantly reasoned that TeamHealth Plaintiffs' Rule 16.1(a)(2) disclosure obligations could be excused because the Nevada Supreme Court says "to try matters on the merits when we can." *Id*. 122:14-16, 123:11-14. *But see Moseley*, 124 Nev. 654. In doing so, the Court offered Defendants the chance to re-depose Mr. Leathers, but Defendants informed the Court that a deposition would not cure the prejudice. *Id.* 122:14-20. Therefore, the Court enabled TeamHealth Plaintiffs' trial by ambush tactics and subjected Defendants to unfair trial steeped in prejudice.

With their trial by ambush strategy condoned, Mr. Leathers was TeamHealth Plaintiffs only damages expert to testify at trial. Said differently, the jury could not have rendered a verdict in TeamHealth Plaintiffs favor without his testimony. As such, Defendants were prejudiced by the Court condoning TeamHealth Plaintiffs' trial by ambush strategy.

The error was compounded when the Court precluded Defendants from using Mr. Phillips' invoices against TeamHealth Plaintiffs. 11/18/2021 Tr. 87:10-91:8. First, TeamHealth Plaintiffs only argument to prevent those invoices from being used against them was that they were irrelevant hearsay because Mr. Phillips was not taking the stand. *Id*. But, the only reason Mr. Phillips did not testify was because the Court condoned TeamHealth Plaintiffs' trial-by-ambush tactics, which, in turn, enabled Mr. Leathers to be their only expert to take the stand.

Second, when TeamHealth Plaintiffs asked the Court to ignore the lack of good cause to relieve their disclose failures, they conceded that Mr. Phillips' invoices were relevant. In TeamHealth Plaintiffs' own words, they were "amendable and willing to afford" the cost of Mr. Leathers' new report so that they could have a backup plan in case Mr. Phillips was unavailable to

testify at trial. *Id*. Thus, the cost of Mr. Phillips' work was directly related to the cost of Mr. Leathers' work. Third, Defendants were denied the ability to rebut TeamHealth Plaintiffs' numerous improper statements that Defendants pay a lot of money to experts and not to them. *Id*.; *see Butler*, 120 Nev. at 898, 102 P.3d at 84 (holding that it is misconduct to "disparage legitimate defense tactics"). Without being afforded the ability to contextualize how much TeamHealth Plaintiffs spent on experts, the jury's passions were inflamed by being lead to believe that Defendants were doing everything they could to not pay TeamHealth Plaintiffs a reasonable reimbursement.[22]

In sum, it was prejudicial error to allow Mr. Leathers to provide expert opinion that was not properly disclosed. And, it was prejudicial error to preclude Defendants from using Mr. Phillips' invoices against TeamHealth Plaintiffs. Therefore, a new trial is required.

B. A NEW TRIAL IS REQUIRED BECAUSE TEAMHEALTH PLAINTIFFS' EXPERT WAS ALLOWED TO PROVIDE DAMAGES OPINION THAT WAS FIRST DISCLOSED TWO DAYS BEFORE TAKING THE STAND.

Mr. Leathers took the stand Tuesday, November 16, 2021. Late Sunday night, November 14, 2021, TeamHealth Plaintiffs disclosed brand new damages opinions that were now part of the untimely report discussed in the proceeding section. These new opinions included a new methodology to compute damages. Just as before, TeamHealth Plaintiffs dubbed these brand new opinions as a supplemental disclosure. These additions and changes were not disclosed before ***pre-trial*** disclosures were due, as required by NRCP 16.1(a)(2) and 26(e), and there was no good cause for relieving TeamHealth Plaintiffs of their disclosure duties. Nonetheless, the Court again condoned TeamHealth Plaintiffs tactics and allowed Defendants to be ambushed. As such, a new trial is required.

The disputed claims list, PX 473, was compiled by TeamHealth Plaintiffs and went through many iterations throughout the course of litigation. 11/16/2021 Tr. 255:2-9. Numerous iterations were required because of TeamHealth Plaintiffs generated list after list that were replete with errors.

[22] As part of closing argument, opposing counsel also disparaged the legitimate defense tactic of hiring "exceptional lawyers" to inflame the jury's passions that Defendants were doing everything they could to not remit a reasonable reimbursement. In closing argument, opposing counsel told the jury that PX 25 was one of the most important documents in the case. 11/23/2021 Tr. 143:11-12.

See id. 255:25-256:3. Finally, in July 2021, every expert except Mr. Leathers received an iteration of the list to provide damages figures. *Id*. 255:9-12. Mr. Leathers first received an iteration of the list in September 2021, after the disclosure deadline. *Id.* 255:16-18. However, TeamHealth Plaintiffs errors in determining what claims they were disputing, and putting Defendants on notice of, persisted. *See id.* 255:25-256:3. Indeed, TeamHealth Plaintiffs had to modify that list four times between July 2021 and when it became PX 473 in the midst of trial. *Id*.

Because the experts calculated their damages figures based on that list, those figures had to be updated with each modification. *Id*. 255:19-21. Except for Mr. Leathers, the experts would update their damages figures by adjusting the change to their already disclosed methodologies for calculating damages. *See id*. 255:22-24. Mr. Leathers, on the other hand, generated his entirely new report discussed in the preceding section after receiving TeamHealth Plaintiffs' then-latest list. *See id*. Because Mr. Leathers' untimely report was not struck, he, like the other experts, had to update his damages figures based on each subsequent modification to the disputed claims list without offering any new opinions, analysis, or methodologies to calculate damages. *See id.* 256:1-16. This was supposed to be a straightforward process

TeamHealth Plaintiffs, however, had other plans. On November 5, 2021, Defendants proposed a stipulation to make sure that they would not be further ambushed by TeamHealth Plaintiffs improper expert practices. *See* **Exhibit** 2 at 1 (top email), 12-14 (having page numbers "Page[s] 2[, 3, 4] of 6," respectively). That stipulation would have been submitted to the Court to memorialize that the parties' experts would only update damages figures using the new inputs provided by TeamHealth Plaintiffs and that no new opinions, analysis, or methodologies to calculate damages would be added. *Id.*; 11/16/2021 Tr. 256:17-22. TeamHealth Plaintiffs, however, would only agree to enter a stipulation that said the parties will base their updated reports on PX 478. *See* **Exhibit** 3 at 1 (top email), 12-13; 11/16/2021 Tr. 256:22-25. Tellingly, they were not willing to agree to refrain from further ambushing Defendants by rejecting the stipulation that the parties will not offer new opinions to calculate damages. *Compare* **Exhibit 2** at 12-14, *with* **Exhibit 3** at 12-13; 11/16/2021 Tr. 256:22-25.

On the night of Sunday, November 14, 2021, TeamHealth Plaintiffs revealed confirmed

Defendants' ambush concerns. TeamHealth Plaintiffs provided Defendants with the "update" to Mr. Leathers' untimely report. 11/16/2021 Tr. 257:6-7. That update included four new exhibits that had never been disclosed before. *See* 11/16/2021 Tr. 257:6-7. Upon review, Defendants discovered that the update provided new opinions and new analysis. *Id*. 257:7-10. It was not a simple update to already disclosed methodologies based on new inputs. *Id*. For example, in "Leathers' Report Exhibit 4, trial," he added a new damages column that was based on a methodology for calculating damages that was not previously disclosed in his affirmative or untimely report. *Id*. 257:16-25; *id*. 262:12-19 (explaining that Mr. Leathers originally "measured damages as the difference between a calculation he called the Data iSight discount allowed and . . . the allowed amount. He didn't take just whatever the bill charge was [and] subtract the allowed [to] come up with" damages). In another exhibit, he added a new analysis regarding "FAIR Health market flags" that Defendants had never seen before and had no idea what it meant because they never had a chance to question him on that new analysis. *Id.* 258:1-5. And, in another, Mr. Leathers added a new analysis entitled "DML," which changed his pervious damages methodology from "Damages based on AG claims" to a new methodology for Data iSight based on general damages as what billed charges might have allowed. *Id*. 258:6-14. Thus, Defendants moved to strike and limit Mr. Leathers to what was previously, but untimely, disclosed.

Alternatively, Defendants argued that even if the newly disclosed methodologies and opinions were not new, they still could not be relied upon because NRCP 16.1(a)(2)(B)(i) requires that the "report" itself, not exhibits, must contain[] [] a complete statement of all opinions the witness will express, and the basis and reasons for them." If that rule is not reasonably complied with, then the Court should "prohibit[] the use of any witness [or] document . . . that should have been disclosed, produced, or exhibited, or exchanged." NRCP 16.1(e)(3)(B). TeamHealth Plaintiffs did not challenge that Mr. Leathers' November 14, 2021, report was incomplete in that not all of his opinions, and basis and reasons for them, were expressed. Thus, Defendants moved to limit Mr. Leathers to his opinions, and basis and reasons for them, that were expressed in his prior reports.

In opposition, TeamHealth Plaintiffs levied the same unavailing argument that convinced this Court to excuse the untimely report that was discussed in the preceding section: Defendants are

not prejudiced by the ambush. *Id.* 258:22-259:2. They did not contend that they had good cause for failing to disclose these new opinions before the deadline. Instead, they argued that anyone can see, if you look just right, that the "updated" opinions found in Mr. Leathers' November 14, 2021, report were already disclosed in his other reports. *Id*. 259:3-261:24. Namely, that Mr. Leathers' damages methodology was always the difference between TeamHealth Plaintiffs' billed charges and the allowed amount for the at-issue claims. *Id*. 259:10-14, 265:24-25.

However, when Defendants questioned Mr. Leathers outside the presence of the jury, he admitted that his reports did not calculate damages based on billed charges less allowed amount. 1/17/2021 Tr. 286:6-24, 288:5-289:24 (admitting that "no part of the damage calculation" in the untimely supplemental report "involve[d] comparing the total allowed to TeamHealth Plaintiffs claims to their total bill charges"), 290:8-292:11 (admitting that "the math" in his affirmative report addressing RICO damages "didn't include bill charges"). Instead, he calculated damages based on methodologies that compared the allowed amount that TeamHealth Plaintiffs received for the at-issue claims to an allowed amount benchmark that he calculated by reviewing the allowed amounts that other out-of-network providers received from claims submitted to Defendants. *Id.* Therefore, when TeamHealth Plaintiffs disclosed on November 14, 2021, that Mr. Leathers was calculating damages based on the difference between TeamHealth Plaintiffs' billed charges and the allowed amount for the at-issue claims, they ambushed Defendants with a new methodology.

To hide their tracks, TeamHealth Plaintiffs told the Court that the new November 14, 2021 methodology was ***similar*** to the opinions Mr. Leathers provided in his affirmative report addressing Nevada RICO damages. *Id*. 259:3-261:24. So, no harm, no foul.[23] But, as noted, Mr. Leathers revealed this was false. *See also* 11/17/2021 286:6-24 (admitting that his untimely, supplemental report was not "associated with the [Nevada] RICO" damages methodology in his affirmative report). Also, TeamHealth Plaintiffs' counsel conceded that the November 14, 2021 update to the untimely, supplemental report provided a new methodology to calculate damages because Mr.

[23] TeamHealth Plaintiffs also tried to sneak new, undisclosed opinion into the record in the midst of Mr. Leathers' testimony by claiming the opinion was "demonstrative" or plain "facts." 11/17/2021 Tr. ("MR. LEYENDECKER: It's demonstrative, Your Honor. . . . did you reach any conclusions or see any trends on what the actual co-insurance was? . . . MR. LEYENDECKER: These are facts.").

Leathers was ***replacing*** his methodology for calculating RICO damages. *Id.* 259:9-16.

Simply, TeamHealth Plaintiffs waited to disclose Mr. Leathers' new methodology even though they knew additional disclosures were required to ambush Defendants. On October 4, 2021, they filed the Second Amended Complaint and abandoned their Nevada RICO cause of action. That abandonment was not haphazard, but well thought out. 10/19/2021 Tr. 115:2-20 (justifying Mr. Leathers' untimely report because counsel "stud[ied] the [First Amended] complaint" in August 2021 to "figur[e] out how to streamline the trial"). Indeed, when they abandoned their Nevada RICO cause of action—*i.e.*, the scope of Mr. Leathers' affirmative report—they filed updated answers to Defendants interrogatories. Thus, TeamHealth Plaintiffs knew they had disclosure obligations and decided to ambush Defendants at trial.

TeamHealth Plaintiffs' excuses for why they did not disclosure the other additions and changes revealed on November 14, 2021, are equally unavailing. They did not disclosure Mr. Leathers' new FAIR Heath analysis because it was purportedly already disclosed as being related to the work papers that they provided to Defendants the night before Mr. Leathers' deposition. *Id.* 259:20-23. Assuming this is true, which it is not, their argument boils down to a request that the Court forgive their latest transgression because of their other transgressions that diminished Defendants' ability to take Mr. Leathers' deposition. Next, TeamHealth Plaintiffs pinned the blame on Defendants for their failure to disclose new expert opinion because at the time of opening statements "it was clear that we were going to use Mr. Leathers and not Mr. Phillips, . . . so the [every] thing was going to come in through" him. *Id*. 260:14-21. This is in direct conflict with their excuse for submitting Mr. Leathers' untimely expert report: that it was to serve as back-up in case Mr. Phillips could not attend trial. *Supra* Course of, or Lead-Up to, Trial Errors Section IV.A.

Finally, TeamHealth Plaintiffs claimed there was no prejudice because Defendants refused an offer to re-depose Mr. Leathers after October 19, 2021. 11/16/2021 Tr. 260:22-24. While TeamHealth Plaintiffs failed to realize it, even they identified part of the absurdity to that argument. They claimed that Defendants refused to re-depose Mr. Leathers but admitted that it would need to occur "once . . . the facts [are] redone with the new claim file." *Id*. Those facts—*i.e.*, Mr. Leathers updated reports—was finally "redone" and provided to Defendants less than two days before he was

set to take the stand. Moreover, any notion that Defendants could have taken an expert deposition after October 19, 2021, in the midst of preparing for trial without being prejudiced is misplaced.

Nonetheless, the Court again condoned TeamHealth Plaintiffs' improper tactics and subjected Defendants to trial by ambush. 1/17/2021 Tr. 301:11-15. It did so despite having never allowed an expert in any other trial to do so. 11/16/2021 Tr. 265:21-22. It also did so despite Defendants proving that the November 14, 2021, "update" contained new opinion and damages methodologies by having Mr. Leathers admit that he never calculated damages based on the difference between TeamHealth Plaintiffs' billed changes and the allowed amounts for the at-issue claims. Instead, the Court disregarded Mr. Leathers' admissions and believed that exhibit 4 to his affirmative report put Defendants on notice of the new methodology. The Court also errantly believed that Defendants had a chance to question Mr. Leathers on this new, undisclosed methodology during his deposition. Aside from being impossible, as detailed in the preceding section, the events leading up to that deposition were fraught with ambush and prejudice to Defendants. Thus, a new trial is required.

* * *

Mr. Leathers was TeamHealth Plaintiffs' only expert to testify at trial. He provided numerous opinions and damages figures that were not properly disclosed to Defendants. Thus, Defendants were subjected to trial by ambush. Moreover, the jury could not render a verdict in TeamHealth Plaintiffs favor without determining damages. So, Mr. Leathers' improper testimony substantially effected the rights of Defendants. Therefore, the errors and prejudice related to Mr. Leathers, individually and cumulatively, require a new trial.

Grounds for a New Trial Based on Jury Instruction Errors

Introduction

The jury was improperly instructed in two critical respects. First, the jury was not read several instructions on which defendants were entitled to have the jury instructed. Second, the jury was improperly instructed on the rebuttable presumption under NRS 47.250(3), a presumption that did not apply and inflamed the jury against defendants. Both of these errors materially affected defendants' substantial rights, depriving them of a fair trial. Thus, a new trial is warranted.

Legal Argument

Nevada Rule of Civil Procedure (NRCP) 59(a)(1) sets forth seven bases for seeking a new trial. This includes, as relevant below, "(A) . . . any abuse of discretion by which either party was prevented from having a fair trial," and an "error in law occurring at the trial and objected to by the party making the motion," NRCP 59(a)(1)(A), (G). Where the error or abuse of discretion "materially affect[ed] the substantial rights of [the] aggrieved party," that party is entitled to a new trial. *Pizarro-Ortega v. Cervantes-Lopez*, 133 Nev. 261, 266, 396 P.3d 783, 788 (Nev. 2017) (quotation omitted).

Defendants seek a new trial for two reasons: (1) due to the failure to give several proffered jury instructions and (2) due to the improper rebuttable presumption instruction.

"The district court has broad discretion to settle jury instructions." *Bass-Davis v. Davis*, 122 Nev. 442, 447, 134 P.3d 103, 106 (Nev. 2006). Despite this broad discretion, "a party is entitled to have the jury instructed on all of his case theories that are supported by the evidence," *Atkinson v. MGM Grand Hotel, Inc.*, 120 Nev. 639, 642, 98 P.3d 678, 680 (Nev. 2004)**Error! Bookmark not defined.**; *Bass-Davis*, 122 Nev. at 447, 134 P.3d at 106, and on Nevada law, *MEI-GSR Holdings, LLC v. Peppermill Casinos, Inc.*, 134 Nev. 235, 238, 416 P.3d 249, 253 (Nev. 2018).

I.
THE FAILURE TO INSTRUCT THE JURY ON THEORIES DEFENDANTS WERE ENTITLED TO, RESULTED IN AN ABUSE OF DISCRETION AND AFFECTED DEFENDANTS' SUBSTANTIAL RIGHTS.

Defendants proffered to this Court a number of instructions that were ultimately rejected. However, Defendants were entitled to have the jury instructed on several of these rejected instructions, which were supported by the evidence and Nevada law.

A. FAILURE OF CONDITION PRECEDENT.

Before Defendants were obliged to reimburse a claim, TeamHealth Plaintiffs were required to submit that claim to one of the Defendants. *See NGA #2 Ltd. Liability Co. v. Rains*, 113 Nev. 1151, 1158-59, 946 P.2d 163, 168 (Nev. 1997) . Evidence presented at trial demonstrated that TeamHealth Plaintiffs did not submit 491 claims found in PX 473, the at-issue claims list created by TeamHealth Plaintiffs, to Defendants. 11/18/2021 Tr. 215:12-217:18, 218:14-23, 226:14-227:4,

254:8-12, 263:8-264:7. Accordingly, Defendants requested that the jury receive the following condition precedent instruction:

> A condition precedent is an act that must be performed before a contract duty arises.
>
> However, any acts that must be performed pursuant to a condition precedent may but need not be performed if they are waived, excused or if the party asserting the condition voluntarily prevented or made the occurrence of the condition impossible.

11/15/2021 Defs' Contested Jury Instructions at 20. This was an accurate statement of the law. *Id.* (citing sources).

The Court, however, determined the instruction need not be given because it believed that the failure to satisfy a condition precedent is not relevant to the formation of an implied-in-fact contract. 11/21/2021 Tr. 43:15-18. This reasoning was an error of law. Whether any contract is formed can depend on a condition precedent being satisfied. *Cain v. Price*, 415 P.3d 25, 28-29 (2018)

("When contracting, a promisor may incorporate into the agreement a 'condition precedent'—that is, an event that must occur before the promisor becomes obligated to perform. . . . An implicit condition precedent can be inferred from a contract's terms and context"); Defs' Trial Brief re Jury Instructions on Formation of an Implied-in-Fact Contract at 4-5 (explaining that "[a]n implied-in-fact contract requires proof of the same elements necessary to evidence an express contract" (quoting numerous sources)); 11/21/2021 Tr. 33:24-34:5 (conceding that TeamHealth Plaintiffs needed to "submit[] claims in the manner which [Defendants] require[d]"). But, this error is beside the point. Whether an instruction is relevant to the claim is not the standard that must be met. "[A] party is *entitled* to have the jury instructed on all of his case theories that are supported by the evidence" and Nevada law. *Atkinson*, 120 Nev. at 642, 98 P.3d at 680; *MEI-GSR Holdings, LLC*, 134 Nev. at 238, 416 P.3d at 253. Because TeamHealth Plaintiffs' failure to satisfy a condition precedent was a defense in this case, the failure to provide the jury with Defendants' proposed condition precedent instruction was an abuse of discretion and a new trial is required.

Alternatively, if a new trial is not ordered, the damages award should be reduced. As TeamHealth Plaintiffs conceded, the verdict should be reduced so that Defendants do not pay

damages based on claims that were not submitted to Defendants. *See* 11/21/2021 Tr. 43:2-9 ("if at the conclusion of the trial . . . there is not evidence of all of the claims that are in our claims dispute, . . . damages should be reduced"). TeamHealth Plaintiffs put on no evidence to indicate that the 491 unmatched claims were ever submitted to Defendants. Therefore, the verdict should be reduced.

B. UNFAIR CLAIMS PRACTICES ACT DEFINITION OF INSURER.

Pursuant to the Unfair Claims Practices Act ("UCPA"), Defendants requested the jury be instructed on the definition of "insurer." Defs' Contested Jury Instructions 11/15/21 at 27. Defendants offered the following instruction:

> Nevada's Unfair Claims Practices Act applies only to insurers. An insurer is a company engaged in the business of entering into contracts between that company and an insured or a prospective insured under which the company agrees to pay a premium in advance on behalf of the insured or prospective insured in exchange for repayment of the amount advanced with interest or some other consideration.
>
> A third-party administrator of an insurance policy is not an insurer under the Nevada Unfair Claims Practices Act. You must determine separately whether each Defendant is an insurer.

Id. This instruction was required to be given based on the evidence presented to the jury and because it is an accurate statement of law. *See* Defs' Response to Plfs' Trial Brief re Applicability of UCPA to All Defendants at 5-9.[24] First, the evidence presented to the jury demonstrated that multiple Defendants were third-party claim administrators—*i.e.*, UHS, UMR, and sometime UHIC. *E.g.*, 11/2/2021 Tr. 164:21–25 (testifying that Defendants perform third party administrator services for ASO clients); 11/3/2021 86:19–87:2 (testifying that as third-party administrators defendants pay a provider bill based on the directives of the self-insured client because defendants only "administer the funds"); 11/8/2021 Tr. 152:23–153:1 (testifying that UMR is a third-party administrator); 11/9/2021 Tr. 130:19–131:10 (testifying that "UMR is the third-party administrator" and "UnitedHealthcare itself is a third-party administrator . . . [f]or self-employed groups"); 11/10/2021 Tr. 21:11–22 (testifying that third-party administrators "do[] not incur the medical cost risk"); id. 24:10–17 Mr. (testifying that UHIC is a third-party administrator and an insurer); id. 29:16–19

[24] This trial brief is incorporated herein in full.

(testifying that an administrative services agreement is between "the employer group, with the third-party administrator to perform services on their behalf"); id. 29:20–30:10 (testifying that certificates of coverage are only associated with fully insured plans and summary plan documents and administrative services agreements are associated with a self-insured plan); 11/15/2021 Tr. 184:21185:4 (testifying that "UMR is a third-party administrator. . . . When your benefit plan pays out 80 percent, it's not an insurance company, it's actually your employer that's paying those claims").

Second, Defendants' proposed instruction was an accurate statement of Nevada law because NRS 686A.310 specifically applies to insurers, which under the UCPA has a very specific definition. NRS 686A.330(2) (defining "company" as "a person engaged in the business of entering into agreements or purchasing agreements"); NRS 686A.520 (limiting UCPA to insurers); Defs' Response to Plfs' Trial Brief re Applicability of UCPA to All Defendants at 5-7 ("there is no individuation that the [Nevada] legislature intended [the UCPA] to apply to other entities beyond insurers" such as third-party administrators (quoting *Albert H. Wohlers & Co. v. Bartigs*, 114 Nev. 1249, 1263, 969 P.2d 949 (1998)); *see also* Defs' Mot. to Apply Statutory Cap on Punitive Damages at 13-14; Defs' Reply in support of Motion to Apply Punitive Damages Cap at 19-20.

As such, Defendants' requested instruction should have been provided to the jury. However, the Court declined to give the instruction because "it would basically direct a verdict to the defendant and it's inconsistent with my prior ruling." 11/21/21 Tr. 50:21-24. But, the failure to instruct the jury on the definition of "insurer" under the UCPA meant the jury never made such a finding in reaching its verdict. The failure to give this instruction was an abuse of discretion as defendants were *entitled* to this instruction.

C. FAILURE TO EXHAUST ADMINISTRATIVE REMEDIES UNDER THE PROMPT PAY ACT.

Defendants' instruction addressing its affirmative defense of failure to exhaust administrative remedies under the Prompt Pay Act ("PPA") was also rejected. 11/21/21 Tr. 77:14-78:1. The Court abused its discretion in declining to instruct the jury on this defense. The instruction was rejected because the Court did not "think it's applicable at the trial level." *Id.* While the Court

has broad discretion to settle jury instructions, if the instruction is supported by evidence and Nevada law, then the party is *entitled* to have the jury instructed on all his case theories. *Bass-Davis*, 122 Nev. at 447, 134 P.3d at 106; *Atkinson*, 120 Nev. at 642, 98 P.3d at 680; *MEI-GSR Holdings, LLC*, 134 Nev. at 238, 416 P.3d at 253.

Defendants' proposed instruction set forth eleven elements that TeamHealth Plaintiffs were required to prove:

> To proceed with Plaintiffs' fourth cause of action, Plaintiffs must prove the following elements for each individual At-Issue Claim:
> 1. Defendants deemed a particular claim submitted by Plaintiffs approved and fully payable;
>
> 2. Plaintiffs are entitled to their full billed charges;
>
> 3. Defendants did not remit timely reimbursement to Plaintiffs, meaning payment to Plaintiffs within 30 days of receipt of the individual claim;
>
> 4. Plaintiffs filed an action against Defendants with the Nevada Department of Insurance within 60 days the alleged failure to provide timely reimbursement;
>
> 5. A hearing was held by the Nevada Insurance Commissioner to assess the alleged failure to provide timely reimbursement;
>
> 6. Plaintiffs were identified as a party of record by the Nevada Insurance Commissioner;
>
> 7. The Nevada Insurance Commissioner rendered a Final Ruling;
>
> 8. The Final Ruling was not in Plaintiffs' favor;
>
> 9. Plaintiffs sought judicial review within 30 days of those Final Rulings being rendered;
>
> 10. The Nevada Insurance Commissioner provided the records of the hearings to the Court; and
>
> 11. Within 40 days of the Court receiving each record, Plaintiffs filed a memoranda supporting their position that the Final Rulings should be reversed.

11/15/21 Defs' Contested Jury Instructions at 37. The requirement of exhaustion is supported by Nevada law. *See Allstate v. Thorpe*, 123 Nev. 565, 571, 170 P.3d 989, 993 (Nev. 2007) (holding Nevada Department of Insurance has exclusive jurisdiction over PPA statutes and a complaint may be filed in the district court "at the conclusion of administrative proceedings"); Defs' Response to

Plfs' Trial Brief re Failure to Exhaust Jury Instruction at 3-5.[25] The evidence presented at trial established TeamHealth Plaintiffs had not pursued any administrative proceedings before filing their complaint. Defendants presented this evidence to support their affirmative defense that TeamHealth Plaintiffs failed to exhaust administrative remedies under the PPA. Although the Court did not believe this instruction was applicable, Defendants were nonetheless entitled to have the jury instructed on this affirmative defense. *See Atkinson*, 120 Nev. at 642, 98 P.3d at 680; *MEI-GSR Holdings, LLC*, 134 Nev. at 238, 416 P.3d at 253. Because the Court declined to instruct the jury on defendants' affirmative defense even though the instruction was supported by Nevada law and the evidence presented at trial, the Court abused its discretion. Furthermore, in refusing to provide the requested jury instruction, the Court effectively granted summary judgment in TeamHealth Plaintiffs' favor. Defs' Response to Plfs' Trial Brief re Failure to Exhaust Jury Instruction at 5.

D. THE FAILURE TO INSTRUCT THE JURY ON ALL THEORIES THAT DEFENDANTS WERE ENTITLED TO MATERIALLY AFFECTED DEFENDANTS' SUBSTANTIAL RIGHTS.

The failure to instruct the jury on Defendants' theories and defenses was prejudicial and materially affected Defendants' substantial rights. As discussed above, Defendants were entitled to have the jury instructed on these theories. The failure to instruct the jury on Defendants' case was prejudicial. As a result of the failure to give Defendants' proffered instructions, the jury was not given the applicable law to evaluate defendants' defenses in light of plaintiffs' evidence and claims. The refusal to give Defendants' proffered instructions was prejudicial to Defendants' case because the jury was not instructed on the applicable theories and defenses supported by the evidence and being relied upon by Defendants. *See Atkinson*, 120 Nev. at 644, 98 P.3d at 644 (finding the failure to give a negligence per se instruction that defendant was entitled to was prejudicial to plaintiff's case and a new trial was necessary). Thus, the failure to give Defendants' requested instructions was an abuse of discretion, which warrants a new trial.

[25] Defendants' response is fully incorporated herein.

II.
THE JURY WAS GIVEN AN UNWARRANTED, ERRONEOUS REBUTTABLE PRESUMPTION INSTRUCTION

TeamHealth Plaintiffs spent the trial looking for every opportunity to blame the shortcomings of their case on alleged gaps in Defendants' 400,000-page document production. At every occasion, Defendants requested that this highly important issue by fully briefed before a decision was rendered. *See* 11/21/2021 Tr. 89:13-18 (noting the prejudice of having the rebuttable presumption issue be decided "in the middle of the case for which we have no time and for which [the] deci[sion] [will] not [be] based on a trial brief . . . [or] a motion," but, instead, "based solely on a one-page draft jury instruction not supported by any kind of factual showing"). That briefing never occurred. Worse, when Defendants thought they had an opportunity to present their argument, the Court cut them off from making their record because it had pre-judged the issue in TeamHealth Plaintiffs' favor. *See id*. 101:1-3 ("I'm going to stop [Defendants] [t]here. I took an oath to be patient, but I really pretty much made up my mind on this.").

Nevada courts strongly favor trial by jury and disposition of a case on the merits. *Havas v. Bank of Nevada*, 96 Nev. 567, 570, 613 P.2d 706, 708 (1980)

. As the Nevada Supreme Court established long ago, "[t]he general rule in the imposing of sanctions is that they be applied only in ***extreme circumstances*** where ***willful noncompliance*** of a court's order is shown by the record." *Finkelman v. Clover Jewelers Boulevard, Inc.*, 91 Nev. 146, 147 532 P.2d 608, 609 (1975) (emphasis added). TeamHealth Plaintiffs did not point to a shred of actual evidence that Defendants failed to comply with its discovery obligations—let alone, willfully. Instead, the Supplemental Jury Instruction confirms the extent to which TeamHealth Plaintiffs went to gain unfair advantage as the parties submit this case to the jury. Because it was error to provide an rebuttable presumption instruction and because the instruction given was itself erroneous, a new trial is required.

A. A REBUTTABLE PRESUMPTION INSTRUCTION WAS NOT WARRANTED.

It was TeamHealth Plaintiffs' burden to establish entitlement to the adverse inference instruction. *See MDB Trucking, LLC v. Versa Prod. Co., Inc.*, 136 Nev. Adv. Op. 72, 475 P.3d 397, 405 (2020) ("the burden lies with the party seeking the imposition of sanctions to prove actual

prejudice by showing that the evidence was material to the party's case"). TeamHealth Plaintiffs based their request for a rebuttable presumption instruction on the lack of documents produced that fell into two broad categories: (1) documents evidencing that demand from Defendants' clients was a motivating factor for the out-of-network programs that were used to adjudicate the at-issue claims; and (2) administrative records, *i.e.*, plan documents, appeals, etc., that relate to the at-issue claims. 11/21/2021 Tr. 80:5-83:1 (arguing that the Court should provide a rebuttable presumption instruction);. Even though they did not meet their burden, the Court instructed provided the rebuttable presumption instruction. 11/23/2021 Tr. 123:19-124:20. TeamHealth Plaintiffs used that instruction to win the jury over. *See id*. 164:17-165:19, 258:17-260:15.

The rebuttable presumption instruction should not have been provided because Defendants produced numerous documents concerning their clients' demand as a motivating factor for the out-of-network programs that were disputed during trial. TeamHealth Plaintiffs only attempt to satisfy their burden with respect to this issue did not come through testimony or evidence, but through attorney argument that "there are no documents, zero, zero, produced from third parties outside of United that indicate that [the OCM program] is client driven. Zero. I mean literally zero." 11/10/2021 Tr. 187:6-8. First, TeamHealth Plaintiffs' complaint that there were no "direct" communications with customers is a product of their own creation. They are responsible for litigating their case. But they did not serve subpoenas on third-parties for this information or request such documents from Defendants. They never even proposed that Defendants include client account executives as custodians. Faced with this reality, TeamHealth Plaintiffs hoped that the Court would absolve them of this defect in their case by giving a rebuttable presumption instruction. But it is not Defendants burden to produce documents from third-parties. Second, TeamHealth Plaintiffs' contention was not true. Defendants produced a chorus of documents to support the testimony that customer demand was a key factor in the development of out-of-network programs. For example:

- **DEF280128** is a fact sheet regarding the Shared Savings Program for ASO clients explaining: "Our client's costs have continued to rise at alarming rates and ***are one of the main concerns our clients raise to their account team***."
- **DEF528207** is a market analysis presentation noting marketplace pressures due to

customer cost concerns: "***Large employers are showing interest in innovative benefits designs around HDHPs to drive down overall healthcare costs***."

- **DEF100526** is a market analysis presentation noting that ***"employers [health plan clients] are increasingly believing that incumbents do not deliver the potential value for money necessary to deliver on their health benefits, driving increasing interest in attackers and innovators to disrupt the system***."
- **DEF413948** is a strategic presentation that explains: ""Demand for Cost of Care tools is high driven by consultant marketing, ***client frustration with limitations of discount tools and competitor promotion of these new tools***."
- **DEF524202** is a market analysis presentation addressing competitor pricing: "UHG is disadvantaged to the market by $1.73 PMPM – if you exclude non-core admin, consistent with our competitors, we are slightly more favorable to the industry but **remain significantly more expensive than Anthem**."
- **DEF305683** is a presentation analyzing UnitedHealthcare's Out of Network Competitive Position based on market information: "'ASO clients are seeking more OON spend solutions, without necessarily shifting greater cost share to employees. . . . UHC has a variety of programs to work and manage non-par spend; however there is still opportunity to do more, particularly with respect to these UCR type claims. Market intel indicates that our competitors have tighter cost controls to help manage this spend.'"
- **DEF482543** is a February 8, 2018 email sent by a UnitedHealthcare Associate Director of Underwriting, National Accounts, reflecting efforts to gather competitive intelligence on other carrier's OON programs: "the heat is on and we need to formulate our position when being compared to our competitors . . . We've got some immediate needs for any insights we can get."
- **DEF394236** includes competitor analysis "UHC can win new business if we offer plans at similar cost while emphasizing the broad set of solutions to lower cost of care."

These produced documents are distillations of customer (or their broker) feedback—precisely the sort of documents that executives like the witnesses in this trial would rely upon to assess customer

demand. These produced documents also support the testimony that Defendants' OON programs were developed, in part, in response to client complaints about medical costs and market analyses of competitor offerings. Moreover, defense counsel brought these documents to the Court's attention and informed that these are only "a portion of the documents that relate to the pressures that [Defendants'] clients were putting on [Defendants]." 11/21/2021 Tr. 85:19-23, 97:5-98:18. However, because the issue was prejudged, these produced documents did not matter and the Court provided the rebuttable presumption instruction.

Next, a rebuttable presumption instruction was not warranted based on a lack of administrative records being produced. Throughout the course of this litigation, TeamHealth Plaintiffs failed to determine what claims were at-issue. *See* Defs' Mot. for New Trial re Trial Errors at __ (section discussing Leathers and PX 473 not being finalized until trial). Indeed, the list of claims that TeamHealth Plaintiffs were putting at-issue, PX 473, was not finalized until the midst of trial. *Id.* Not only did that deprive Defendants from knowing what claims it needed to defend against at trial, but it also subjected Defendants to discovery that was unduly burdensome, inefficient, not proportional to the needs of the case. To be sure, even though PX 473 put 11,563 claims at-issue, the earlier iterations that informed Defendants' collection and production of documents put more than 23,000 claims at issue. *See* 11/22/2021 Tr. 142:24-143:19.[26] Because there are typically multiple types of documents comprising the administrative record for each at-issue claim, there were tens of thousands, if not hundreds of thousands, of administrative record documents requested by TeamHealth Plaintiffs.[27] But, by the time of trial, the relevant universe was half of what it was during discovery.

Defendants previously informed the Court – through sworn employee declarations – of how arduous and disproportional it would be to collect and produce every administrative record for

[26] By late May 2021, after the close of discovery, TeamHealth Plaintiffs had only culled the at-issue claims list down to about 19,500 claims. 11/22/2021 Tr. 145:16-20. By the end of July 2021, that number fell to 12,500.

[27] Some of the administrative records produced by Defendants included summary plan documents written and maintained by the third-party-claim-administrator-Defendants' clients—*i.e.*, self-insured employers. These clients could revise the summary plan documents at any time, which Defendants were not always provided. 11/21/2021 Tr. 90:11-24.

22,153 at-issue claims. *See* 9/28/2020 Granting Plfs' Mot. to Compel At-Issue Claims Files at 2-3 ¶¶ 2-4, 7; 9/4/2020 Defs' Opp. to Plfs' Mot. to Compel At-Issue Claims Files at 4-5. Indeed, Defendants stressed that the majority of these documents would need to be manually generated and/or retrieved on a claim-by-claim basis. *See* 9/4/2020 Defs' Opp. to Plfs' Mot. to Compel At-Issue Claims Files at 3-7, 11-14. The Court was seemingly indifferent to this significant burden, so Defendants were afforded no relief. 9/28/2020 Granting Plfs' Mot. to Compel At-Issue Claims Files at 5-6 ¶¶ 13, 15-16, 18. In a good faith effort to comply with their discovery obligations that were dictated by an overwhelming amount of then-at-issue claims that would be later abandoned, Defendants produced over 200,000 pages of administrative records, including more than 7,000 plan documents and explanation of benefits forms associated with almost 16,446 unique claims. *See* 11/21/2021 90:4-7. To do so, Defendants devoted extensive employee labor and developed new administrative record lookup technologies. 3/22/2021 Opp'n at 6. In fact, TeamHealth Plaintiffs received the plan documents covering every at-issue claim pertaining to Defendants SHL and HPN. 11/21/2021 Tr. 90:3-16. Had TeamHealth Plaintiffs properly informed Defendants of what claims would be tried, or that were genuinely in dispute,[28] Defendants' discovery efforts could have been directed at collecting and producing administrative records relevant to the claims at-issue in PX 473 – or only portions of the administrative records of more interest to TeamHealth Plaintiffs. Instead, TeamHealth Plaintiffs litigation tactics caused administrative records, including plan documents,

[28] TeamHealth Plaintiffs responsibility to ensure they were only challenge claims that met their own alleged definition of what qualified as an "at-issue claims" was foisted upon Defendants. *See* 2/25/2021 Hr. Tr. 10:13-15 (noting how Defendants were forced to help TeamHealth Plaintiffs determine whether the 22,153 claims then-at-issue could be disputed). In essence, TeamHealth Plaintiffs' claims data could not accurately depict which claims met the definition of what they alleged were at-issue claims—*i.e.*, claims that were submitted to Defendants but not reimbursed pursuant to a government program or a contracted rate. TeamHealth Plaintiffs should have been able to, and required to, accurately determine what claims they were disputing. *See Banks v. Sunrise Hospital*, 120 Nev. 822, 849, 102 P.3d 52, 70 (2004) (Maupin, J., concurring) ("Because a potential plaintiff has absolute control over whether to file a lawsuit and which theories of recovery he or she chooses to allege, it is perfectly appropriate to impose a duty to preserve evidence and impose sanctions in connection with its loss or destruction."). But they were not required to do so and they could not because their data was flawed. So, not only did Defendants have to collect documents from a massive universe that would later be more than halved, they had to figure out TeamHealth Plaintiffs case.

related to PX 473 at-issue claims to be missing at-trial.

When the consequences of their own litigation tactics came to haunt them at trial, TeamHealth Plaintiffs sought the Court's assistance to win the case. In an effort to dupe John Haben into testifying favorably for TeamHealth Plaintiffs, opposing counsel cherry picked a series of exhibits from the administrative records of several AT&T insureds, including an explanation of benefits ("EOB"), appeals record, and summary plan description. *See* 11/9/2021 Tr. 24:16-45:10; *see also* PXs 120, 290, 444, and 470. Attempting to suggest that the plan document did not align with the payment terms of the EOB, TeamHealth Plaintiffs asked Mr. Haben whether the EOB and plan documents exhibits they presented him matched. As Mr. Haben explained, there was no way to confirm that the EOB and plan documents were related. 11/9/2021 Tr. 45:6-10 (testifying that there was no way to "know if that plan [reflected in PX 120] is associated with that claim [reflected in PX 444]." That is because "AT&T has . . . multiple policy numbers," meaning that it is necessary to match the plan document with member's group number to confirm which policy provisions apply. *Id*. 38:17-22. So, in light of the harmful testimony to their case that they elicited and could not rebut due to their own litigation tactics, TeamHealth Plaintiffs complained that an rebuttable presumption instruction was required. They did so by convincing the Court that it had already ordered that an adverse inference would be provided. 8/3/2021 Order at 11; 11/21/2021 Tr. 81:23-82:4, 91:10-23.

However, the August 3, 2021, Order cited by TeamHealth Plaintiffs did not concern administrative records. That order derives from TeamHealth Plaintiffs March 8, 2021 motion. But, their moving papers explicitly disclaimed, and belittled, the administrative records produced by Defendants:

> [Defendants are] not in compliance with [discovery] . . . because it has failed to produce critical information and documents . . . . [Defendants] will undoubtedly point to the number of pages of its document production, but the substance is lacking. Of the 97,901 pages of documents United has produced, 91,800 are at-issue claims files (which United refers to as the administrative record), leaving 6,101 pages of non-administrative record documents. Of those 6,096 pages, at least 2,617 pages are contracts or benefit plan templates.

3/8/2021 Plfs' Mot. for Sanctions at 2. Further, TeamHealth Plaintiffs only claimed they would "suffer substantial prejudice" if Defendants "further delay[ed] in producing th[e] critical information" encompassed by their motion—*i.e.*, not administrative records, including plan

documents. *See id*. at 5-14 (arguing for sanctions because Defendants did not satisfy their production obligations, for example, with respect to RFP No. 5, by "point[ing] to administrative records" or with respect to Interrogatory Nos. 2, 3, 10, 12, "by pointing to the health benefit plans," which administrative record documents). As such, TeamHealth Plaintiffs were not seeking additional administrative records be produced or that sanctions should be levied vis-à-vis a lack of administrative records. *See also* 11/21/2021 Tr. 96:19-25 ("[TeamHealth Plaintiffs] were very clear that they weren't seeking sanctions on the administrative records because [Defendants] had bene producing so many of them and they believed those records were non-substantive."). Therefore, the Court's August, 2, 2021 Order did not pertain to administrative records.

Nonetheless, the Court accepted TeamHealth Plaintiffs' position and provided the rebuttable presumption instruction based on every administrative record not being produced. A new trial is required because Defendants produced administrative records for 16,446 unique claims even though TeamHealth Plaintiffs would only present 11,563 claims to the jury. Moreover, the August 2, 2021 Order did not pertain to administrative records, so the Court erred in basing its decision to provide a rebuttable presumption instruction on that order. Therefore, a new trial is required.

Defendants SHL and HPN have an additional reason for why the rebuttable presumption instruction was given in error. TeamHealth Plaintiffs received every plan document covering the at-issue claims related to Defendants SHL and HPN. As such, those Defendants should have been carved out from the rebuttable presumption instruction. But they were not. Thus, a new trial is required.

B. THE JURY WAS ERRONEOUSLY INSTRUCTED ON THE REBUTTABLE PRESUMPTION UNDER NRS 47.250(3).

Over Defendants' objection, the jury was instructed on the rebuttable presumption under NRS 47.250(3). 11/23/2021 Tr. 123:19-124:20. The jury was improperly given this instruction as TeamHealth Plaintiffs failed to meet their burden to prove both the loss or destruction of evidence and that such loss or destruction resulted was willful or committed with the intent to harm TeamHealth Plaintiffs.

"[B]efore a rebuttable presumption that willfully suppressed evidence was adverse to the

destroying party applies, *the party seeking the presumption's benefit* has the burden of demonstrating that the evidence was destroyed *with intent to harm*." *Bass-Davis*, 122 Nev. at 448, 135 P.3d at 107 (emphasis added). Only once there is evidence of willful suppression or destruction of evidence with intent to harm does the rebuttable presumption apply. *Id.* And the burden shifts to the destroying party to prove by a preponderance of the evidence that the destroyed evidence was not unfavorable. *Id.*

TeamHealth Plaintiffs pointed to no evidence to demonstrate that any evidence was ***lost or destroyed***. *See Samsara Investments LLC Series #4 v. Carrington Mort. Servs., LLC*, 488 P.3d 678, 2021 WL 2493878, *3 (Nev. Ct. App. 2021). The best they can do is point to this Court's ruling that Defendants ***unduly delayed*** in producing other discoverable material—*i.e.*, the material giving rise to TeamHealth Plaintiffs' request for a rebuttable presumption was not encompassed by the Court's prior ruling. 8/3/2021 Order at 8 ¶ 21 ("The Court finds that [Defendants] ha[ve] shown a consistent pattern of . . . delay and obstruction"); *supra* III.B.1 (detailing the predicate for that order). However, the Nevada Supreme Court made clear last week that spoliation instructions—whether for an adverse inference or a rebuttable presumption—are only "appropriate when evidence has been lost or destroyed," ***in fact***. *See Rives v. Farris*, 138 Nev. Adv. Op. 17, __P.3d __, at *13, *16 & n.7 (March 31, 2022) (slip. op.) (holding an adverse inference instruction is inappropriate based on intentional concealment of evidence because that evidence "was not lost or destroyed").[29] Accordingly, evidence is not "lost or destroyed" based on disclosure lapses such as a failure of disclosure or an undue delay in disclosure. *See id.* Thus, TeamHealth Plaintiffs could not use the Court's prior undue delay ruling as proof that any evidence was "lost or destroyed," in fact. Indeed,

[29] A courtesy copy is attached as **Exhibit** 4. In *Rives*, the defendant-doctor in a malpractice action responded to an interrogatory request about other malpractice lawsuits filed against him by copying a list from a similar response in another case, but omitting that other case itself from the list. *Id*. at *3. The other lawsuit came to light during a deposition. *Id*. at *3-4. After an evidentiary hearing, the district court concluded that the doctor "'relied on counsel' to prepare the interrogatory responses and, thus, had 'an intent not to read the interrogatories,' which the court considered 'intentional conduct' warranting an adverse-inference instruction." *Id*. at *4. The Supreme Court reversed, concluding that "[w]hile the district court may have correctly determined that Rives's discovery behavior warranted sanctions, it nonetheless abused its discretion by giving an adverse-inference instruction." *Id*. at *16 n.7 (citing *Bass-Davis*, 122 Nev. at 447-48, 134 P.3d at 106).

"the Court d[id] not believe there ha[d] been any destruction or fabrication of evidence." 8/3/2021 Order at 11 ¶ 32.

Defendants produced over 400,000 pages during discovery. Yet TeamHealth Plaintiffs asserted the rebuttable presumption instruction was warranted due to Defendants' failure to produce the materials discussed in the preceding section. *Supra* Jury Instruction Errors Section II.A. But, as noted above, Defendants' productions indicate otherwise. *See also, e.g.*, Defs' Opp. To Plfs' Supplemental Jury Instruction (Contested) 3-4. The record clearly does not demonstrate any evidence has been lost or destroyed. Rather, Defendants simply did not have enough time, during discovery, to gather and produce tens of thousands of administrative records.

Moreover, TeamHealth Plaintiffs were required to establish more than just that evidence was lost or destroyed. *Bass-Davis*, 122 Nev. at 449, 135 P.3d at 107 ("the rebuttable presumption . . . applies only when evidence is willfully suppressed, it should not be applied when evidence is negligently lost or destroyed"). They needed to demonstrate that Defendants *willfully* destroyed or suppressed evidence. *Id.* "[T]his requires more than simple destruction of evidence and instead requires that evidence be destroyed *with the intent to harm another party*." *MDB Trucking, LLC v. Versa Prods. Co., Inc.*, 136 Nev. 626, 632, 475 P.3d 397, 404 (Nev. 2020). Just as there is no evidence in the record to establish evidence was lost or destroyed (as opposed to unable to be collected), there is zero evidence in the record that Defendants acted willfully or with the intent to harm TeamHealth Plaintiffs. Instead, as noted above, TeamHealth Plaintiffs improperly relied on the Court's August 3, 2021 Order. 8/3/2021 Order at 11 ¶ 32 ("the Court does not believe there has been any destruction or fabrication of evidence"). However, the August 3, 2021 Order makes no finding that Defendants willfully suppressed evidence. *Id.* It only found willful delay, which is insufficient to support the instruction that was given. *See id.* at 8 ¶ 21; *Bass-Davis*, 122 Nev. at 449, 134 P.3d at 107; *Rives*, 138 Nev. Adv. Op. at *13, *16 & n.7.

TeamHealth Plaintiffs bore the burden to demonstrate Defendants willfully destroyed or suppressed evidence *before* the rebuttable presumption instruction under NRS 47.250(3) applied. Because TeamHealth Plaintiffs failed to meet that burden, the rebuttable presumption instruction could not apply. Given TeamHealth Plaintiffs' failure to satisfy its burden, it was an abuse of

discretion to instruct the jury on the rebuttable presumption. As a result, Defendants' substantial rights were materially affected. *See Pizarro-Ortega*, 133 Nev. at 263, 396 P.3d at 786.

Additionally, the rebuttable presumption instruction should not have been given to the jury because TeamHealth Plaintiffs could not satisfy the threshold to have the jury receive an adverse inference instruction. Compared to a rebuttable presumption instruction, an adverse inference is a lesser spoliation instruction. *Bass-Davis*, 122 Nev. at 449-52, 134 P.3d at 107-09. To obtain an adverse inference instruction, the requesting party does not have to show that its opponent willfully destroyed evidence with the intent to harm but that its opponent negligently lost or destroyed evidence. *Id.* Negligent loss or destruction of evidence is proven by showing that "the party controlling the evidence had notice that [the evidence] was relevant at the time when [it] was lost or destroyed." *Id.*; *see also Michaels v. Pentair Water Pool & Spa*, 131 Nev. 804, 820, 357 P.3d 387, 399 (Nev. Ct. App. 2015) ("An adverse inference instruction may be given when a district court concludes that particular evidence was negligently destroyed."). But again, TeamHealth Plaintiffs did not and cannot demonstrate any evidence was lost or destroyed, so they were not entitled to the adverse inference instruction.

Even assuming, *arguendo*, that there was evidence of lost or destroyed evidence, there is no evidence to indicate that Defendants "had notice that [negligently lost or destroyed evidence] was relevant at the time when th[at] evidence was lost or destroyed." *Bass-Davis*, 122 Nev. at 449, 135 P.3d at 108. Only documents that Defendants controlled after their preservation obligations began could be subject to an adverse inference. *Id.* ("the threshold question should be whether the alleged spoliator was under any obligation to preserve the missing or destroyed evidence"). So, Defendants were not under any obligation to preserve plan documents maintained or controlled by Defendants' self-insured clients until they were on notice of a potential legal claim. But, the Court does need to go down that rabbit hole because TeamHealth Plaintiffs only contend in general that there are missing, not lost or destroyed, documents and there was undue delay in producing similar documents. Accordingly, a new trial is required because the rebuttable presumption instruction should not have been given to the jury.

Furthermore, not only did the Court err in providing the rebuttable presumption instruction

in the first place, it erred in taking the willfulness decision out of the hands of the jury. Pursuant to Nevada law, the jury must decide if "a party seeking the [rebuttable] presumption's benefit has demonstrated that . . . evidence was destroyed with intent to harm, . . .the presumption that the evidence was adverse applies, and [if] the burden of proof shifts." *See Bass-Davis*, 122 Nev. at 448, 134 P.3d at 106-07 (holding that the requesting party must carry its burden through presentation of evidence); Nev. J.I. 2.5; *see also Boland v. Nev. Rock & Sand Co.*, 111 Nev. 608, 613, 894 P.2d 988, 991 (1995) ("willfulness is generally a question of fact"). Even though Defendants informed the Court that "only the jury may find willfulness," 11/21/2021 Tr. 87:6-8, the jury was instructed that Defendants violated the Court's order and the Court had already found that Defendants' conduct was willful. 11/23/2021 Tr. 123:19-23. The Court did not tell the jury that it had only found that Defendants willfully delayed in producing documents, even though willful delay is not willful suppression or destruction. *Id.*; *Bass-Davis*, 122 Nev. at 448, 134 P.3d at 106-07; Nev. J.I. 2.5.

So, the jury was instructed that its role was limited to determining whether "defendants have . . . rebutted [the] evidence introduced by plaintiff that relevant evidence was suppressed." 11/23/2021 Tr. 124:17-20. If not, then the jury was "required to presume that the evidence was adverse to the defendants." 11/23/2021 Tr. 124:17-20. In other words, the jury was instructed that Defendants had engaged in willful conduct, which was completely unsupported by the evidence; this stripped the jury of its duties.

Informing the jury of this "misconduct" and requiring the jury to presume the evidence was adverse to Defendants affected the integrity of the verdict. *See McNamara v. State*, 132 Nev. 606, 622, 377 P.3d 106, 117 (Nev. 2016) ; *Palmer v. Ted Stevens Honda, Inc.*, 193 Cal. Rptr. 363, 369 (App. 1987) ("Not only was admission of this evidence of defendant's litigation conduct and plaintiff's attorney fees error, we conclude it undermines the integrity of the punitive damages award."). Although the record is completely devoid of any evidence to establish Defendants willfully suppressed or destroyed evidence, during closing arguments, TeamHealth Plaintiffs relied heavily on the rebuttable presumption instruction during closing arguments to assert that Defendants must pay more under the plan documents. *See* 11/23/2021 Tr. 163:5-165:19. And TeamHealth Plaintiffs reminded the jury that the presumption was mandatory if Defendants did not

refute it by a preponderance of the evidence. *Id.* Since TeamHealth Plaintiffs were not entitled to this instruction and the jury should not have been instructed on the rebuttable presumption, it is hard to imagine how such an instruction did not undermine the integrity of the verdict.

The Court should grant Defendants' motion for a new trial because they have satisfied their burden under NRCP 59(a)(1). Defendants have established it was an abuse of discretion to instruct the jury on the rebuttable presumption and its substantial rights were materially affected such that a new trial is warranted. *See Pizarro-Ortega*, 133 Nev. at 263, 396 P.3d at 786.

* * *

Cumulative Error

As noted throughout this Motion, Defendants move for a new trial based on the cumulative weight of the errors that occurred throughout this litigation. Without rehashing the arguments above, the cumulative effect of the errors necessitates a new trial. *Harper*, 533 F.3d at 1030 (cumulative effect of evidentiary errors basis for new trial); *Pertgen v. State*, 110 Nev. 554, 566, 875 P.2d 361, 368 (1994) (observing that errors in isolation can sometimes be characterized as "harmless" may, when considered together, prove to be sufficiently prejudicial that a new trial is required), *abrogated on other grounds* by *Pellegrini v. State*, 117 Nev. 860, 34 P.3d 519 (2001).

CONCLUSION

The number of errors that occurred in this litigation are overwhelming. Any one of them requires a new trial. Cumulatively, it is beyond question that the verdicts cannot stand. Therefore, Defendants request that the Court set-aside the spoiled verdicts and order a new trial.

Dated this 6th day of April, 2022.

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CERTIFICATE OF SERVICE

I hereby certify that on the April 6, 2022, service of the above and foregoing **"Motion for New Trial"** was made upon each of the parties via electronic service through the Eighth Judicial District Court's Odyssey E-file and Serve system.

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EXHIBIT 1

EXHIBIT 1

Fremont Emergency Services (Mandavia) Ltd., et al., v. UnitedHealth Group, Inc., et al.

Defendants' MIL No. 24 to Preclude TeamHealth Plaintiffs from Referring to Themselves as Doctors or Healthcare Professionals

Motions in Limine – No. 24

- TeamHealth Plaintiffs are ***not*** ER doctors or even healthcare providers.
- They are corporations that provide ER staffing services to hospitals – similar to staffing agencies in other industries like Manpower, Ranstaad or Adecco.
- They are subsidiaries of a multi-billion dollar company that is owned by private-equity giant, Blackstone.
- The ER physicians who rendered the disputed services are independent contractors of TeamHealth Plaintiffs.

TeamHealth Plaintiffs' Contracts

PROFESSIONAL AND SUPPORT SERVICES AGREEMENT

THIS PROFESSIONAL AND SUPPORT SERVICES AGREEMENT ("Agreement") is entered into effective as of the 1st day of April, 2016 ("Effective Date"), by and between **FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.** ("Company"), and **INPATIENT CONSULTANTS OF NEVADA, INC.** ("Provider").

A. Company is in the business of entering into contracts with hospitals and/or other healthcare facilities or providers (collectively, the "Facilities") to arrange for the provision of physician staffing services and other mutually agreed upon services in such Facilities' emergency departments, anesthesiology departments, hospital medicine programs or other departments, as applicable (the "Facility Contracts");

B. Provider is in the business of rendering clinical services through its employed or contracted physicians and other healthcare professionals who are licensed to practice medicine in the states in which the Facilities are located;

TeamHealth Plaintiffs' Contracts

3.1 Clinical Services. Provider agrees to supply (i) physicians to perform or provide any and all physician services ("Physicians") and (ii) other healthcare professionals such as advance practice clinicians (*e.g.*, physician assistants, nurse practitioners, certified registered nurse anesthetists and anesthesiologists) to perform or provide any and all non-physician clinical services ("Other Healthcare Professionals") required to be provided by Company under the Facility Contracts at such times and locations designated by Company. The Physicians and Other

TeamHealth Plaintiffs' Contracts

4.1 Billing and Collection Information and Services. Provider shall provide Company with information and assistance necessary for Company (or its designee) to bill patients or other third party payors for services rendered by the Physicians and Other Healthcare Professionals pursuant to the Facility Contracts. Company agrees to provide, or cause to be

TeamHealth Plaintiffs' Contracts

5. Relationship of the Parties. The parties shall not, by virtue of this Agreement, be deemed partners or joint venturers, nor shall either party be deemed to be the partner, joint venturer, agent or employee of the other party. Company shall not, by entering into and

ER Physicians Are Independent Contractors of TeamHealth Plaintiffs

TeamHealth Plaintiffs' executive, Dr. Robert Frantz, confirmed that the ER physicians are independent contractors, not employees. Sept. 24, 2021 Frantz Depo. at 80:19-82:15

Q. And it's a lengthy paragraph, but about halfway down there's a sentence that states, "The parties acknowledge that provider is and at all times shall be an independent contractor of Company."

Do you see that?

A. Yes, I do now.

Q. And to your understanding -- and I understand

that Inpatient Consultants is a provider of the hospitalists, not the actual ER physicians, but would the relationship be the same in regard to Fremont's relationship with the ER physicians; that they would be considered independent contractors of Fremont similar to the situation here with the hospitalists?

MR. MCMANIS: Objection. Foundation. Calls for a legal conclusion.

A. I'm not positive. I believe the ER physicians are independent contractors and the APCs are employed.

BY MR. BALKENBUSH:

Q. And just so I'm clear, the APCs, that's the nurse practitioners and physician assistants you include under that definition?

A. Correct. It's an inclusive term, yeah.

Motions in Limine – No. 24

- TeamHealth Plaintiffs intend to argue that Defendants' underpayments caused reduced compensation to ER physicians in states other than Nevada. (*See* MIL No. 37.)
  - "In a meeting with TeamHealth's CEO, [Defendants] stated that . . . 'physician pay had to come down, and that those were problems TeamHealth had to deal with . . . ." Sur-Reply to Defs. Mot. Summ. J. at 7
- <u>But this is false</u>.
- If damages were awarded to TeamHealth Plaintiffs, the damages would be paid to the staffing companies, not the ER physicians who rendered the disputed services.
- (See paras 6-25 (**Exhibit 5**, Rebuttal Expert Report of Bruce Deal (Sept. 17, 2021) at ¶¶ 6-25 (explaining that the agreements between each TeamHealth Plaintiff and TeamHealth provides that the physicians are paid a set compensation and that any net collections are kept as income to TeamHealth).

Motions in Limine – No. 24

Q. So after all of the group expenses have been paid with the group's money and all of Quantum's expenses have been paid with the group's money, Quantum keeps all the rest, right? A hundred percent of anything that's left over is what Quantum has characterized as payment for the management fees? "Compensation for the management assistance services."

A. Yes.

Q. So when you have money left over after expenses, we generally call that a profit, right?

A. Yes.

Q. So if ACS or EST generate $1 of profit, that amount is characterized as an "additional management fee" that's kept by Quantum, right?

A. Effectively, yes.

Q. And if they generate a hundred million dollars of profit, then all hundred million dollars of that money is also the management fee and is kept by Quantum as well, right?

A. Yes.

Q. So once the money, on a daily basis, goes from ACS and EST over to Quantum, it never, ever goes back, right?

A. It goes back in the form of paying the reasonable compensation expenses that the group incurred.

Q. Can you explain that to me? I'm sorry.

A. Well, just as we've talked about, doctors come and perform shifts, and we pay them reasonable fair market value for all their services. And that is what the corporation is paying to the group for those reasonable expenses incurred.

Q. Then everything that's left over is tacked on as additional management fees?

A. Effectively, yes, after all the reasonable expenses are accounted for. Yes.

Molina, Bristow Tr. at 146:24-150:6

TeamHealth Plaintiffs Are Not Disparaged

- TeamHealth Plaintiffs conflate dissemination of a damages award to disparagement, but Defendants will not tell the jury that an award of damages will not go to the providers who actually serviced patients

  "United seeks to . . . disparagingly renam[e] the Health Care Providers" Pls.' Opp. at 5:1-2

- The damages example was to illustrate that actual health care providers are not involved in this case

  "If damages were granted to TeamHealth Plaintiffs, it would result in a payment to TeamHealth Plaintiffs and ultimately TeamHealth, who will have no obligation to share such funds with any doctor." Def. Mot. at 6:16-18.

- TeamHealth Plaintiffs are not disparaged by an order prohibiting them from making a knowing misrepresentation to the jury.

Prejudicial Under NRS 48.035

- Allowing TeamHealth Plaintiffs to refer to themselves as “health care providers” would be confusing and unfairly prejudicial.

- *See State v. Eighth Jud. Dist. Ct. (Armstrong)*, 127 Nev. 927, 933, 267 P.3d 777, 781 (2011) (noting that “unfair prejudice” under NRS 48.035 is “an appeal to the emotional and sympathetic tendencies of a jury, rather than the jury’s intellectual ability to evaluate evidence”

Other Courts Have Prohibited TeamHealth Affiliates From Calling Themselves Physicians or Healthcare Providers

Other trial courts in cases filed by TeamHealth against health insurers have precluded TeamHealth Plaintiffs from referring to themselves as health care providers

MR. FORD: Well, Your Honor, they want us to not talk about the plaintiffs -- the Professional Association of Physician Providers. I think that it's -- I'm not -- there's no question that ACS as an entity is not a doctor, but there is certainly -- it's certainly true that ACS and EST provide physician services to emergency rooms.

Molina, Mot. *in Limine* Hearing at 118:1-119:11

Other Courts Have Prohibited TeamHealth Affiliates From Calling Themselves Physicians or Healthcare Providers

MR. LaVIGNE: It's a branding issue. It's the constant reference to themselves, not as the "plaintiffs" and the "defendants" but the "doctor plaintiffs" and the "insurance defendants." It's so pernicious. Even in the charge they submitted, they don't define themselves as the "plaintiffs from ACS and EST." It's the "doctor plaintiffs." It's the adjectives. It's the constant branding of those things, as if to play on the jurors' natural sympathies that doctors save lives and insurance companies somehow don't.

You know, it's -- how about calling yourselves "the plaintiffs" or "ACS" and "We have doctors"? And that's fine. I'm just saying they shouldn't be able to rebrand themselves with adjectives. The Rules of Civil Procedure call themselves "plaintiffs," not "doctor plaintiffs." Call them "plaintiffs."

THE COURT: Anything else?

MR. LaVIGNE: No.

THE COURT: Thirty-two is granted.

Molina, Mot. *in Limine* Hearing at 118:1-119:11

EXHIBIT 2

EXHIBIT 2

From: Blalack II, K. Lee
Sent: Friday, November 5, 2021 7:48 PM
To: Kevin Leyendecker; Ruth Deres; Michael Killingsworth; Myrna Flores
Cc: Yan, Jason; Plaza, Cecilia; Levine, Adam
Subject: FW: Partially Denied Claim Issue
Attachments: P473.pdf; Stipulation and Order (003).DOCX

Kevin:

This revised list looks correct to us. We agree that this new exhibit contains the operative list of disputed claims. Accordingly, we think we can try the case based on this list.

The next step here is for our experts (Deal and Leathers) to revise their calculations to reflect this new and final list of disputed claims. As I mentioned in a prior email, I propose that the parties reach agreement on a process and timeline to amend those prior reports in a manner that reduces the possibility of disputes about what the experts are changing based on this final list. To that end, I am attaching a proposed stipulation and order for your consideration. The idea here is that the SAO would identify your new list as the operative list of disputed claims and it would also acknowledge that the parties' experts (Deal and Leathers) need to revise their calculations. It proposes a deadline of Wednesday, November 10th, to complete that process and makes clear that none of the experts can introduce any new opinions or methodologies; instead, they can merely perform the prior calculations in their reports using the final list of disputed claims.

In any event, take a look at the proposed SAO and let me know if this approach is acceptable to you all.

Best. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Friday, November 5, 2021 1:32 PM
To: Blalack II, K. Lee <lblalack@omm.com>
Cc: Ruth Deres <rderes@AZALAW.COM>; Michael Killingsworth <mkillingsworth@AZALAW.COM>; Myrna Flores <mflores@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Thanks Lee.

I gave Leathers the excel version to rerun his analysis and numbers. I've PDF'd this and would like to replace the current P473 with it. I've hidden some of the columns to make it easier to read on computer when zoom in and I"ve added column headings to each page.

Please let me know if you have any objections to this new version of P473.

thanks

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Friday, November 5, 2021 7:24 AM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>
Subject: FW: Partially Denied Claim Issue

Kevin,

My folks reviewed the spreadsheet you sent. There is one claim you've tagged as DiS which was not identified as non-DiS. That claim is Acct # 233718879/526.

Please let me know if you have any questions. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Wednesday, November 3, 2021 2:28 PM
To: Plaza, Cecilia <cplaza@omm.com>; Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Lee/Ceci,

I've added a column to this that tags what I believe are the iSight claims.

Please review and let me know if you have any issues with those designations.

Thanks

From: Plaza, Cecilia <cplaza@omm.com>
Sent: Sunday, October 31, 2021 3:35 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Kevin,

We have reviewed and did not find any errors in the edits to the charge and CPT columns.

Thanks,
Ceci

Cecilia Plaza
O: +1-212-728-5962

cplaza@omm.com

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Sunday, October 31, 2021 1:55 PM
To: Plaza, Cecilia <cplaza@omm.com>; Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Lee/Ceci,

Here is an updated version of what I consider to be the final. I substituted the net charge (orig – denied) for the Total Charge column; and I also edited the CPT column to remove the denied CPTs.

Please review and let me know if you find any mistakes in either.
.

From: Plaza, Cecilia <cplaza@omm.com>
Sent: Sunday, October 31, 2021 11:05 AM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Kevin,

We have reviewed your list and confirmed that, consistent with our discussions, all the relevant claims have been removed. We are in agreement that this is the final list of disputed claims. Please see attached a spreadsheet reflecting the final list of claims. Note that we deleted the extra columns ("KL delete claim" and "FAIR Health 80th"), renamed a few of the columns for clarity, and deleted the extra tab that shows denied billed charges for each disputed claim. It is otherwise the same as the spreadsheet you sent yesterday.

Thanks,
Ceci

Cecilia Plaza
O: +1-212-728-5962
cplaza@omm.com

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Saturday, October 30, 2021 9:04 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Per this discussion, I've removed those two other claims.

Please have your crew review and let me know if we've now removed all the claims consistent with these discussions.

If we are in agreement, I will produce just the claim file as 29011 (B).

K

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Saturday, October 30, 2021 8:37 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Kevin,

Yes, not to belabor this issue, we will waive an ERISA claim based on partially denied claims if you remove these last two. That would resolve the issue that we raised in our SJ motion. That obviously does not result in waiver of other ERISA arguments that have nothing to do with a partially denied claim (e.g., basic conflict preemption, which is the argument that we presented originally in the case when we removed the case to federal court). We are preserving those other ERISA arguments but the removal of these last two partially denied claims would obviate the ERISA argument stated in our SJ motion.

Thanks. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Saturday, October 30, 2021 11:07 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Hmmm… if there is a 99291, 99292 claim and the 99292 was denied, but the 99291 claim was allowed and I've adjusted the ttl charge to reflect the denied charges, then how is it different than if the denied claim was a 93010 and I removed the denied charge for the 93010?

Regardless, if you are saying you are effectively walking away from ERISA arguments if I remove the 2 claims, then the answer to that riddle is obvious.

So what say you?

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Saturday, October 30, 2021 7:57 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>

Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Not unless you are seeking to recover damages for the denied claim lines. The whole point of our proposal was to remove from your damages calculations any claims lines that were denied. If you all do that, and I think you have except for these last two, then it would mean that you are only seeking damages for underpayments of claims that were allowed at an amount less than full charges and you would not be seeking any damages for claim lines that were denied. If that is the case, while I might have other ERISA objections to this entire party, I don't think we would have an argument that you all were seeking to recover damages for a service as to which coverage was denied by my clients. Lee

---

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Saturday, October 30, 2021 6:09 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: Re: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Don't you have the erisa argument in all the other 1700 plus where a non core er code was denied?

Get Outlook for iOS

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Saturday, October 30, 2021 2:49:39 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Thanks Kevin. It looks this resolves all issues but the 2 remaining partially denied claims. I leave it to you all whether you want to keep these last two on your list. But just to be clear, if you leave them on the list, I still have my ERISA objection that there are coverage denials at issue in your damages calculation. If you remove them, I don't. Whether those two claims are worth it to you or not, I leave to your client and your judgment.

Let me know if you all want to stand pat on this list or remove those final two partially denied claims. Once we have the final list, we will send you our understanding of your final list of disputed claims. Perhaps you all can then review that list and confirm that we're in agreement that it is the final list of disputed claims for trial and we can then enter a stipulation to that effect to help make sure our experts are not ships passing in the night with different disputed claims.

Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Saturday, October 30, 2021 1:40 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Honest Abe, here is where I am.

I've noted all but the 2 (with 99291 allowed) should come out. And that's bc those partial denials are no different than all the others where a core EM line was not denied.

So now its your turn to say, ok we're there.

K

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Friday, October 29, 2021 8:25 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

I cannot tell a lie . . .

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Friday, October 29, 2021 11:07 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: Re: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

The question is clear.

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From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Friday, October 29, 2021 8:02:22 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Now, do I need to swear I wrote it all by myself? If not, I have my pinky ready to go . . .

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Friday, October 29, 2021 10:54 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: Re: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Lee,

If you pinky swear that you wrote this email, I will give further consideration to your requests.

Get Outlook for iOS

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Friday, October 29, 2021 6:18:10 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Kevin,

Thanks for pulling this revised list together. We have reviewed your comments.

You identified 5 claims (rows 5, 8, 9, 13, and 14) which were part of the original 17 claims you noted that appeared to be allowed, but denied. As previously stated, these claims were denied in full. For all 17 of these claims, including the 5 you identified in your most recent spreadsheet, we reviewed PRAs, EOBs, or disallowed reason codes and confirmed that they were denied in full. Based on our review of your spreadsheet, it appears that TeamHealth may have recorded an allowed amount for these claims due to an amount being paid by the patient or simply due to error. Indeed, for most of these 5 claims, the allowed amount corresponds exactly to the amount of the patient deductible noted in your spreadsheet.

You also identified 2 claims with an ED CPT code that were not denied. We agree that these were not denied in full, but they were partially denied. You noted in row 11,508 that the 99291 claim line was still at issue, which is correct, but the 99292 claim line on that same claim was denied. Likewise, you noted in row 11,083 that the 99291 claim line was still at issue. Again, that is correct, but the 99292 claim line on that same claim was denied. So, these 2 claims are just like all of the other partially denied claims about which we have been conferring – there is a line on the claim that was paid and a line on the claim that was denied. The ERISA defense and issue we are raising does not turn on whether the denied claim line was an ER service or a non-ER service. It turns on whether the claim was fully approved and payable or whether the claim contains some claim lines that were denied as not covered and not payable. These two claims fall into that category. Let me know if you all see the data differently.

Finally, there are still 9 CollectRx resolved claims on this list (rows 11585 to 11594) which should be removed based on our prior discussion. Please let me know if you all see those 9 Collect Rx claims differently.

If we can reach agreement on these last group of claims, then I think we have a final list of disputed claims for trial and we can have our respective experts update their analysis based on this final list. Thanks. Lee

---

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Thursday, October 28, 2021 4:42 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Couple of issues with a few, but I think we are very close. Please review and let me know.

K

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Monday, October 25, 2021 8:07 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Kevin,

Per your request, we have added a column (AD) to the spreadsheet showing the CPT codes for the denied charges. Please see attached.

Regarding the 18 account numbers in Bruce Deal's work papers: We have removed those from the list. In the initial spreadsheet, these claims were marked as denied but with denied charges of $0. It appears that either TeamHealth is not disputing the billed charges associated with the denied lines, or those line items were re-adjudicated later and United allowed some amount.

Regarding the 17 claims which appear to be denied in full: These claims are recorded as denied in full in Defendants' claims data. We have reviewed the denial reasons for these claims and they were indeed denied in full. While TeamHealth recorded an allowed amount for these claims, there is no corresponding allowed amount in Defendants' claims data. It is possible that the allowed amount recorded by TeamHealth was paid by the patient or a different payor; was recorded in error; or was the result of a claim initially being allowed but later reversed and denied.

Please let me know if you have further questions. Thanks. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Sunday, October 24, 2021 2:18 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Also, I note that the following 17 records, using your denied charges, suggest that the claim was denied in full, but if every one of them has an allowed amount, so that doesn't make sense to me.

DOS	ACCOUNT #	BILLED CPT (BUNDLED)	TOTAL CHARGE	CHARGE F	ALLOW	Lee Deni	Lee Denied Charge
7/12/2019	243523324/526	99283	510.00	-	185.00	Y	$510
7/31/2019	244445501/526	99283	508.00	-	185.00	Y	$508
11/21/2019	253083102/526	99283*X0066	508.00	-	112.44	Y	$508
10/19/2019	267845844/526	99284:SA*99053	1,019.00	-	214.51	Y	$1,019
6/27/2019	242549357/526	99284*99053	1,019.00	-	185.00	Y	$1,019
12/30/2019	256501044/526	99284	973.00	-	214.51	Y	$973
4/30/2019	238092469/526	99284	973.00	-	185.00	Y	$973
11/22/2019	260379513/526	99285:SA*99053:SA	1,474.00	-	315.25	Y	$1,474
1/14/2020	256857574/526	99285*99053	1,474.00	-	185.00	Y	$1,474
9/14/2019	247949711/526	99285	1,428.00	-	315.25	Y	$1,428
1/12/2020	256663800/526	99285	1,428.00	-	185.00	Y	$1,428
5/30/2019	240602924/526	99285	1,421.00	-	185.00	Y	$1,421
6/9/2018	214814153/526	99285:SA	1,360.00	-	315.25	Y	$1,360
7/15/2018	217423278/526	99285:SA	1,360.00	-	841.75	Y	$1,360
1/10/2020	256617535/526	99285	1,360.00	-	185.00	Y	$1,360
7/24/2019	244028178/471	99285:SA	1,138.00	-	368.78	Y	$1,138
8/3/2019	246698881/526	99291*99053	1,899.00	-	185.00	Y	$1,899

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Sunday, October 24, 2021 11:42 AM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>
Subject: RE: Partially Denied Claim Issue

Kevin,

We have now had the opportunity to review the spreadsheet that you sent on Thursday to address our objections to the disputed claims that contain coverage denials. Thanks to you all for taking a crack at solving this problem but, unfortunately, your proposed method of removing the denied claim lines doesn't solve the problem. Your approach assumes that all the primary ED CPT codes on these claims were allowed and paid, while all the secondary CPT codes were denied. This creates two problems: First, this approach excludes claim lines with secondary CPT codes that were allowed and paid. Second, this approach includes claim lines with ED CPT codes which were denied. It is therefore both over- and under-inclusive.

I want to propose an alternative way to solve the problem. We have prepared a spreadsheet that flags the denied claims (see attached spreadsheet column AB) and lists the amount of charges that were denied for each claim (see column AC). This spreadsheet accurately captures the charges actually denied for each claim. This method thus targets narrowly the issue of partial denials. It does not remove any claim lines that were paid and it removes all claim lines that were denied. Please share this analysis with Mr. Leathers and your broader team and let me know if they have any questions and, if they do, we would be willing to put our experts together with your experts to get aligned on this problem. If you all are willing to remove the denied claim lines from your damages analysis, which would be consistent with the position that your colleague communicated to Judge Allf at the hearing on our summary judgment motion last week, then I think this will resolve our objection about the partially denied claims on the disputed claims list.

By the way, please note that this spreadsheet already removes the claims conceded in Plaintiffs' opposition to Defendants' motion for partial summary judgment (i.e., UHC and UMR claims with a Jan 2020 DOS, claims resolved through negotiated agreements with DiS, the non-ER claims identified by Mr. Leathers for removal, and the 10 additional Data iSight claims about which we corresponded previously).

Best. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Thursday, October 21, 2021 5:56 PM

To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Lee, see enclosed. Per my text, I've added three columns to FESM 20911 (B) for the purpose of isolating the partially denied claims and once identified, extracting the core EM cpt so that when assessed for damages, column M (CPT FOR TRIAL (KL)) and column O (CHARGES FOR TRIAL (KL)) , will result in the same damage number regardless of whether that claim is measured against a bundled or unbundled cpt source file.

Also, I'm waiting to hear back from Louis as to the other 10 iSight claims. If we agree, those will come out to.

Expert will have to do math as well to see if they get same result and will also have to set the data in the "charge for trial column.

Let me know what you (Deal) thinks of this approach to resolving your concern that we are seeking damages for the denied claim lines associated with the bills that had a denied claim line.

K

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SAO

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Times Square Tower, Seven Times Square
New York, NY 10036
Telephone: (212) 728-5857

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,

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

STIPULATION AND ORDER REGARDING REVISING THE PARTIES' EXPERT REPORTS USING THE FINAL DISPUTED CLAIMS LIST

vs.

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

Defendants.

Plaintiffs Fremont Emergency Services (Mandavia), Ltd; Team Physicians of Nevada-Mandavia, P.C.; Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine (collectively "Plaintiffs") and Defendants UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Sierra Health and Life Insurance Company, Inc.; and Health Plan of Nevada, Inc. (collectively "Defendants"), referred to individually as a "Party" or collectively as the "Parties," stipulate and agree to the following:

WHEREAS, the Plaintiffs produced an initial list of disputed claims in this case, FESM000011, marked as Defendants' Exhibit 4686, and then produced amended lists of disputed claims during the course of fact and expert discovery, FESM000344, marked as Defendants' Exhibit 4705; FESM003527, marked as Defendants' Exhibit 4824; FESM020911, marked as Defendants' Exhibit 4978.

WHEREAS, the Plaintiffs' expert witness David Leathers used a fifth amended list of disputed claims for his affirmative report, "FESM020911 – UHC NV ED 2104", marked as Defendants' Exhibit 5140, and a sixth amended list of disputed claims for his supplemental report, "08_24_Disputed_Claims", marked as Defendants' Exhibit 5142.

WHEREAS, on DATE, the Plaintiffs produced a seventh and final amended list of disputed claims, BATES, marked as Plaintiffs' Exhibit #.

WHEREAS, the Defendants dispute liability for the claims identified by the Plaintiffs in Plaintiffs' Exhibit #, but agree that Plaintiffs' Exhibit # contains the operative list of claims in dispute for trial.

WHEREAS, the Defendants served the Expert Report of Bruce Deal on July 30, 2021; the Expert Rebuttal Report of Bruce Deal on August 31, 2021; the Revised Initial Report of Bruce Deal on August 31, 2021; the Expert Rebuttal Report of Bruce Deal to Dr. Joseph T. Crane on September 17, 2021; the Expert Rebuttal Report of Bruce Deal to Dr. Robert Frantz on October 8, 2021; and the Expert Rebuttal Report of Bruce Deal to David Leathers on November 3, 2021 (the "Deal Reports").

WHEREAS, the Plaintiffs served the Expert Report of David Leathers on July 30, 2021 and the Supplemental Expert Report of David Leathers on September 9, 2021.

WHEREAS, the Parties agree that Bruce Deal and David Leathers must revise their expert calculations included in the Deal Reports and the Supplemental Expert Report of David Leathers, respectively, using the data in Plaintiffs' Exhibit #.

1. The Parties hereby agree and stipulate that Plaintiffs' Exhibit # contains the operative list of claims in dispute for trial.

2. The Parties agree that Defendants' expert witness Bruce Deal will amend his expert reports and Plaintiffs' expert witness David Leathers will amend his Supplemental Expert Report, where appropriate, to include revised calculations based on the operative disputed claims list, which is Plaintiffs' Exhibit #.

3. The Parties agree that Defendants' expert witness Bruce Deal and Plaintiffs' expert witness David Leathers will file their amended expert reports by no later than November 10, 2021.

4. The Parties further agree that, when revising their calculations, both Parties' expert

witnesses will use methodologies identical to those contained in the Deal Reports and David Leathers' Supplemental Expert Report, respectively.

5. The Parties agree that their respective expert witnesses will not include any new opinions or new methodologies in their amended expert reports.

6. The Parties agree that the sole purpose of the amended expert reports is to revise the calculations and related exhibits and figures expressing those calculations contained in their respective prior reports using Plaintiffs' Ex. #.

DATED this 5th day of November, 2021.

AHMAD, ZAVITSANOS, ANAIPAKOS, ALAVI & MENSING, P.C

By: /s/ _____

Joseph Y. Ahmad (*Pro Hac Vice*)
John Zavitsanos (*Pro Hac Vice*)
Jason S. McManis (*Pro Hac Vice*)
Michael Killingsworth (*Pro Hac Vice*)
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2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102

DATED this 5th day of November, 2021.

O'MELVENY & MYERS LLP

By: /s/ _____

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Attorneys for Defendants

ORDER

IT IS SO ORDERED that pursuant to the Parties' agreement, the Parties may file amended expert reports from their expert witnesses: Defendants' expert witness Bruce Deal and Plaintiffs' expert witness David Leathers. The Parties will file their amended expert reports by no later than November 10, 2021. The Parties' amended expert reports will not contain new opinions or new methodologies that differ from those contained in their respective prior expert reports. The sole purpose of these amendments is to amend prior calculations to account for changes in the list of disputed claims asserted by Plaintiffs, as reflected in Plaintiffs Ex. #.

DATED this __ day of November, 2021.

Respectfully Submitted by:
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
By: /s/ _____
D. Lee Roberts, Jr. (NSBN 8877)
Colby L. Balkenbush (NSBN 13066)
Brittany M. Llewellyn (NSBN 13527)
Attorneys for Defendants

EXHIBIT 3

EXHIBIT 3

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Sunday, November 7, 2021 7:19 PM
To: Blalack II, K. Lee; Ruth Deres; Michael Killingsworth; Myrna Flores
Cc: Yan, Jason; Plaza, Cecilia; Levine, Adam
Subject: RE: Partially Denied Claim Issue
Attachments: Stipulation and Order (003) KL.DOCX

[EXTERNAL MESSAGE]

Lee,

Here is my suggested edits to the stip.

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Friday, November 5, 2021 4:48 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Ruth Deres <rderes@AZALAW.COM>; Michael Killingsworth <mkillingsworth@AZALAW.COM>; Myrna Flores <mflores@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Levine, Adam <alevine@omm.com>
Subject: FW: Partially Denied Claim Issue

Kevin:

This revised list looks correct to us. We agree that this new exhibit contains the operative list of disputed claims. Accordingly, we think we can try the case based on this list.

The next step here is for our experts (Deal and Leathers) to revise their calculations to reflect this new and final list of disputed claims. As I mentioned in a prior email, I propose that the parties reach agreement on a process and timeline to amend those prior reports in a manner that reduces the possibility of disputes about what the experts are changing based on this final list. To that end, I am attaching a proposed stipulation and order for your consideration. The idea here is that the SAO would identify your new list as the operative list of disputed claims and it would also acknowledge that the parties' experts (Deal and Leathers) need to revise their calculations. It proposes a deadline of Wednesday, November 10th, to complete that process and makes clear that none of the experts can introduce any new opinions or methodologies; instead, they can merely perform the prior calculations in their reports using the final list of disputed claims.

In any event, take a look at the proposed SAO and let me know if this approach is acceptable to you all.

Best. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Friday, November 5, 2021 1:32 PM
To: Blalack II, K. Lee <lblalack@omm.com>
Cc: Ruth Deres <rderes@AZALAW.COM>; Michael Killingsworth <mkillingsworth@AZALAW.COM>; Myrna Flores <mflores@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Thanks Lee.

I gave Leathers the excel version to rerun his analysis and numbers. I've PDF'd this and would like to replace the current P473 with it. I've hidden some of the columns to make it easier to read on computer when zoom in and I"ve added column headings to each page.

Please let me know if you have any objections to this new version of P473.

thanks

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Friday, November 5, 2021 7:24 AM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>
Subject: FW: Partially Denied Claim Issue

Kevin,

My folks reviewed the spreadsheet you sent. There is one claim you've tagged as DiS which was not identified as non-DiS. That claim is Acct # 233718879/526.

Please let me know if you have any questions. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Wednesday, November 3, 2021 2:28 PM
To: Plaza, Cecilia <cplaza@omm.com>; Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Lee/Ceci,

I've added a column to this that tags what I believe are the iSight claims.

Please review and let me know if you have any issues with those designations.

Thanks

From: Plaza, Cecilia <cplaza@omm.com>
Sent: Sunday, October 31, 2021 3:35 PM

To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Kevin,

We have reviewed and did not find any errors in the edits to the charge and CPT columns.

Thanks,
Ceci

Cecilia Plaza
O: +1-212-728-5962
cplaza@omm.com

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Sunday, October 31, 2021 1:55 PM
To: Plaza, Cecilia <cplaza@omm.com>; Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Lee/Ceci,

Here is an updated version of what I consider to be the final. I substituted the net charge (orig – denied) for the Total Charge column; and I also edited the CPT column to remove the denied CPTs.

Please review and let me know if you find any mistakes in either.
.

From: Plaza, Cecilia <cplaza@omm.com>
Sent: Sunday, October 31, 2021 11:05 AM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Kevin,

We have reviewed your list and confirmed that, consistent with our discussions, all the relevant claims have been removed. We are in agreement that this is the final list of disputed claims. Please see attached a spreadsheet reflecting the final list of claims. Note that we deleted the extra columns ("KL delete claim" and "FAIR Health 80th"), renamed a few of the columns for clarity, and deleted the extra tab that shows denied billed charges for each disputed claim. It is otherwise the same as the spreadsheet you sent yesterday.

Thanks,

Ceci

Cecilia Plaza
O: +1-212-728-5962
cplaza@omm.com

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Saturday, October 30, 2021 9:04 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Per this discussion, I've removed those two other claims.

Please have your crew review and let me know if we've now removed all the claims consistent with these discussions.

If we are in agreement, I will produce just the claim file as 29011 (B).

K

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Saturday, October 30, 2021 8:37 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Kevin,

Yes, not to belabor this issue, we will waive an ERISA claim based on partially denied claims if you remove these last two. That would resolve the issue that we raised in our SJ motion. That obviously does not result in waiver of other ERISA arguments that have nothing to do with a partially denied claim (e.g., basic conflict preemption, which is the argument that we presented originally in the case when we removed the case to federal court). We are preserving those other ERISA arguments but the removal of these last two partially denied claims would obviate the ERISA argument stated in our SJ motion.

Thanks. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Saturday, October 30, 2021 11:07 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Hmmm… if there is a 99291, 99292 claim and the 99292 was denied, but the 99291 claim was allowed and I've adjusted the ttl charge to reflect the denied charges, then how is it different than if the denied claim was a 93010 and I removed the denied charge for the 93010?

Regardless, if you are saying you are effectively walking away from ERISA arguments if I remove the 2 claims, then the answer to that riddle is obvious.

So what say you?

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Saturday, October 30, 2021 7:57 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Not unless you are seeking to recover damages for the denied claim lines. The whole point of our proposal was to remove from your damages calculations any claims lines that were denied. If you all do that, and I think you have except for these last two, then it would mean that you are only seeking damages for underpayments of claims that were allowed at an amount less than full charges and you would not be seeking any damages for claim lines that were denied. If that is the case, while I might have other ERISA objections to this entire party, I don't think we would have an argument that you all were seeking to recover damages for a service as to which coverage was denied by my clients. Lee

---

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Saturday, October 30, 2021 6:09 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: Re: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Don't you have the erisa argument in all the other 1700 plus where a non core er code was denied?

Get Outlook for iOS

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Saturday, October 30, 2021 2:49:39 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Thanks Kevin. It looks this resolves all issues but the 2 remaining partially denied claims. I leave it to you all whether you want to keep these last two on your list. But just to be clear, if you leave them on the list, I still have my ERISA objection that there are coverage denials at issue in your damages calculation. If you remove them, I don't. Whether those two claims are worth it to you or not, I leave to your client and your judgment.

Let me know if you all want to stand pat on this list or remove those final two partially denied claims. Once we have the final list, we will send you our understanding of your final list of disputed claims. Perhaps you all can then review that list and confirm that we're in agreement that it is the final list of disputed claims for trial and we

can then enter a stipulation to that effect to help make sure our experts are not ships passing in the night with different disputed claims.

Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Saturday, October 30, 2021 1:40 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Honest Abe, here is where I am.

I've noted all but the 2 (with 99291 allowed) should come out. And that's bc those partial denials are no different than all the others where a core EM line was not denied.

So now its your turn to say, ok we're there.

K

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Friday, October 29, 2021 8:25 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

I cannot tell a lie . . .

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Friday, October 29, 2021 11:07 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: Re: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

The question is clear.

Get Outlook for iOS

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Friday, October 29, 2021 8:02:22 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Now, do I need to swear I wrote it all by myself? If not, I have my pinky ready to go . . .

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Friday, October 29, 2021 10:54 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: Re: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Lee,

If you pinky swear that you wrote this email, I will give further consideration to your requests.

Get Outlook for iOS

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Friday, October 29, 2021 6:18:10 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Kevin,

Thanks for pulling this revised list together. We have reviewed your comments.

You identified 5 claims (rows 5, 8, 9, 13, and 14) which were part of the original 17 claims you noted that appeared to be allowed, but denied. As previously stated, these claims were denied in full. For all 17 of these claims, including the 5 you identified in your most recent spreadsheet, we reviewed PRAs, EOBs, or disallowed reason codes and confirmed that they were denied in full. Based on our review of your spreadsheet, it appears that TeamHealth may have recorded an allowed amount for these claims due to an amount being paid by the patient or simply due to error. Indeed, for most of these 5 claims, the allowed amount corresponds exactly to the amount of the patient deductible noted in your spreadsheet.

You also identified 2 claims with an ED CPT code that were not denied. We agree that these were not denied in full, but they were partially denied. You noted in row 11,508 that the 99291 claim line was still at issue, which is correct, but the 99292 claim line on that same claim was denied. Likewise, you noted in row 11,083 that the 99291 claim line was still at issue. Again, that is correct, but the 99292 claim line on that same claim was denied. So, these 2 claims are just like all of the other partially denied claims about which we have been conferring – there is a line on the claim that was paid and a line on the claim that was denied. The ERISA defense and issue we are raising does not turn on whether the denied claim line was an ER service or a non-ER service. It turns on whether the claim was fully approved and payable or whether the claim contains some claim lines that were denied as not covered and not payable. These two claims fall into that category. Let me know if you all see the data differently.

Finally, there are still 9 CollectRx resolved claims on this list (rows 11585 to 11594) which should be removed based on our prior discussion. Please let me know if you all see those 9 Collect Rx claims differently.

If we can reach agreement on these last group of claims, then I think we have a final list of disputed claims for trial and we can have our respective experts update their analysis based on this final list. Thanks. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Thursday, October 28, 2021 4:42 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Couple of issues with a few, but I think we are very close. Please review and let me know.

K

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Monday, October 25, 2021 8:07 PM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

Kevin,

Per your request, we have added a column (AD) to the spreadsheet showing the CPT codes for the denied charges. Please see attached.

Regarding the 18 account numbers in Bruce Deal's work papers: We have removed those from the list. In the initial spreadsheet, these claims were marked as denied but with denied charges of $0. It appears that either TeamHealth is not disputing the billed charges associated with the denied lines, or those line items were re-adjudicated later and United allowed some amount.

Regarding the 17 claims which appear to be denied in full: These claims are recorded as denied in full in Defendants' claims data. We have reviewed the denial reasons for these claims and they were indeed denied in full. While TeamHealth recorded an allowed amount for these claims, there is no corresponding allowed amount in Defendants' claims data. It is possible that the allowed amount recorded by TeamHealth was paid by the patient or a different payor; was recorded in error; or was the result of a claim initially being allowed but later reversed and denied.

Please let me know if you have further questions. Thanks. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Sunday, October 24, 2021 2:18 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: RE: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Also, I note that the following 17 records, using your denied charges, suggest that the claim was denied in full, but if every one of them has an allowed amount, so that doesn't make sense to me.

DOS	ACCOUNT #	BILLED CPT (BUNDLED)	TOTAL CHARGE	CHARGE F	ALLOW	Lee Denie	Lee Denied Charge
7/12/2019	243523324/526	99283	510.00	-	185.00	Y	$510
7/31/2019	244445501/526	99283	508.00	-	185.00	Y	$508
11/21/2019	253083102/526	99283*X0066	508.00	-	112.44	Y	$508
10/19/2019	267845844/526	99284:SA*99053	1,019.00	-	214.51	Y	$1,019
6/27/2019	242549357/526	99284*99053	1,019.00	-	185.00	Y	$1,019
12/30/2019	256501044/526	99284	973.00	-	214.51	Y	$973
4/30/2019	238092469/526	99284	973.00	-	185.00	Y	$973
11/22/2019	260379513/526	99285:SA*99053:SA	1,474.00	-	315.25	Y	$1,474
1/14/2020	256857574/526	99285*99053	1,474.00	-	185.00	Y	$1,474
9/14/2019	247949711/526	99285	1,428.00	-	315.25	Y	$1,428
1/12/2020	256663800/526	99285	1,428.00	-	185.00	Y	$1,428
5/30/2019	240602924/526	99285	1,421.00	-	185.00	Y	$1,421
6/9/2018	214814153/526	99285:SA	1,360.00	-	315.25	Y	$1,360
7/15/2018	217423278/526	99285:SA	1,360.00	-	841.75	Y	$1,360
1/10/2020	256617535/526	99285	1,360.00	-	185.00	Y	$1,360
7/24/2019	244028178/471	99285:SA	1,138.00	-	368.78	Y	$1,138
8/3/2019	246698881/526	99291*99053	1,899.00	-	185.00	Y	$1,899

From: Blalack II, K. Lee <lblalack@omm.com>
Sent: Sunday, October 24, 2021 11:42 AM
To: Kevin Leyendecker <kleyendecker@AZALAW.COM>; Louis Liao <lliao@AZALAW.COM>
Cc: Yan, Jason <jyan@omm.com>; Plaza, Cecilia <cplaza@omm.com>
Subject: RE: Partially Denied Claim Issue

Kevin,

We have now had the opportunity to review the spreadsheet that you sent on Thursday to address our objections to the disputed claims that contain coverage denials. Thanks to you all for taking a crack at solving this problem but, unfortunately, your proposed method of removing the denied claim lines doesn't solve the problem. Your approach assumes that all the primary ED CPT codes on these claims were allowed and paid, while all the secondary CPT codes were denied. This creates two problems: First, this approach excludes claim lines with secondary CPT codes that were allowed and paid. Second, this approach includes claim lines with ED CPT codes which were denied. It is therefore both over- and under-inclusive.

I want to propose an alternative way to solve the problem. We have prepared a spreadsheet that flags the denied claims (see attached spreadsheet column AB) and lists the amount of charges that were denied for each claim (see column AC). This spreadsheet accurately captures the charges actually denied for each claim. This method thus targets narrowly the issue of partial denials. It does not remove any claim lines that were paid and it removes all claim lines that were denied. Please share this analysis with Mr. Leathers and your broader team and let me know if they have any questions and, if they do, we would be willing to put our experts together with your experts to get aligned on this problem. If you all are willing to remove the denied claim lines from your damages analysis, which would be consistent with the position that your colleague communicated to Judge Allf at the hearing on our summary judgment motion last week, then I think this will resolve our objection about the partially denied claims on the disputed claims list.

By the way, please note that this spreadsheet already removes the claims conceded in Plaintiffs' opposition to Defendants' motion for partial summary judgment (i.e., UHC and UMR claims with a Jan 2020 DOS, claims resolved through negotiated agreements with DiS, the non-ER claims identified by Mr. Leathers for removal, and the 10 additional Data iSight claims about which we corresponded previously).

Best. Lee

From: Kevin Leyendecker <kleyendecker@AZALAW.COM>
Sent: Thursday, October 21, 2021 5:56 PM
To: Blalack II, K. Lee <lblalack@omm.com>; Louis Liao <lliao@AZALAW.COM>
Subject: Partially Denied Claim Issue

[EXTERNAL MESSAGE]

Lee, see enclosed. Per my text, I've added three columns to FESM 20911 (B) for the purpose of isolating the partially denied claims and once identified, extracting the core EM cpt so that when assessed for damages, column M (CPT FOR TRIAL (KL)) and column O (CHARGES FOR TRIAL (KL)) , will result in the same damage number regardless of whether that claim is measured against a bundled or unbundled cpt source file.

Also, I'm waiting to hear back from Louis as to the other 10 iSight claims. If we agree, those will come out to.

Expert will have to do math as well to see if they get same result and will also have to set the data in the "charge for trial column.

Let me know what you (Deal) thinks of this approach to resolving your concern that we are seeking damages for the denied claim lines associated with the bills that had a denied claim line.

K

Disclaimer

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

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

STIPULATION AND ORDER REGARDING REVISING THE PARTIES' EXPERT REPORTS USING THE FINAL DISPUTED CLAIMS LIST

vs.

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

Defendants.

Plaintiffs Fremont Emergency Services (Mandavia), Ltd; Team Physicians of Nevada-Mandavia, P.C.; Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine (collectively "Plaintiffs") and Defendants UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Sierra Health and Life Insurance Company, Inc.; and Health Plan of Nevada, Inc. (collectively "Defendants"), referred to individually as a "Party" or collectively as the "Parties," stipulate and agree to the following:

WHEREAS, the Plaintiffs produced an initial list of disputed claims in this case, FESM000011, marked as Defendants' Exhibit 4686, and thereafter produced various amended lists of disputed claims.

WHEREAS, following the parties' joint efforts to confer and remove certain claims from the various lists produced to date, Plaintiffs produced a final amended list of disputed claims (FESM 000291 (B), marked as Plaintiffs' Exhibit 473.

WHEREAS, the Defendants dispute liability for the claims identified by the Plaintiffs in Plaintiffs' Exhibit 473, but agree that Plaintiffs' Exhibit 473 contains the operative list of claims in dispute for trial.

WHEREAS, the Parties' experts previously produced reports based on prior versions of the operative disputed claim file.

WHEREAS, the Parties agree that their respective experts (Bruce Deal for Defendants and David Leathers for Plaintiffs should revise their analysis and calculations using the final claims data reflected in Plaintiffs' Exhibit 473.

THEREFORE, THE PARTIES AGREE AND STIPULATE AS FOLLOWS:

1. Plaintiffs' Exhibit 473 contains the operative list of claims in dispute for trial and shall be admitted into evidence for all purposes.

2. The Parties' respective experts (Defendants' expert witness Bruce Deal will and Plaintiffs' expert witness David Leathers) will amend their reports where appropriate to include revised calculations based on the operative disputed claims list reflected in Plaintiffs' Exhibit 473.

3. The Parties will exchange such amended reports by _____.

4. When revising their reports, both Parties' experts will use the same methodologies as those contained in their prior reports.

DATED this 5th day of November, 2021.

AHMAD, ZAVITSANOS, ANAIPAKOS, ALAVI & MENSING, P.C

By: /s/ _____
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John Zavitsanos (*Pro Hac Vice*)
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DATED this 5th day of November, 2021.

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Attorneys for Defendants

ORDER

IT IS SO ORDERED that pursuant to the Parties' agreement, the Parties may file amended expert reports from their expert witnesses: Defendants' expert witness Bruce Deal and Plaintiffs' expert witness David Leathers. The Parties will file their amended expert reports by no later than November 10, 2021. The Parties' amended expert reports will not contain new opinions or new methodologies that differ from those contained in their respective prior expert reports. The sole purpose of these amendments is to amend prior calculations to account for changes in the list of disputed claims asserted by Plaintiffs, as reflected in Plaintiffs Ex. #.

DATED this __ day of November, 2021.

Respectfully Submitted by:
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
By: /s/ _____
D. Lee Roberts, Jr. (NSBN 8877)
Colby L. Balkenbush (NSBN 13066)
Brittany M. Llewellyn (NSBN 13527)
Attorneys for Defendants

EXHIBIT 4

EXHIBIT 4

138 Nev., Advance Opinion 17

IN THE SUPREME COURT OF THE STATE OF NEVADA

BARRY JAMES RIVES, M.D.; AND LAPAROSCOPIC SURGERY OF NEVADA, LLC,
Appellants/Cross-Respondents,
vs.
TITINA FARRIS; AND PATRICK FARRIS,
Respondents/Cross-Appellants.

No. 80271

BARRY JAMES RIVES, M.D.; AND LAPAROSCOPIC SURGERY OF NEVADA, LLC,
Appellants,
vs.
TITINA FARRIS; AND PATRICK FARRIS,
Respondents.

No. 81052

Consolidated appeals and a cross-appeal from a district court judgment in a medical malpractice action and a post-judgment order awarding attorney fees and costs. Eighth Judicial District Court, Clark County; Joanna Kishner, Judge.

Reversed in part, vacated in part, and remanded.

Lemons, Grundy & Eisenberg and Robert L. Eisenberg, Reno,
for Appellants/Cross-Respondents.

Claggett & Sykes Law Firm and Micah S. Echols, Las Vegas; Hand & Sullivan, LLC, and George F. Hand, Las Vegas; Bighorn Law and Kimball J. Jones and Jacob G. Leavitt, Las Vegas,
for Respondents/Cross-Appellants.

22-09994

BEFORE THE SUPREME COURT, EN BANC.

OPINION

By the Court, CADISH, J.:

Appellants appeal from a $6 million judgment, challenging several evidentiary rulings they claim warrant reversal and remand for a new trial. Respondents assert that because appellants did not move for a new trial in district court, they waived the issues, such that their assignments of error on appeal cannot provide the basis for a new trial. Respondents fail to present a convincing argument that the procedural bars they claim prohibit our review on the merits apply here. The plain language of our jurisdictional rules confirms that appellants are not required to file a motion for a new trial in district court to preserve their ability to request a new trial on appeal. As to the merits of appellants' claims, we conclude that the district court abused its discretion by admitting evidence of another medical malpractice case against appellant Barry James Rives, M.D., as that evidence was not relevant for an admissible purpose, and any potential relevance was substantially outweighed by the evidence's fairly obvious prejudicial effect. As this evidentiary ruling was harmful, we reverse the judgment, vacate the attorney fees and costs order, and remand for a new trial.

FACTS AND PROCEDURAL HISTORY

Respondent Titina Farris suffered from back pain with pain and burning in her feet. She was diagnosed with uncontrolled diabetes causing neuropathy. In 2014, Farris was referred to appellant Barry James Rives, M.D., for swelling in her upper abdomen. Rives diagnosed Farris with a hernia, which he surgically repaired on two occasions, first in 2014

and second in 2015. During the second surgery, Rives noticed that part of Farris's colon was stuck in the mesh from the 2014 surgery. Rives freed the colon from the mesh; however, he caused two small holes in the colon, which he repaired with a stapling device. Farris had several problems following the 2015 surgery, including sepsis. Although a CT scan on July 5 and an x-ray on July 12 showed no signs of a leak in Farris's colon, a CT scan on July 15 showed a leak, which another surgeon corrected. But Farris's sepsis continued, and she eventually developed drop foot in both feet, hindering her ability to walk unassisted. Farris and her husband, respondent Patrick Farris (collectively "respondents"), filed this medical malpractice lawsuit against Rives and appellant Laparoscopic Surgery of Nevada LLC (collectively "appellants"), alleging that Rives fell below the standard of care in performing the surgery and monitoring Farris after, that Laparoscopic Surgery of Nevada LLC was vicariously liable for Rives's actions, and for loss of consortium.

In an unrelated matter, another patient, Vickie Center, sued Rives for malpractice related to her hernia surgery, which took place five months before Farris's surgery. The same defense firm represented Rives in both the *Farris* and *Center* cases. In the *Center* case, Rives responded to an interrogatory that asked him to provide information concerning other lawsuits in which he was involved. One month later, Rives responded to a similar interrogatory request in the *Farris* case, and his attorney copied the interrogatory responses from the *Center* case without adding the *Center* case to the list of other suits.

Respondents' counsel deposed Rives. At the deposition, counsel asked questions regarding the other cases Rives disclosed in his interrogatory response. Rives's responses did not mention the *Center* case,

but defense counsel interjected with information about that case. Rives was then asked several questions regarding the *Center* case, and respondents' counsel discussed the *Center* case with Center's counsel "weeks to months before the trial in" the *Center* case started.

Before the trial in this matter, respondents filed a pretrial motion for sanctions, contending that Rives intentionally concealed the *Center* case. Respondents asserted that they "had no reasonable opportunity to further investigate this critical and admissible information" and requested that the district court strike appellants' answer. Appellants opposed, arguing that the omission was accidental and there was no prejudice to respondents. They also argued that the *Center* case was not admissible, as it was irrelevant, unduly prejudicial, misleading to the jury, and improper character evidence.

The district court held an evidentiary hearing on the motion, at which Rives testified that he relied on his counsel to prepare the interrogatory responses in the *Farris* case and conceded that he did not read them. The district court concluded that Rives "relied on counsel" to prepare the interrogatory responses and, thus, had "an intent not to read the interrogatories," which the court considered "intentional conduct" warranting an adverse-inference instruction.[1] While the district court

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[1]Ultimately, the district court read the following adverse-inference instruction before the opening statements and at the end of trial:

> Members of the jury, Dr. Barry Rives was sued in a medical malpractice case in case *Vickie Center v. Barry James Rives, M.D., et al.* Dr. Barry Rives was asked about the *Vickie Center* case under oath, and he did not disclose the case in his interrogatories or at his deposition. You may infer

permitted respondents to introduce evidence of the *Center* case, it did not make an express ruling on its admissibility until trial.

At trial, respondents mentioned the *Center* case roughly 180 times in front of the jury. Appellants objected several times, on various grounds, including that the evidence was irrelevant and that the danger of unfair prejudice, confusion of the issues, or misleading the jury substantially outweighed the probative value of the *Center* case. While the district court sustained some objections, it often allowed respondents to point to the *Center* case in making arguments or questioning witnesses. Respondents used the *Center* case to imply that Rives should have known his behavior was negligent and hinted that Rives had a propensity to commit malpractice. Respondents elicited that Vickie Center lost her legs because of Rives's actions. The district court allowed an extended examination of Rives regarding whether he informed Center's counsel of the specifics of the *Farris* case and the extent of Vickie Center's similar injuries. Respondents also mentioned the *Center* case in their closing argument.

The jury returned its verdict, concluding that Rives negligently treated Farris, causing her injuries, and awarding respondents $13,640,479.90 in total damages. The district court reduced the jury's award of noneconomic damages to $350,000 pursuant to NRS 41A.035 and entered a judgment for a total of $6,367,805.52. The district court granted in part respondents' motion for attorney fees and costs, awarding

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> that the failure to timely disclose evidence of a prior medical malpractice lawsuit against Dr. Barry Rives is unfavorable to him. You may infer that the evidence of the other medical malpractice lawsuit would be adverse to him in this lawsuit had he disclosed it. This instruction is given pursuant to a prior [c]ourt ruling.

$821,468.66 consistent with NRCP 68 and NRS 7.095, or alternatively, as a sanction for Rives's discovery behavior. Appellants appeal from the judgment and the attorney fees and costs award, while respondents cross-appeal from the judgment to contest the district court's application of NRS 41A.035.

DISCUSSION

Appellants did not waive their right to seek reversal and remand for a new trial on appeal by not filing a motion for a new trial in district court

Appellants assert that the district court committed evidentiary errors warranting reversal and remand for a new trial. Respondents argue that by failing to file a motion for a new trial in district court, appellants waived their ability to request a new trial on appeal. Respondents contend that the failure to seek a new trial in district court deprives the court of the chance to consider and correct any errors and prevents this court from "conduct[ing] a proper review of whether the [d]istrict [c]ourt properly or improperly granted a new trial because there is no appealable order to review." They further argue that appellants "ask this Court to review, in the first instance, their arguments for a new trial, which contain factual issues and would convert this Court into a factfinder." We disagree.[2]

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[2]Relying on *Rust v. Clark County School District*, 103 Nev. 686, 747 P.2d 1380 (1987), respondents also argue that we lack jurisdiction to consider appellants' challenges to the district court's oral evidentiary rulings made at trial. In *Rust*, we held the following:

> An oral pronouncement of judgment is not valid for any purpose. therefore, only a written judgment has any effect, and only a written judgment may be appealed. The district court's oral pronouncement from the bench, the clerk's minute order, and even

While we have not explicitly addressed whether a party must both object to trial rulings and file a motion for a new trial to preserve the party's ability to request a new trial on appeal, the plain language of our jurisdictional rule and the preserved error rule make it clear that a party is not required to file a motion for a new trial to preserve the party's ability to request such a remedy on appeal for harmful error to which the party objected. First, NRAP 3A(a) expressly provides that "[a] party who is aggrieved by an appealable judgment or order may appeal from that judgment or order, with or without first moving for a new trial." The rule thus contemplates this very situation. Second, it is well-established that a timely objection alone is sufficient to raise and preserve an issue for appellate review. *See Thomas v. Hardwick*, 126 Nev. 142, 155, 231 P.3d 1111, 1120 (2010) (concluding that when a trial court properly declines to

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> an unfiled written order are ineffective for any purpose and cannot be appealed.

Id. at 689, 747 P.2d at 1382 (internal citations omitted). However, *Rust* dealt with a premature notice of appeal filed prior to the district court entering a written, final judgment and is plainly inapplicable here, where appellants are appealing from a final, written judgment. *Cf. Consol. Generator-Nev., Inc. v. Cummins Engine Co.*, 114 Nev. 1304, 1312, 971 P.2d 1251, 1256 (1998) (explaining that this court will review interlocutory decisions that "are not independently appealable" in an appeal from a final judgment). Moreover, NRS 47.040 provides both the authority and framework for addressing alleged error in evidentiary rulings, depending on whether a party preserved error through objection, as we have recognized in various cases. *See, e.g., Rimer v. State*, 131 Nev. 307, 332, 351 P.3d 697, 715 (2015) (explaining that a party preserves a claim of error by objecting and stating the grounds for the objection at trial); *In re J.D.N.*, 128 Nev. 462, 468-69, 283 P.3d 842, 846-47 (2012) (observing that the scope of review depends on whether a party preserved error by objecting to the admission of evidence). Thus, we have the ability to review appellants' evidentiary challenges, and nothing in *Rust* precludes our review.

give a definitive ruling on a pretrial motion, the contemporaneous objection rule requires the party to object at trial in order to preserve its argument on appeal); *Landmark Hotel & Casino, Inc. v. Moore*, 104 Nev. 297, 299, 757 P.2d 361, 362 (1988) ("[F]ailure to object to a ruling or order of the court results in waiver of the objection and such objection may not be considered on appeal."); *see also* NRS 47.040(1)(a) (requiring "a timely objection or motion to strike . . . stating the specific ground of objection" to preserve the issue for appeal); *cf. In re J.D.N.*, 128 Nev. 462, 468, 283 P.3d 842, 846 (2012) (explaining that a party preserves a claim of error by objecting and stating the grounds for the objection at trial). Taken together, these authorities make clear that a party need not file a motion for a new trial to raise a preserved issue on appeal or request a new trial as a remedy for alleged errors below. Such a holding is consistent with both the federal approach and our past decisions considering a preserved error without the appellant having moved for a new trial below.[3] *See, e.g.*, *Richardson v. Oldham*, 12 F.3d 1373, 1377 (5th Cir. 1994) ("Filing a Rule 59 motion is not a prerequisite to taking an appeal . . . ."); *Floyd v. Laws*, 929 F.2d 1390, 1400-01 (9th Cir. 1991) ("A question raised and ruled upon need not be raised again on a motion for a new trial to preserve it for review.");

---

[3]While NRAP 3A(a) does not require a party move for a new trial prior to bringing an appeal, we note that there are several practical benefits to doing so. First, it allows the district court to correct alleged errors, which allows for the prompt resolution of a case without potentially unnecessary appellate litigation. Second, it develops a better record for appellate review as the parties crystalize their arguments while giving the district court an opportunity to fully articulate the reasoning for its evidentiary rulings. Thus, while not required, moving for a new trial prior to pursuing an appeal provides distinct benefits that litigants should consider prior to bringing an appeal.

LaBarbera v. Wynn Las Vegas, LLC, 134 Nev. 393, 398, 422 P.3d 138, 142 (2018) (concluding the district court abused its discretion by excluding certain pieces of evidence and remanding for a new trial without mentioning whether the appellant filed a motion for a new trial before pursuing the appeal).

Respondents' contrary arguments are not persuasive, as the Nevada cases on which they rely are either inapposite or distinguishable. Neither *Old Aztec Mine, Inc. v. Brown*, 97 Nev. 49, 623 P.2d 981 (1981), nor *Schuck v. Signature Flight Support of Nevada, Inc.*, 126 Nev. 434, 245 P.3d 542 (2010), require a motion for a new trial as a prerequisite to filing an appeal regarding an otherwise preserved error. In *Old Aztec*, this court declined to consider the appellant's argument regarding its counterclaim because it failed "to direct the trial court's attention to its asserted omission to mention the counterclaim expressly in its judgment." 97 Nev. at 52-53, 623 P.2d at 983-84. It thus determined that the waiver doctrine rendered the claim of unpreserved error unreviewable. In *Schuck*, the appellant challenged summary judgment by raising several new legal arguments, which this court refused to consider for the first time on appeal. 126 Nev. at 436-38, 245 P.3d at 544-45. Neither case addressed whether a motion for a new trial is required to preserve a claim of error for appellate review. Further, the cases from other jurisdictions to which respondents point are factually dissimilar in that the appellants either failed to preserve their appellate arguments with timely objections at trial or the jurisdictions, unlike Nevada, have procedural rules requiring a new trial motion before appealing. *See, e.g., State v. Davis*, 250 P.2d 548, 549 (Wash. 1952) (concluding that the appellant, who failed to object at the time the prejudicial conduct occurred or to preserve the issue raised on appeal in any

way, waived his argument, while observing that a new trial motion gives "the trial court an opportunity to pass upon questions not before submitted for its ruling" without addressing whether the appellant would be required to seek a new trial if he had objected to the prejudicial conduct during trial); *Spotts v. Spotts*, 55 S.W.2d 977, 980 (Mo. 1932) (applying a Missouri statute in concluding that appellant must object and file a new trial motion to preserve a "writ of error" challenge to a jury verdict). Accordingly, appellants did not need to move for a new trial below to raise preserved issues on appeal or to request a new trial as an appellate remedy for those alleged errors.[4]

The district court abused its discretion by allowing evidence of the Center *malpractice case, and the error is not harmless*

Appellants argue that the district court abused its discretion in admitting evidence of the *Center* case because that evidence is irrelevant, since an unrelated, prior medical malpractice suit does not address whether Rives's conduct in this specific case fell below the applicable standard of care. They further contend that the *Center* case evidence, even if relevant,

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[4]Respondents' remaining arguments on this issue are without merit. They conflate the abuse-of-discretion standard of review that applies to an order granting or denying a motion for a new trial with the appellate remedy of a new trial for harmful error. *See* NRCP 61 (addressing correction of errors that affect the party's substantial rights at all stages of the proceeding). Although they point out that there is no "order to review," appellants did not file a motion for a new trial, and thus, this court is not tasked with determining whether the district court abused its discretion by denying a motion for a new trial. Instead, appellants seek our review in evaluating whether the district court erred by admitting or excluding several pieces of evidence and whether those errors, preserved by timely objections, are harmful. Similarly, respondents' argument that appellants seek to "convert this Court into a factfinder" is misplaced, as this court is merely conducting routine error analysis of several evidentiary rulings.

is inadmissible because the danger of unfair prejudice, confusing the issues, or misleading the jury substantially outweighs its probative value. We agree.

Generally, relevant evidence is admissible, while irrelevant evidence is not admissible. NRS 48.025. Evidence is relevant if it "ha[s] any tendency to make the existence of any fact . . . of consequence . . . more or less probable than it would be without the evidence." NRS 48.015. However, relevant "evidence is not admissible if its probative value is substantially outweighed by the danger of unfair prejudice, of confusion of the issues or of misleading the jury." NRS 48.035(1). While evidence of a doctor's other acts is inadmissible to show propensity, such evidence "may . . . be admissible for other purposes," such as to show "absence of mistake or accident." NRS 48.045(2).

Reviewing for an abuse of discretion, *Hansen v. Universal Health Servs. of Nev., Inc.*, 115 Nev. 24, 27, 974 P.2d 1158, 1160 (1999), we conclude that respondents did not present evidence regarding the *Center* case for an admissible, relevant purpose, and thus it should have been excluded. While respondents argue that the case is relevant to establish that Rives's actions would cause foreseeable harm, the fact that Rives was sued or acted inconsistently with the standard of care in a prior case does not make it more or less probable that he acted below the standard of care in *this* case. *See Stottlemyer v. Ghramm*, 597 S.E.2d 191, 194 (Va. 2004) (affirming district court's exclusion of evidence of the doctor-defendant's past medical malpractice suits because "[e]vidence that a defendant was negligent on a prior occasion simply has no relevance or bearing upon whether the defendant was negligent during the occasion that is the subject of the litigation"); *cf. Mitchell v. Eighth Judicial Dist. Court*, 131 Nev. 163,

174-75, 359 P.3d 1096, 1103-04 (2015) ("Of legal consequence to a medical malpractice claim is whether the practitioner's conduct fell below the standard of care, not why. Put another way, [plaintiff] wins if she shows that [the practitioner's] misadministration of the anesthetic fell below the standard of care and caused [the victim's] injuries; legally, [the practitioner's] diminished capacity doesn't matter." (emphases and citation omitted)). Thus, the alleged foreseeability of the harm is not relevant in this kind of case, aside from the establishment of the standard of care through experts. *See Rees v. Roderiques*, 101 Nev. 302, 304, 701 P.2d 1017, 1019 (1985) ("The standard of care to be applied in a medical malpractice case is to be established by the testimony of expert witnesses with knowledge of the prevailing standards.").

Even if the *Center* case evidence had been offered for an admissible purpose, we conclude the district court abused its discretion in admitting the evidence and allowing it to be presented so extensively because the danger of unfair prejudice, confusing the issues, or misleading the jury substantially outweighed the probative value of that evidence. The *Center* case is somewhat factually similar to this case, but it arises from a different surgery on a different patient on a different day with different consequences. Introduction of such evidence injects a collateral matter into appellants' trial that would likely confuse the jury. *See Hansen*, 115 Nev. at 27-28, 974 P.2d at 1160 (affirming a district court's exclusion of a report containing brief descriptions of medical complications experienced by the doctor-defendant's patients who underwent the same surgery as the plaintiff because "injecting these other cases into [the plaintiff's] trial would prolong the trial, confuse the issues and divert the jury from [the plaintiff's] case to collateral matters"); *see also Kunnanz v. Edge*, 515 N.W.2d 167, 171

(N.D. 1994) ("The purpose of [plaintiffs'] proffered evidence was to show that [defendant] was negligent in treating [a third party]. However, that evidence was not admissible to show that [defendant] was negligent in treating [plaintiff], and its introduction would have injected a collateral matter into this trial and confused the jury."). Further, in addressing whether appellants should be sanctioned for intentional concealment of the *Center* case, respondents acknowledged that they thought the case was useful to show propensity when they stated that appellants "didn't want us to know what [Rives] knew, what his knowledge level was. [Appellants] didn't want us to know that he had gone through this exact same thing, had the same opportunity to make good decisions and protect this patient but failed to do so." Nevada law precludes admitting evidence for propensity purposes.[5] NRS 48.045(2) (prohibiting use of other wrongs or acts to prove a person's character or to show the person acted in conformity therewith); *Bongiovi v Sullivan*, 122 Nev. 556, 574, 138 P.3d 433, 447 (2006) (holding that prior bad-acts evidence is inadmissible to prove propensity); *see also Bair v. Callahan*, 664 F.3d 1225, 1229 (8th Cir. 2012) (concluding that evidence of prior malpractice is inadmissible under Federal Rule of Evidence (FRE) 404, which prohibits evidence of a person's character to prove that on a particular occasion the person acted in accordance therewith, because it allows the jury to infer the doctor has a propensity for

[5]This opinion does not concern the exception to this rule in NRS 48.045(3), which "permits the district court to admit evidence of a separate sexual offense for purposes of proving propensity in a sexual offense prosecution" so long as that evidence is relevant, proven by a preponderance of the evidence, and the danger of unfair prejudice does not substantially outweigh the probative value of the evidence. *Franks v. State*, 135 Nev. 1, 2, 432 P.3d 752, 754 (2019).

negligence); *Lai v. Sagle*, 818 A.2d 237, 247 (Md. 2003) ("[S]imilar acts of prior malpractice litigation should be excluded to prevent a jury from concluding that a doctor has a propensity to commit medical malpractice.").

Respondents' arguments to the contrary are unpersuasive. First, they argue "that bias is a relevant inquiry into the *Center* case" but fail to explain—here or below—how a prior medical malpractice case shows that the doctor-defendant is biased. Thus, we need not consider this argument. *See Edwards v. Emperor's Garden Rest.*, 122 Nev. 317, 330 n.38, 130 P.3d 1280, 1288 n.38 (2006) (explaining that this court will not consider claims unsupported by cogent argument and relevant authority). Second, they argue that the *Center* case is admissible under NRS 48.045(2) as modus operandi evidence. However, modus operandi is a narrow exception typically applied in criminal cases when there is a question regarding the defendant's identity and a defendant has committed prior offenses in the same unique way that would establish he is the offender in the present case. *See Rosky v. State*, 121 Nev. 184, 197, 111 P.3d 690, 698 (2005) (holding that the district court abused its discretion by admitting evidence of the defendant's prior bad acts as modus operandi evidence because the defendant's identity was not at issue during the trial). Here, it appears respondents argue that the modus operandi exception applies to show Rives's negligent surgical techniques, which is an inadmissible propensity use of the evidence, as it encourages the jury to infer from Rives's prior act that Rives has a propensity to commit medical malpractice; clearly, there was no question about Rives's identity here.[6]

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[6]At oral argument before this court, respondents asserted that the evidence of the *Center* case was admissible for impeachment purposes. But we need not consider this argument, as it was raised for the first time at

Further, respondents' arguments to the contrary notwithstanding, the *Center* case evidence is not admissible to show knowledge. The knowledge exception is typically applied to refute, among other things, a defendant's claim that he was unaware of the illegality of his conduct, not that he was aware his professional actions were negligent on an earlier occasion, and thus, he knew he could potentially injure another party in rendering similar professional services. *See, e.g., Fields v. State*, 125 Nev. 785, 792, 220 P.3d 709, 714 (2009) (explaining that a defendant's "knowing participation in prior bad acts with" coconspirators may be used to refute the defendant's claim that he was an unwitting or innocent bystander to the crime); *Cirillo v. State*, 96 Nev. 489, 492, 611 P.2d 1093, 1095 (1980) (concluding that "evidence of previous instances of [drug] possession may be used to show the defendant's knowledge of the controlled nature of a substance, when such knowledge is an element of the offense charged"); *see also United States v. Vo*, 413 F.3d 1010, 1019 (9th Cir. 2005) (concluding that the defendant's prior conviction for drug trafficking was admissible under FRE 404(b) because it "was evidence of his knowledge of drug trafficking and distribution in general" and "tended to show that [the defendant] was familiar with distribution of illegal drugs and that his actions in this case were not an accident or a mistake"). Moreover, other jurisdictions that addressed this issue have concluded that prior medical

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oral argument. *See State ex rel. Dep't of Highways v. Pinson*, 65 Nev. 510, 530, 199 P.2d 631, 641 (1948) ("The parties, in oral arguments, are confined to issues or matters properly before the court, and we can consider nothing else . . . ."). Even if we consider this argument, however, the numerous times respondents mentioned the *Center* case and the scope of what was mentioned far exceeded what would have been permissible for impeachment purposes.

malpractice suits do not fall within the knowledge exception, and we find their reasoning persuasive. *See, e.g., Bair*, 664 F.3d at 1229 (rejecting the appellant's argument that the doctor's past treatment of other patients is admissible to show the doctor did not know how to properly carry out the surgery because that "is not the kind of 'knowledge' Rule 404(b) contemplates," as the doctor "had the knowledge to perform the surgery" due to his training and the appellant's evidence allows the jury to infer the defendant "had a propensity to commit malpractice" (internal quotation marks omitted)).

Because the *Center* case was mentioned over 180 times during trial, including details of how the patient went septic and her legs were amputated, similar to—but worse than—the injuries suffered by Farris, the error in admitting it was not harmless. Rather, the evidence had no probative value, drew the jury's attention to a collateral matter, and likely led to the jury drawing improper conclusions about Rives's propensity to commit malpractice, unfairly prejudicing him.[7] *See Bongiovi*, 122 Nev. at

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[7]While the district court may have correctly determined that Rives's discovery behavior warranted sanctions, it nonetheless abused its discretion by giving an adverse-inference instruction. *See Bass-Davis v. Davis*, 122 Nev. 442, 447-48, 134 P.3d 103, 106 (2006) (reviewing a district court's decision to give an adverse-inference instruction for an abuse of discretion). As discussed above, the *Center* case evidence was inadmissible, and a district court may not admit otherwise inadmissible evidence as a discovery sanction. *See* NRS 48.025(2) ("Evidence which is not relevant is not admissible."); NRS 48.035(1) (providing that otherwise relevant evidence is not admissible if the danger of unfair prejudice substantially outweighs the evidence's probative value). Further, an adverse inference instruction is appropriate when evidence is lost or destroyed. *See Bass-Davis*, 122 Nev. at 448-49, 134 P.3d at 106-07. Here, the evidence was not lost or destroyed, and Farris presented details regarding the *Center* case at trial. Accordingly, the adverse inference instruction was improper.

575, 138 P.3d at 447 (explaining that evidence is inadmissible if the danger of unfair prejudice substantially outweighs the evidence's probative value). Thus, we reverse the district court's judgment and remand for a new trial.[8] *See Khoury v. Seastrand*, 132 Nev. 520, 539, 377 P.3d 81, 94 (2016) (concluding that an error is prejudicial, and thus reversible, when it affects the party's substantial rights).

CONCLUSION

An appellant who made an evidentiary objection during trial need not move for a new trial in the district court before filing an appeal to preserve the appellate remedy of reversal and remand for a new trial. Further, an appellate court has jurisdiction to review a district court's oral evidentiary rulings made during the course of trial on appeal from a final judgment. Additionally, evidence of a doctor's prior medical malpractice suits is generally not relevant to whether the doctor met the standard of care in the current malpractice lawsuit. On this record, we conclude the district court abused its discretion by admitting evidence of the *Center* case and that the error was not harmless due to the evidence's tendency to encourage the jury to reach an improper propensity conclusion, as well as to cause unfair prejudice to Rives due to the severe injuries suffered by that

[8]In light of our conclusion, we need not address appellants' remaining arguments. Similarly, we vacate the district court's order awarding attorney fees and costs. As we are remanding for a new trial, the cross-appeal regarding the district court's reduction of the noneconomic damages awarded is similarly moot.

patient. Accordingly, we reverse the district court's judgment, vacate the corresponding fees and costs order, and remand for a new trial.

_____, J.
Cadish

We concur:

_____ C.J.
Parraguirre

_____, J.
Hardesty

_____, J.
Stiglich

_____, J.
Silver

_____, J.
Pickering

_____, J.
Herndon

EXHIBIT D TO DOCKETING STATEMENT

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

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

HEARING REQUESTED

DEFENDANTS' MOTION FOR REMITTITUR AND TO ALTER OR AMEND THE JUDGMENT

LEWIS ROCA

vs.

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

Defendants.

Defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services Inc. ("UHS"), which does business as UnitedHealthcare or "UHC" and through UHIC), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Company ("SHL"), and Health Plan of Nevada, Inc. ("HPN") (collectively, "Defendants"), move the Court to remit the excessive award of punitive damages in the judgment pursuant to NRCP 59(a), NRCP 59(e), and U.S. Const. amend. XIV, § 2.

As discussed in the concurrently filed Rule 50(b) motion, liability should not have been found as a matter of law, including because TeamHealth Plaintiffs[1] do not have standing to bring an Unfair Claims Practices Act cause of action. Therefore, the punitive damages award cannot stand. *See Wolf v. Bonanza Inv. Co.*, 77 Nev. 138, 143, 360 P.2d 360, 362 (1961) ("[I]n the absence of a judgment for actual damages, there [cannot be] a valid judgment for exemplary damages.").

But even assuming that Defendants were liable, the jury clearly rejected TeamHealth Plaintiffs' claim that they were entitled to their full billed charges. There is simply no justification for the colossal $60 million punitive damages award. "Awards of punitive damages are generally limited by procedural and substantive due process concerns." *Wyeth v. Rowatt*, 126 Nev. 446, 474, 244 P.3d 765, 784 (2010), *citing State Farm Mut. Automobile Ins. Co. v. Campbell*, 538 U.S. 408,

[1] The "TeamHealth Plaintiffs" collectively refers to the three Plaintiffs that initiated this action, each of which is owned by and affiliated with TeamHealth Holdings, Inc.: Fremont Emergency Services (Mandavia), Ltd. ("Fremont"), Team Physicians of Nevada-Mandavia, P.C. ("TPN"), and Crum, Stefanko and Jones, Ltd., d/b/a Ruby Crest Emergency Medicine ("Ruby Crest").

416–17, 123 S. Ct. 1513 (2003). And in Nevada, as in many other states, they are also limited by statute. NRS 42.005(1).[2] Here the punitive damages award blew past both limitations. This Court should now vacate, or at the very least significantly reduce, that award.

I.

THE PUNITIVE DAMAGES ARE UNCONSTITUTIONALLY EXCESSIVE

The punitive damages award in this case exceeds constitutional limits. Even when punitive damages are not limited by the cap of NRS 42.005, the federal and state Due Process Clauses independently prohibit the imposition of "grossly excessive" punishments on a tortfeasor. *Bongiovi v. Sullivan*, 122 Nev. 556, 582–83, 138 P.3d 433, 451–52 (2006); *BMW of N. Am., Inc. v. Gore*, 517 U.S. 559, 562, 116 S. Ct. 1589, 1592 (1996).

A. The Guideposts for Assessing Constitutionality

This Court must review the "excessiveness of a punitive damages award" using "the federal standard's three guideposts." *Bongiovi*, 122 Nev. at 683, 138 P.3d at 452. Those guideposts are: "(1) the degree of reprehensibility of the defendant's misconduct; (2) the disparity between the actual or potential harm suffered by the plaintiff and the punitive damages award; and (3) the difference between the punitive damages awarded by the jury and the civil penalties authorized or imposed in comparable cases." *Id.*; *State Farm*, 538 U.S. at 418. And because consideration of these guideposts is an "application of law," no deference to the jury's verdict is warranted. *Id.* (internal quotation marks omitted). Considering those guideposts here, this Court should conclude that the award of punitive damages against Defendants was grossly excessive.

B. This Case Does Not Exhibit Reprehensibility Necessary to Justify $60 Million in Punitive Damages

Reprehensibility of the defendant's conduct is "[p]erhaps the most important indicium of

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[2] Defendants understand that this Court previously rejected application of the statutory cap in NRS 42.005(1). While Defendants preserve and renew their objection to that ruling here, the discussion on constitutional limits in section I below is an independent basis compelling remittitur of the punitive-damages award. This Court should therefore grant remittitur even if it does not reconsider the application of NRS 42.005(1).

the reasonableness of a punitive damages award." *BMW of North America v. Gore*, 517 U.S. 559, 575 (1996). Importantly, for purposes of the Court's post-judgment scrutiny of the judgment for excessiveness, the question of degree of any reprehensibility is distinct from jury's finding. "That conduct is sufficiently reprehensible to give rise to tort liability, and even a modest award of exemplary damages[,]" as a threshold matter, "does not establish the high degree of culpability that warrants a ***substantial*** punitive damages award." *Id*., 517 U.S. at 580 (emphasis added). As the United States Supreme Court has said, "[i]t should be presumed a plaintiff has been made whole for his injuries by compensatory damages, so punitive damages should only be awarded if the defendant's culpability, after having paid compensatory damages, is ***so*** reprehensible as to warrant the imposition of further sanctions to achieve punishment or deterrence." *State Farm*, 538 U.S. at 419 (emphasis added).

1. The *Gore* Factors for Determining the Degree of Reprehensibility Militate Against a Large Award

In *Gore*, the US Supreme Court identified five factors courts should consider in evaluating the reprehensibility of a defendant's conduct. 517 U.S. at 576-80. Each factor weighs heavily in favor of reducing this punitive damages award.

Whether the harm suffered by the plaintiff is "purely economic in nature." 517 U.S. at 576. The harm in this case was "purely economic." Consequently, this factor weighs against reprehensibility. In analyzing whether conduct is outrageous or reprehensible in a way that permits an award of punitive damages, economic harms are considered less reprehensible as threats to the "health or safety of others." *Bains LLC v. Acro Prods. Co.*, 405 F.3d 764, 775 (9th Cir. 2005) ; *see also Calloway v. Reno*, 116 Nev. 250, 993 P.2d 1259, 1267 (2000) ("Purely economic loss is generally defined as 'the loss of the benefit of the user's bargain . . . including . . . pecuniary damage for inadequate value, . . . or consequent loss of profits."). Also, "socially valuable task[s]" or "conduct that might have some legitimate purpose" is considered less reprehensible than conduct that is discriminatory. *Bains LLC*, 405 F.3d at 775. TeamHealth Plaintiffs argued to the jury that an excessive punitive damages award was justified "[b]ecause [Defendants'] greed is utterly, totally uninhibited and unhinged." 12/07/2021 Tr. 99:10. But this statement at

best only demonstrates that TeamHealth Plaintiffs suffered purely economic harm. TeamHealth Plaintiffs did not present and cannot now point to *any* evidence that establishes that the conduct here resulted in any physical harm. In the absence of physical harm, this factor weighs in favor of reducing the punitive damages award. *See State Farm*, 538 U.S. at 419, 426, 123 S.Ct. 1521, 1524-25; *Bains LLC*, 405 F.3d at 775.

Whether the defendant's "conduct evinced . . . indifference to or reckless disregard for the *health and safety* of others." 517 U.S. at 576. This is a business case. As set out more fully in Defendants' Motion for New Trial Due to Trial Errors, the only harm for which TeamHealth Plaintiffs presented evidence is economic: they received less payment than they demanded as reimbursement for certain out-of-network emergency medicine services. There is no evidence that these "underpayments" threatened anyone's health or physical safety—rather, TeamHealth Plaintiffs' parent company and investors received less of a windfall than they might have anticipated. There was no evidence presented that doctors' compensation was reduced or any emergency room in Nevada was forced to close due to these alleged underpayments. And there was no evidence presented that patient care was impacted.by these alleged underpayments. Moreover, the Defendants' motive in paying less than TeamHealth Plaintiffs' full billed charges was not "evil" or fraudulent—the only testimony on this subject consistently affirmed that Defendants intended to control skyrocketing healthcare costs for their clients and members. This factor weighs against reprehensibility.

Whether the plaintiff was "financially vulnerable." 517 U.S. at 576. While TeamHealth Plaintiffs claimed that Defendants' low reimbursement rates caused financial harm to TeamHealth Plaintiffs' business, *see, e.g.*, 11/12/2021 Tr. 115:19-24 (opposing counsel testifying that "[Defendants] shouldn't have cut [TeamHealth Plaintiffs'] reimbursement by taking the money out of our pocket and putting it into yours."), the same can be said of almost any business venture. TeamHealth Plaintiffs were not uniquely vulnerable. For instance, this case does not involve individuals with low incomes or senior citizens with fixed incomes, which are the types of circumstances this factor typically contemplates. *See, e.g.*, *Lompe v. Sunridge Partners, LLC*, 818 F.3d 1041, 1066 (10th Cir. 2016) (concluding plaintiff as a low-income college student was

financially vulnerable). And even considering the business enterprise, TeamHealth Plaintiffs were *never* on a financial precipice such that Defendants' reimbursement rates imperiled their commercial viability.[3] Indeed, opposing counsel inflamed the jury's passions by depicting TeamHealth Plaintiffs as righteous business entities that brought suit to look after smaller market players, including mom and pop practices, because they have the resources to take on a litigant with the size and power of Defendants. *See* 11/12/2021 Tr. 111:11-16 ("do you think that a mom and pop operation with four, or five, or six doctors has the resources to take on UnitedHealthcare?"); 11/23/2021 Tr. 151:4-8 ("[I]f you're a doctor in a practice of three or four people . . . are you really going to hire a lawyer or do something about it? I mean [Defendants] know that they have all the power and all the leverage"); 11/23/2021 Tr. 145:25-9. TeamHealth Plaintiffs presented no evidence regarding doctor compensation, let alone any evidence showing doctor compensation was affected by Defendants' reimbursement rates. Nor did TeamHealth Plaintiffs present any evidence that doctors were leaving the state or that emergency rooms had to close as a result of Defendants' reimbursement rates. This factor also weighs against reprehensibility.

Whether the "defendant has repeatedly engaged in prohibited conduct." 517 U.S. at 576. While TeamHealth Plaintiffs will argue that the jury found Defendants liable for underpaying a large number claims, it cannot be said that Defendants "repeatedly engaged in prohibited conduct." Defendants refused to pay the full amounts of TeamHealth Plaintiffs' invoices because they were unreasonable—and the jury agreed. *See* 11/29/2021 Verdict at Interrogatory Nos. 2-4, 7-9 (refusing to award TeamHealth Plaintiffs' billed charges). The jury thus found that Defendants' decision not to pay TeamHealth Plaintiffs' full billed charges was not "prohibited conduct." And while it is true that the jury found that Defendants underpaid TeamHealth Plaintiffs for the at-issue

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[3] Plaintiffs argued to the jury that Defendants "cut us to the bone," 12/7/2021 Tr. 106:18, and scared the jury with visions of Defendants "gobbling up doctor's practices," such that when someone goes to the ER, Plaintiffs will no longer be able to staff ER doctors, but rather the patient will be "treated by someone that ultimately reports to an insurance executive whose job it is to cut costs." 12/7/2021 Tr. 110:2-10. The Court sustained Defendants' objection to this argument, noting that "[n]one of this is in evidence." 12/7/2021 Tr. 110:14-16.

claims,[4] those claims were reimbursed by consistently applying plan document benefits. *See* 11/10/2021 Tr. 25:24-28:5 (Mr. Haben testified that the allowed amount payable to providers "is defined by the benefit plan" and is not the billed charges); *id*. 33:22-34:2 (Mr. Haben testified that the allowed amount for out-of-network claims is paid based on what is "[d]efined in the benefit plan"); 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). In other words, it is not as if each occurrence of declining to pay facially unreasonable invoices entailed an independent moment of *mens rea* by a managerial agent. This factor weighs against reprehensibility, or at least against finding reprehensibility to a significant extent.

Whether the defendant's conduct involved "deliberate false statements, acts of affirmative misconduct, or concealment." 517 U.S. at 579. First, TeamHealth Plaintiffs did not raise, and the jury did not determine, a cause of action for fraud. Second, the Court cannot infer from the verdict any determinations of intentional, deliberate, or affirmative acts to harm TeamHealth Plaintiffs, because imposing liability under the actual causes of action did not entail such findings.

For instance, liability for unjust enrichment lies as long as "retention of the benefit is unjust." Jury Instruction No. 22. The jury was not required to find that Defendants were *aware* of any unjustness, such that the verdict can be deemed to imply intentional misconduct. *Id*. Nor does anything in the instruction regarding breach of an implied contract connote intentional conduct. *See* Jury Instruction No. 26. Rather the Court explained to the jury that "contractual intent is determined by the *objective* meaning of the conduct of the parties under the circumstances," *not* by subjective intent. Jury Instruction No. 29 (emphasis added). Liability under the Unfair Claims Practices Act ("UCPA") required the jury to make an objective finding that Defendants owed money on a claim that they did not satisfy, and a subjective finding that Defendants had subjective awareness that that money was not *paid*. Jury Instructions Nos. 36, 37.

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[4] The jury found that the appropriate reimbursement rate was, on average ~319% of Medicare, compared to the ~760% of Medicare TeamHealth Plaintiffs demanded, on average, for the At-Issue Claims, *see* 12/7/2021 Tr. 81:7-13, 116:19-25; 11/29/2021 Verdict at Interrogatory Nos. 2-4, 7-9, further underscoring the comparative reasonableness of Defendants' reimbursement at, on average, ~164% of Medicare.

But liability under the UCPA does *not* consider whether Defendants subjectively knew its *coverage determination* was incorrect, which is the only evidence of Defendants' conduct TeamHealth Plaintiffs presented. *See, e.g.*, Defs' Rule 50(b) Mot. at II.B.5. The jury instead determined that Defendants' *obligation to pay* the amount claimed "has become reasonably clear" by objective standards. Jury Instruction No. 36.[5] Similarly, to succeed on the claim under the Prompt Pay Act, the jury determined only that Defendants failed to pay a claim the jury deemed payable (Jury Instruction No. 38), not that Defendants were *aware* the claim required payment. Put simply, the causes of action underlying the compensatory damages do not require *mens rea*, so the verdict cannot imply *mens rea*.

Even the jury's imposition of punitive damages does not necessarily imply "deliberate false statements, acts of affirmative misconduct, or concealment." 517 U.S. at 579. The Court's instruction empowered the jury to impose punitive damages for "oppression, fraud, *or malice*," (Jury Instruction No. 39), and the verdict form similarly inquired whether they the jury found any of those three: "Do you find . . . oppression, fraud, or malice in any of the conduct[.]" "Special Verdict Form," filed Nov. 29, 2021, interrogatories 15 and 16. By the Court's instruction, "malice" may entail "conduct that is intended to injure a person ***or*** despicable conduct engaged in with conscious disregard," which in turn "means *knowledge of the probable harmful consequences* of a wrongful act and a willful and deliberate *failure to avoid* these consequences." Jury Instruction No. 39. Thus, the Court may infer from the jury's imposition of punitive damages nothing more than a determination that Defendants' failure to pay the amounts the jury deemed payable was "wrongful" and foreseeably harmful, and that Defendants were indifferent to financial harm that withholding the funds might cause. While it is possible the jury found Defendants culpable of fraud or oppression, it is not necessarily so, and there is no indication whatsoever that the jury did so, as compared to simply malicious. So, the Court cannot infer the jury did.

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[5] As discussed in Defendants' Rule 50(b) Renewed Motion for Judgment as a Matter of Law, the jury's award of compensatory damages at a rate far below what TeamHealth Plaintiffs asserted was the amount owed, and different from the damages estimate either party's expert presented, necessarily means that Defendants' obligation to pay the amount the jury awarded had *not* become reasonably clear. Defs' Rule 50(b) Mot. at II.B.3.

Given the absence of any record that TeamHealth Plaintiffs' harm "was the result of intentional malice, trickery or deceit," *State Farm*, 538 U.S. at 419, this factor also militates against finding Defendants acted with a degree of repressibility "that warrants a substantial punitive damages award." *Gore*, 517 U.S. at 580.

2. Analogous Caselaw Confirms the Court Cannot Impute Sufficient Reprehensibility to Justify this Massive Award

Nevada case law on economic harm supports reducing the punitive damages award. In *Ace Truck v. Kahn*, which involved a pure business transaction, the court found a roughly one-to-one punitive to compensatory damage ratio appropriate. 103 Nev. 503, 511, 746 P.2d 132, 137-38 (1987). *Ace Truck* predates *Bongiovi*'s adoption of the federal guideposts articulated in *Gore*, but as the *Bongiovi* court observed, Nevada's pre-*Gore* standard "varie[d] only slightly from the federal standard" articulated in *Gore*. *Bongiovi*, 122 Nev. at 583, 138 P.3d at 452. *Ace Truck*, therefore, remains persuasive on the permissible amount of punitive damages allowable in business transaction cases.[6]

The Nevada Supreme Court has found larger punitive damages awards appropriate, but only where defendants reprehensibility was *much* higher than that supported by the jury's verdict. In *Evans v. Dean Witter Reynolds*, which supported a punitive damages award of ***2.4*** times compensatory damages, the defendants assisted a fiduciary with looting millions of dollars from the estate of his mentally and physically incompetent beneficiary. 116 Nev. 598, 602-04, 5 P.3d 1043, 1045-47 (2000). The reprehensibility of the *Evans* defendants was two-fold: (1) the particular vulnerability of an incompetent client; and (2) the fiduciary relationship that was violated.

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[6] In unpublished decisions following *Bongiovi*, the Nevada Supreme Court continued to rely on *Ace Truck*'s pronouncement that "a simple business sales transaction in which the plaintiffs accused the defendants of misrepresentation and fraud ... can probably be said to be toward the lower end of the spectrum of malevolence found in punitive damages case." *Ace Truck v. Kahn*, 103 Nev. 503, 511, 746 P.2d 132, 137 (1987), *cited in Exposure Graphics v. Rapid Mounting Display*, No. 54069, 128 Nev. 895, 2012 WL 1080596, at *2 (2012) (concluding that this pre-*Bongiovi* assessment remains good law under the current "reprehensibility" framework). Defendants do not cite *Exposure Graphics* itself as controlling or precedential authority, NRAP 36(c)(3), but merely point out the Supreme Court's continued reliance on the published authority of *Ace Truck*, which has not been abrogated for this purpose.

This case stands in stark contrast to *Evans*. Whereas *Evans* centered on an utterly incompetent and helpless widow bilked of funds on which she relied for sustenance, *id.* at 1045-47), TeamHealth Plaintiffs are private equity backed business-savvy physician-staffing companies who were market driven to maximize their own interests in negotiation with other business entities at arm's length. In fact, this Court's rulings recognize that the parties are equally sophisticated. *See* 10/22/2021 Tr. 65:3-4 ("This is big business against big business."). And TeamHealth Plaintiffs dropped their allegation that there was a "special element of reliance or trust" between the parties such that "Defendants were in a superior or entrusted position of knowledge." *Compare* First Amend. Compl. ¶ 209 *to* Second Amend. Compl. TeamHealth Plaintiffs successfully moved *in limine* to exclude any reference to this allegation. 11/1/2021 Order Granting Plfs' Mot. *in Limine* to Exclude Evidence re Dismissed Claims.

This case also does not involve a fiduciary relationship, which further distinguishes it from *Evans* and emphasizes that this case is unlike the type of consumer-insurance-coverage cases quintessentially contemplated in NRS 42.005(2)(b)'s exception to Nevada's statutory cap on punitive damages. *Id*. ("The limitations on the amount of an award of exemplary or punitive damages prescribed in subsection 1 do not apply to an action brought against: . . . (b) An insurer who acts in bad faith regarding its obligations to provide insurance coverage"). "The duty owed by an insurance company *to an insured* is fiduciary in nature." *Powers v. United Servs. Auto. Ass'n*, 115 Nev. 38, 42, 979 P.2d 1286, 1288 (1999) (emphasis added). "A fiduciary relationship exists when one has the right to expect trust and confidence in the integrity and fidelity of another." *Id*. However, TeamHealth Plaintiffs abandoned any ability to claim that they are Defendants' fiduciaries when they dismissed their allegation that there was "special element of reliance or trust" existing between them. Not only are TeamHealth Plaintiffs not insureds, they also argued at trial that they are in direct competition with Defendants. *See* 12/7/2021 Tr. 110:2-3. It defies logic that a sophisticated commercial entity had the right to expect trust and confidence of an equally sophisticated competitor.

As discussed more fully below, the jury awarded punitive damages that were on average just under *23 times* the amount of compensatory damages. Even *if* TeamHealth Plaintiffs proved

facts satisfactory under the *Evans* standard, which they did not, the punitive damages award is excessive and should be reduced. Because the harm in this case is akin to that in *Ace Truck*, the damages award should be reduced even more.

C. The Extreme Disparity between the Compensatory and Punitive Damages is Unsustainable

The Nevada Supreme Court has held that "awards of punitive damages are generally limited by procedural and substantive due process concerns." *Wyeth*, 126 Nev. At 474–75, 244 P.3d at 784–85, *citing State Farm*, 538 U.S. at 416–17. And "the Fourteenth Amendment's Due Process Clause prohibits punitive damages awards that are grossly excessive or arbitrary." *Id*.; *Bongiovi*, 122 Nev. at 582, 138 P.3d at 451. An important guidepost for recognizing excessiveness is "the ratio of the punitive damages award to the actual harm inflicted on the plaintiff." *Id*.; *see Gore*, 517 U.S. 559.

1. The Ratios Between Compensatory and Punitive Damages are Absurd and Must Be Remitted

Here, the ratios are obscene. The *lowest* ratio is nearly 5:1, where the jury awarded $1,007,374.49 in compensatory damages to TeamHealth Plaintiff Fremont Emergency Services against Defendant Sierra Health and Life Insurance Company, and $5 million in punitive damages for the same plaintiff-defendant pairing. *Compare* 11/29/21 Special Verdict Form at 3, *with* 12/07/21 Special Verdict Form at 3. At the high end, however, the punitive damages award shot up to *14,210 times* compensatory damages—representing $281.49 in compensatory damages and $4 million in punitive damages to TeamHealth Plaintiff Ruby Crest against Defendant HPN. *Compare* 11/29/21 Special Verdict Form, at 4, *with* 12/07/21 Special Verdict Form, at 3. Given the minimal evidence introduced at trial related to defendant HPN, this outcome shocks the conscience. Overall, the punitive damages awards against all Defendants ($60 million) exceeded the compensatory awards ($2.65 million) by nearly 23 times.[7]

[7] As noted in the Motion for New Trial, opposing counsels' misconduct plagued the lability and punitive damages verdicts. Mot. for New Trial re Trial Errors at Sections I.A.2-3, I.B.1-2. In particular, TeamHealth Plaintiffs conditioned the jury into believing this case was about the quality of care regarding emergency medicine services and that Defendants were underpaying claims that saved lives. *Id*. at Sections I.A.2-3. Opposing counsel then parlayed that improper conditioning to inflame the jury's passions when arguing that the jury should award massive punitive damages.

The U.S. Supreme Court has not set a fixed ratio limiting punitive damages. *State Farm*, 538 U.S. at 425 ("[T]here are no rigid benchmarks that a punitive damages award may not surpass . . . ."). It has noted, however, that ***"few awards exceeding a single-digit ratio between punitive and compensatory damages ... will satisfy due process."*** *Id.* (emphasis added).

But punitive damages do not normally, or may not always constitutionally, exceed compensatory damages. As discussed *supra*, Section I.B.1., in cases of purely economic harm, the *high* end of such a ratio should be closer to 1-to-1. *Ace Truck*, 103 Nev. at 512, 746 P.2d at 138; *Bongiovi*, 122 Nev. At 583, 138 P.3d at 452. And *Bongiovi* itself involved a 1:1 ratio, which the Nevada Supreme Court considered substantial and justified only because "Bongiovi's conduct was reprehensible to a large degree because of the egregiousness and offensiveness of his statements about Sullivan" and because "Sullivan suffered *great emotional harm* and lost business." *Id.* Even under the extreme facts of the *Evans* case above, an appropriate ratio would be only 2.5 to one.

And when, as here, the compensatory damages here are substantial, the Supreme Court has noted that "a lesser ratio, perhaps only equal to compensatory damages, can reach the outermost limit of the due process guarantee." *State Farm*, 538 U.S. at 425.

This is not an exceptional case where the compensatory award itself was small in absolute terms or the injury was hard to detect. *See Gore*, 517 U.S. at 581. Indeed, the jury's compensatory awards were extremely precise because the economic injury consisted solely of the difference between what Defendants had already reimbursed and what the jury determined to be a reasonable rate of reimbursement; TeamHealth Plaintiffs disclaimed consequential damages. In addition, the awards taken together were substantial, totaling more than $2.65 million dollars. Even assuming that the smallest compensatory awards on their own might permit a higher ratio than 1:1, even up to the presumptive outer bound of 9:1, there is *no* constitutional justification for an overall

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See id. at Sections I.B.1-2; *id*. at __ (arguing that "if you [the jury] talk with a whisper, I'm sorry, you have wasted a month and a half of your lives" (quoting 12/7/2021 Tr. 107:14-15)). As such, TeamHealth Plaintiffs were able to obtain an unconstitutionally disproportional punitive damages award through misconduct tactics that inflamed the passions of the jury.

punitives-to-compensatory ratio of almost 23:1. Even an award equal to compensatory damages, as in *Bongiovi* or *Ace Truck*, or perhaps as much as 2.5 times, as in *Evans*, would meet or even exceed the constitutional limit.

2. The Jury's Verdict Does Not Reflect the Requisite Individualized Analysis and is Thus Unreliable

Jurors are charged to thoughtfully, carefully and impartially consider the evidence before deciding upon a verdict. NEVADA JURY INSTRUCTIONS—CIVIL (2011 ed.) Instruction No. 11.01 ("Whatever your verdict is, it must be the product of a careful and impartial consideration of all the evidence in the case under the rules of law as given you by the court.").

In stark contrast to the deliberation taken in determining the compensatory award, the jury awarded punitive damages by repeatedly using the same round numbers. 12/7/21 Special Verdict Form at 2; 11/23/21 Special Verdict Form. This is striking because the evidence pertaining to each TeamHealth Plaintiff-Defendant pairing was vastly different. That is, the conduct of each Defendant differed vis-à-vis each TeamHealth Plaintiff and the harms of each TeamHealth Plaintiff varied. To be sure, of the 11,563 at-issue claims, UHS was responsible for 3,803 and HPN was responsible for 119. *See* PX 473. However, the jury awarded $4,500,000 in punitive damages to each TeamHealth Plaintiff against UHS and $4,000,000 in punitive damages to each TeamHealth Plaintiff against HPN. 12/7/21 Special Verdict Form at 2. In other words, while HPN was only responsible for 1% of the claims at-issue, it is responsible for 20% of the punitive damages award. *See* PX 473; 12/7/21 Special Verdict Form at 2. This is absurd. Moreover, of the 119 at-issue claims that HPN is responsible for, 109 were asserted by Fremont, 6 were asserted by Team Physicians, and 4 were asserted by Ruby Crest. PX 473. It shocks the conscious that HPN's conduct can be equally reprehensible vis-à-vis each TeamHealth Plaintiff. Similarly, even though Fremont asserted 10,387 of the at-issue claims, *i.e.*, ~90% of the at-issue claims, each TeamHealth Plaintiff was awarded the same punitive damages amount. PX 473; 12/7/21 Special Verdict Form at 2. It shocks the conscious that the jury could find that Defendants' conduct vis-à-vis Fremont was equally reprehensible to Defendants' conduct vis-à-vis Team Physicians and/or

Ruby Crest. Thus, the jury did not thoughtfully, carefully and impartially consider the evidence before deciding the punitive damages award and it is unreliable.

D. In Light of the Penalty Interest under the Prompt Pay Act, No Further Punitive Damages Are Appropriate

TeamHealth Plaintiffs have not demonstrated that Defendants would have been subject to any civil penalties—at least no penalties that are not already reflected in the compensatory damage award. For instance, although the Prompt Pay Act provides for heightened interest on unpaid claims—6% above the prime rate, *e.g.*, NRS 689B.255(1), as opposed to 2% above prime for ordinary prejudgment interest, NRS 17.130(2), NRS 99.040(1)(a)—those penalties are already reflected in the compensatory award.

Indeed, for that very reason, the judgment—with Prompt Pay Act penalty interest on the compensatory award—already reflects a punitive element. *Cf. Countrywide Home Loans, Inc. v. Thitchener*, 124 Nev. 725, 735 n.14, 192 P.3d 243, 250 n.14 (2008). TeamHealth Plaintiffs in this instance have to choose between the statutory penalty and punitive damages. An additional award of punitive damages for precisely the same conduct as that which gave rise to Prompt Pay Act liability—paying an unreasonably low reimbursement rate—is improper.

Alternatively, even if punitive damages may be combined with Prompt Pay Act interest, the award here is still grossly excessive. Looking at the Prompt Pay Act interest as an appropriate comparator, the *total* amount ($779,361.97) is just 29% of the compensatory award. That, of course, includes all of the interest, not just the 4% difference between ordinary judgment interest and the "penalty" interest under the Prompt Pay Act. This only confirms the analysis above: that a punitives award *equal* to compensatory damages—many times more than the comparable Prompt Pay Act penalty—scrapes the outer constitutional limit.

E. The No Surprises Act Replaces Jury Awards and Punitive Damages with a Regulatory Mechanism

Also significant is the Legislature's decision via the No Surprises Act (and Congress's similar effort at the federal level) to take the question of setting reimbursement rates for emergency medical services away from juries altogether. As of January 1, 2022, rather than allowing those disputes to proceed in a forum where claims for punitive damages or other penalties, may be

engineered, Assembly Bill 469 creates an expedited regulatory process: unreconciled differences proceed to binding arbitration. NRS 439B.160; NRS 439B.751(2); NRS 439.754; *see also* H.R. 133, § 103 (effective January 1, 2022).

Far from authorizing astronomical civil penalties for an insurer's alleged underpayment of a claim for emergency services, the Legislature has streamlined the resolution of rate-of-payment disputes and removed the threat of large punitive damages awards altogether. *See* NRS 439B.754. In this circumstance, the jury's award of $60 million in punitive damages is wildly incomparable to any civil penalty the Legislature did or would now authorize.

The purpose of punitive damages is to punish and deter a defendant's culpable conduct. *Bongiovi*, 122 Nev. at 580, 138 P.3d at 450. The enactment of the No Surprises Act may impact how insurers consider reimbursement rates, so the conduct at issue here—the way Defendants set their reimbursement rates—has already been addressed. Punitive damages awards are also intended to demonstrate to defendants and others that particular conduct is not acceptable and will not be tolerated. *Id.* But again, Defendants' future conduct has already been altered by the No Surprise Act. Thus, any additional deterrence is unnecessary based on the regulatory scheme set forth by the No Surprise Act. The Court should thus vacate the punitive damages award in its entirety.[8]

[8] As discussed *supra*, if the Court disagrees that punitive damages are entirely inappropriate, the Court should remit the award to an amount that comports with NRS 40.005 and both federal and state Due Process requirements. *See Ace Truck*, 103 Nev. at 511, 746 P.3d at 138 (remitting punitive damages award as the amount was disproportionate); *Albert H. Wohlers*, 114 Nev. at 1268, 969 P.2d at 962 (remitting award after concluding the punitives damage award was clearly disproportionate to the degree of reprehensibility); *Kellar v. Brown*, 101 Nev. 273, 274, 701 P. 2d 359, 359-60 (1985) (ordering remittitur because punitive award of more than five times the compensatory damages was disproportionate and unnecessary to deter future wrongdoing); *Mendez-Matos v. Municipality of Guaynabo*, 557 F.3d 36, 56 (1st Cir. 2009) (affirming district court's remittitur of punitive damages award because punitive damages award grossly exceeded what was necessary to punish and deter defendant's conduct).

II.

THE JUDGMENT MUST NOT BE READ TO IMPOSE PROMPT PAY ACT INTEREST ON TOP OF POST-JUDGMENT INTEREST

Once a judgment is entered, the principal amount is fixed for purposes of post-judgment interest.[9] NRS 17.130(2) does not authorize compound interest. *Torres v. Goodyear Tire & Rubber Co.*, 130 Nev. 22, 24, 317 P.3d 828, 829 (2014). Here, TeamHealth Plaintiffs' judgment includes a fixed amount of Prompt Pay Act interest. That interest, incorporated into the judgment, is fixed for purposes of calculating ordinary post-judgment interest. To allow plaintiffs to *continue* to seek Prompt Pay Act interest on top of post-judgment interest would impermissibly authorize compound interest. "As a general rule, compound interest is not favored by the law and is generally allowed *only* in the presence of a statute or an agreement between the parties allowing for compound interest." *Id.* Neither is present here. There is no statute authorizing TeamHealth Plaintiffs to recover compound interest, and Defendants have not agreed to permit TeamHealth Plaintiffs to recover compound interest. Accordingly, the Court should prohibit TeamHealth Plaintiffs from incurring any additional post-judgment interest under the Prompt Pay Act.

CONCLUSION

For the foregoing reasons, this Court should eliminate the award of punitive damages. Alternatively, it should reduce the ratio of punitive damages to be equal to the compensatory damages.

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[9] Of course, if the judgment is partially satisfied, post-judgment interest runs only on the unsatisfied amount. NRS 17.130(1).

Dated this 6th day of April, 2022.

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CERTIFICATE OF SERVICE

I hereby certify that on the 6th day of April, 2022, a true and correct copy of the foregoing **"DEFENDANTS' MOTION FOR REMITTITUR AND TO ALTER OR AMEND THE JUDGMENT"** was electronically filed and served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

NOTICE OF APPEAL

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

Defendants.

NOTICE OF APPEAL

Please take notice that defendants United Healthcare Insurance Company ("UHIC"), United Health Care Services Inc. ("UHS", which does business as UnitedHealthcare or "UHC" and through UHIC), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Company ("SHL"), and Health Plan of Nevada, Inc. ("HPN") hereby appeal to the Supreme Court of Nevada from:

1. All judgments and orders in this case;

2. "Judgment," filed on March 9, 2022, notice of entry of which was served electronically on March 9, 2022 (Exhibit A); and

3. All rulings and interlocutory orders made appealable by any of the foregoing.

Dated this 6th day of April, 2022.

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CERTIFICATE OF SERVICE

I hereby certify that on the 6th day of April, 2022, a true and correct copy of the foregoing "Notice of Appeal" was electronically filed/served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

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EXHIBIT A

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DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation, Defendants	Case No.: A-19-792978-B Dept. No.: XXVII **NOTICE OF ENTRY OF JUDGMENT**

Please take notice than a Judgement was entered on March 9, 2022, a copy of which is attached hereto.

DATED this 9th day of March, 2022.

McDONALD CARANO LLP

By: */s/ Kristen T. Gallagher*

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 9th day of March, 2022, I caused a true and correct copy of the foregoing **NOTICE OF ENTRY OF JUDGMENT** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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

JUDG

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation, Defendants.	Case No.: A-19-792978-B Dept. No.: XXVII **JUDGMENT**

This action came on for trial before the Court and a jury, the Honorable Nancy L. Allf, District Court 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.

Dated this 9th day of March, 2022

Nancy L Allf

TW

519 56D 37C6 D5AF
Nancy Allf
District Court Judge

CERTIFICATE OF SERVICE

I certify that on this 4th day of March, 2022, I caused a true and correct copy of the foregoing to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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/s/
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CSERV

DISTRICT COURT
CLARK COUNTY, NEVADA

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

AUTOMATED CERTIFICATE OF SERVICE

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

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DISTRICT COURT

CLARK COUNTY, NEVADA

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

Plaintiffs,

vs.

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

Defendants

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

SECOND AMENDED COMPLAINT

Jury Trial Demanded

Plaintiffs Fremont Emergency Services (Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest" and collectively the "Health Care Providers") as and for their First Amended Complaint against defendants United Healthcare Insurance Company ("UHCIC") United Health Care Services Inc. dba UnitedHealthcare ("UHC Services"); UMR, Inc. dba United Medical Resources ("UMR"); (together with UHC Services and UMR, and with UHCIC, the "UH Parties"); Sierra Health and Life Insurance Company, Inc. ("Sierra Health"); Health Plan of Nevada, Inc. ("HPN") (collectively "Defendants") hereby complain and allege as follows:

NATURE OF THIS ACTION

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

PARTIES

2. Plaintiff Fremont Emergency Services (Mandavia), Ltd. ("Fremont") is a professional emergency medicine services group practice that staffs the emergency departments at ER at Aliante; ER at The Lakes; Mountainview Hospital; Dignity Health – St. Rose

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

Dominican Hospitals, Rose de Lima Campus; Dignity Health – St. Rose Dominican Hospitals, San Martin Campus; Dignity Health – St. Rose Dominican Hospitals, Siena Campus; Southern Hills Hospital and Medical Center; and Sunrise Hospital and Medical Center located throughout Clark County, Nevada. Fremont is part of the TeamHealth Holdings, Inc. ("TeamHealth") organization.

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

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

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

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

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

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

belief, Sierra Health is a licensed Nevada health insurance company.

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

JURISDICTION AND VENUE

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

11. The Eighth Judicial District Court, Clark County, has subject matter jurisdiction over the matters alleged herein since only state law claims have been asserted and no diversity of citizenship exists. Venue is proper in Clark County, Nevada.

FACTS COMMON TO ALL CAUSES OF ACTION

The Health Care Providers Provide Necessary Emergency Care to Patients

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

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

14. Upon information and belief, Defendants operate as an HMO under NRS Chapter

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

15. 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.

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

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

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

19. Relevant to this action:

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

October 2018); Dignity Health – St. Rose Dominican Hospitals, Siena Campus (approximately July 2017-October 2018); Southern Hills Hospital and Medical Center (approximately July 2017-present); and Sunrise Hospital and Medical Center (approximately July 2017-present).

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

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

The Relationship Between the Health Care Providers and Defendants

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

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

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

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

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

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

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

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

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

30. For all claims at issue in this lawsuit, the Health Care Providers were non-participating providers, meaning they did not have an express contract with Defendants.

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

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

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

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

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

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

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

Defendants Paid the Health Care Providers Unreasonable Rates

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

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

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

40. Defendants' Members received a wide variety of emergency services (in some instances, life-saving services) from the Health Care Providers' physicians: treatment of conditions ranging from cardiac arrest, to broken limbs, to burns, to diabetic ketoacidosis and shock, to gastric and/or obstetrical distress.

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

42. Defendants paid claims 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 influence and leverage the Health Care Providers as well as to unfairly and illegally profit from a manipulation of payment rates.

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

44. The Health Care Providers contested the unsatisfactory rate of payment received

from Defendants in connection with the claims that are the subject of this action.

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

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

Defendants' Prior Manipulation of Reimbursement Rates

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

48. In 2009, 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.

49. 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.

50. 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.

51. 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."

52. Also in 2009, for the same conduct, UnitedHealth Group, Inc. and Defendants 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.).

53. 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.

54. 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.

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

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

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

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

59. Defendants' detrimental approach to payments for members in fully funded plans continues today,

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

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

FIRST CLAIM FOR RELIEF

(Breach of Implied-in-Fact Contract)

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

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

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

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

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

67. From approximately March 1, 2019 to the present Fremont has undertaken to provide emergency medicine services to the patients of Sierra and HPN, and Sierra and HPN have undertaken to pay for such services provided to their Patients.

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

69. At all material times, Defendants have received the Health Care Providers' bills for the emergency medicine services the Health Care Providers have provided and continue to provide to Defendants' Patients, and Defendants have consistently adjudicated and paid, and continue to adjudicate and pay, the Health Care Providers directly for the non-participating claims.

70. Through the parties' conduct and respective undertaking of obligations concerning emergency medicine services provided by the Health Care Providers to Defendants'

Patients, the parties implicitly agreed, and the Health Care Providers had a reasonable expectation and understanding, that Defendants would reimburse the Health Care Providers for non-participating claims at rates in accordance with the standards acceptable under Nevada law.

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

72. Defendants, by undertaking responsibility for payment to the Health Care Providers for the services rendered to the Defendants' Patients, impliedly agreed to reimburse the Health Care Providers at the reasonable value of the professional emergency medical services provided by the Health Care Providers.

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

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

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

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

77. The Health Care Providers have suffered damages in an amount equal to the difference between the amounts paid by Defendants and the reasonable value of their

professional emergency medicine services, that remain unpaid by the Defendants through the date of trial, plus the Health Care Providers' loss of use of that money.

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

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

SECOND CLAIM FOR RELIEF

(Alternative Claim for Unjust Enrichment)

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

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

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

83. Defendants accepted and retained the benefit of the services provided by the Health Care Providers at the request of the members of its Health Plans, knowing that the Health Care Providers expected to be paid the reasonable value of services provided, for the medically necessary, covered emergency medicine services it performed for Defendants' Patients.

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

85. Under the circumstances set forth above, it is unjust and inequitable for Defendants to retain the benefit they received without paying the value of that benefit; i.e., by paying the Health Care Providers at the reasonable value of services provided, for the claims that

are the subject of this action and for all emergency medicine services that the Health Care Providers will continue to provide to Defendants' Members.

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

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

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

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

THIRD CLAIM FOR RELIEF

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

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

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

92. 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).

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

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

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

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

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

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

FOURTH CLAIM FOR RELIEF

(Violations of Nevada Prompt Pay Statutes & Regulations)

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

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

100. Despite this obligation, as alleged herein, Defendants have failed to reimburse the

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

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

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

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

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

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

REQUEST FOR RELIEF

WHEREFORE, the Health Care Providers request the following relief:

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

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

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

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

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

F. Reasonable attorneys' fees and court costs;

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

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

JURY DEMAND

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

DATED this 4th day of October, 2021.

AHMAD, ZAVITSANOS, ANAIPAKOS, ALAVI & MENSING, P.C

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 7th day of October, 2021, I caused a true and correct copy of the foregoing **SECOND AMENDED COMPLAINT** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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