Case No. 85369

In the Supreme Court of Nevada

SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.,

Appellant,

vs.

SANDRA L. ESKEW, as special administrator of the Estate of William George Eskew,

Respondent.

Appeal from the Eighth Judicial District Court, Clark County
The Honorable Nadia Krall, District Judge
District Court No. A-19-788630-C

JOINT APPENDIX
Volume 11 of 18

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DISTRICT COURT

CLARK COUNTY, NEVADA

SANDRA ESKEW, ET AL., Plaintiff, vs. SIERRA HEALTH AND LIFE INSURANCE COMPNAY, INC., ET AL., Defendants.	CASE#: A-19-788630-C DEPT. IV

BEFORE THE HONORABLE NADIA KRALL
DISTRICT COURT JUDGE
MONDAY, MARCH 28, 2022

RECORDER'S TRANSCRIPT OF JURY TRIAL - DAY 9

APPEARANCES

For the Plaintiffs:	MATTHEW L. SHARP, ESQ. DOUGLAS A. TERRY, ESQ.
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RECORDED BY: MELISSA BURGENER, COURT RECORDER

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FOR THE PLAINTIFFS	MARKED	RECEIVED
None		

FOR THE DEFENDANTS	MARKED	RECEIVED
None		

Las Vegas, Nevada, Monday, March 28, 2022

[Case called at 9:14 a.m.]

THE MARSHAL: Department 4 is now in session. The Honorable Judge Nadia Krall presiding.

THE COURT: Good morning, everyone.

THE WITNESS: Good morning.

THE COURT: Please be seated. Are the parties ready for the jury?

MR. ROBERTS: Yes, Your Honor.

THE COURT: Mr. Sharp?

THE CLERK: Counsel?

MR. SHARP: Yes, Your Honor.

THE COURT: Thank you.

THE MARSHAL: All rise for the jury.

[Jury in at 9:15 a.m.]

THE MARSHAL: Judge, all jurors are present.

THE COURT: Thank you. Do the parties stipulate to the presence of the jury?

MR. ROBERTS: Yes, Your Honor.

MR. SHARP: Yes, Your Honor.

THE COURT: Thank you. Please be seated. Mr. Roberts, will you call your next witness.

MR. ROBERTS: Thank you, Your Honor. For our next witness the Defense would call Dr. Gary Owens M.D.

THE COURT: Dr. Owens, will you stand to be sworn in by the clerk.

GARY OWENS, DEFENDANTS' WITNESS, SWORN

THE CLERK: Will you please state and spell your first and last name for the record?

THE WITNESS: Yes. My name Gary, G-A-R-Y, Owens O-W-E-N-S.

THE COURT: Thank you.

DIRECT EXAMINATION

BY MR. ROBERTS:

Q Good morning, Dr. Owens.

A Good morning, Mr. Roberts.

Q So what I'd like to start out with is to familiarize the jury with your background and experience. And with everyone's indulgence I'd like to go through it in some detail so people can get a really good idea of the things that you've done over your career, okay?

A Certainly.

Q Could start out by telling the jury your history and your education starting with college?

A I certainly will. I went to and was fortunate to be admitted the University of Pennsylvania back in 1969 actually. I graduated from the University of Pennsylvania in 1971 with honors in both science and pre-medicine.

I then moved across town to Philadelphia where I trained in medicine at Thomas Jefferson University, which is one of the oldest

medical schools in the country founded in the early 1800's. From my -- I got my MD degree there and also graduated what's knowns as AOA, Alpha Omega Alpha from medical school, which the equivalent to Phi Beta Kappa in undergrad.

From that I proceeded to do a residency in family medicine at what was then the Medical Center of Delaware, which is located in Northern Delaware. It's now called Christiana Care. And after I got my residency certification in family medicine I became board certified in 1978. Became fellow of the American Academy of Family Physicians, that was in 1981. And started a primary care medical practice as my first job in 1978 in Northern Delaware.

Q And how long did you maintain the clinical practice in the field in which you were board certified?

A I maintained the clinical practice in my field from 1978 through 1991 when I made my next career transition.

Q Okay. And that was in -- from clinical practice to getting involved in managed care?

A That is correct.

Q How would you define managed care?

A I would define managed care as a system that is in place to basically look at the provision of care. It's really a three legged stool. It provides access to care; it provides quality care, and it provides coverage for that in essence access to care. And it's done basically through a process of creating networks, creating, I guess the best way to put it is contracting with specific hospitals and doctors. And then of course

looking to manage or oversee the provision of care by those physicians under contract.

Q What do you mean by managing the provision of care?

A Basically we do some review of that care. That review is done under fairly strict guidance and in well-developed policies and procedures at the insurance company, which I generally refer to as health plans. So if I use those interchangeably, insurance versus health plan, please forgive me.

Q Thank you, sir.

MR. ROBERTS: Audra, could you put up the second slide?

BY MR. ROBERTS:

Q And I've thrown just some highlights from your CV here to assists us in walking the jury through your work experience.

A Sure.

MR. ROBERTS: So could -- is it possible to blow that up just a little bit, Audra? Perfect.

BY MR. ROBERTS:

Q Okay. So let's start out with 1986 to 1991, Delaware Valley HMO. Tell us what your duties and responsibilities were there?

A Well, that was my first -- well, actually my second introduction to health plans, HMO's and managed care. I might need to go back in time just a little bit.

In the early 1980s I was president of the Delaware Academy of Family Physicians and was also on the board of directors of the Medical Society of Delaware. And those organizations were approached by a

large insurance carrier Cigna with the concept to develop an independent practice association type of managed care plan in Delaware, the first to come to the State. So we formed a committee of medical and surgical specialists under the auspices of the Academy of Family Physicians and the Medical Society of Delaware. Two -- really ultimately over about two years developed and launched the Diamond State IPA, which was part of the first health plan in the State of Delaware.

From that --

Q When you say the first health plan, do you mean the first insurance company or the first something else?

A First managed care company. I will use that specially. So we did our first managed care company, and I was on the board of directors of that IPA.

As you know in the early 1980s that was really the beginnings of managed care. And a new competitor came into the state that had started in southeastern Pennsylvania and you may know that Northern Delaware and Southeastern Pennsylvania are contiguous. I know we're in Nevada, so some of that geography may not be as familiar. That company -- actually based on my experience with the Diamond State IPA and my experience with --

Q So when you say that company, are you going back to Delaware Valley HMO?

A That is correct.

Q Okay. Tell us about how you got started there.

A Yeah. Delaware Valley approached me --

THE COURT RECORDER: One at a time.

THE WITNESS: -- to see if I would be interested in becoming the medical director for their Delaware plan. And after much discussion and of course I had to resign from the IPA board, I became the medical director for Delaware Valley HMO's Delaware plan, which I did as a part time position in addition to my full time clinical practice.

Q Is it unusual for a health plan to have part time medical directors?

A Back in those days it was almost the norm, most of those health plans, those managed care plans were relatively small by today's standards. For instance, Delaware Valley HMO when I first started with them had around 50,000 total enrollees. There were three medical directors at the plan, and we were all part time.

Q So what types of things did you do for the HMO as an associate medical director?

A We wrote policies, number one in conjunction with a very small medical policy department. We created our utilization management program. We created our quality assurance program. We also did network recruitment. I would go and speak with physicians about participating in that health plan along with other representatives of the company. And of course, I did front line utilization review during my tenure at Delaware Valley.

Q So I see here that you moved to Keystone Health Plan East in 1992. Why did you move?

A That was as a result of an acquisition, Keystone Health Plan

East and Delaware Valley HMO along with a third health plan called Vista Health Plan were all competing in the same region that is Southern Pennsylvania and Northern Delaware. And the three of those organizations merged, read that as an acquisition by Keystone to become Keystone Health Plan East.

At that point Keystone Health Plan East offered me a full time position as a medical director in the newly formed and enlarged health plan organization. That was a very difficult decision for me because number one, I really enjoyed primary care medicine. I was generally listed by one of the major publications in Northern Delaware as one of the top docs in the State. I was vice chairman of the Department of Family Practice at the Medical Center of Delaware. And was chief of the Department of Family Practice at Saint Frances Hospital. So I had a lot to stay in clinical practice for.

But what I was looking at, at the time was a bit of a visionary type of approach, which is this is new and growing trend that's going to happen in the country. Especially in 1992 because it was being driven forward by the Clinton health care proposed plan, which of course as we know never succeeded. So I --

Q And when you say growing trend, what are you referring to?

A I'm merely referring to the fact that we were switching over from the older insurance type of -- health insurance type of approach, which was called indemnity insurance where basically you signed up members, paid claims and that was about it. To where we were actually developing systems of care and care management.

Q On the older indemnity plans that were common before the 1980s, was there any such thing as preauthorization review?

A There was not.

Q So tell us about your work as a full time medical director at Keystone in this 1992 to 1996 time period.

A I will. At Keystone my first job was to actually lead and develop our utilization management practices, which included overseeing hospitalizations as well as a small select group of prior authorizations. I think at that time we were managing care for about, if you merge the three organizations 100,000 lives. That organization grew very quickly, and we added, you know, medical directors over that time period. We quickly added two part time and a couple of full time medical directors.

So the next step in my career was I was promoted to senior medical director at Keystone Health Plan East with oversight responsibility, not only for the utilization management people, but also for the newly added medical directors. At the same time I was also appointed chairman of our pharmacy and therapeutics committee, but that's not really germane for this discussion, but just another duty.

Q Okay. Thank you, Doctor. I see there's a slash here for Independence Blue Cross. Tell me how you got involved with Independence Blue Cross.

A I will. And I'll need to explain that Independence Blue Cross is the Blue Cross plan that serves the six counties in Southeastern Pennsylvania.

While Blue Cross is a national logo, everybody's seen the blue cross and of course the blue shield. All of the Blue Cross plans are independent of each other. Back in those days there were 80 of them, now there are 33 or 34 because of mergers. But Independence Blue Cross was by far the largest insurance carrier in Southeastern Pennsylvania, headquartered in Philadelphia.

And Independence also recognized that there needed to be a transition in their model of doing business, so they purchased Keystone Health Plan East and Keystone Health Plan East became a subsidiary of Independence Blue Cross.

So in essence after that purchase, which was around 1993 give or take a bit I became an employee of Independence Blue Cross with dedicated duties in Keystone Health Plan East.

Q So even though you had three different companies on here, you -- have you just stayed with the same firm just through mergers all the way through Independence Blue Cross?

A You picked it up exactly. From that 1984 period until my retirement from there in 2006, a period of 22 years. In essence I was with the same company, just with some name changes due to acquisitions and mergers.

Q Now you mentioned that every Blue Cross is independent. I mean, the jury may be familiar with Anthem for our --

A Yeah.

Q -- local Blue Cross plan. Tell -- are they completely independent or is there some commonality between all of these Blue

Cross plans?

A There is commonality, and that commonality is what's called Blue Cross and Blue Shield Association and that is headquartered in Chicago. And the Blue Cross and Blue Shield Association basically oversees all of the Blue Cross plans. It sets all of the guidelines and regulations and requirements of the Blue Cross plans, including setting the requirements to market in their individual service areas.

So let's take Anthem for instance in Nevada. Anthem is part of the largest merger ever in the Blue Cross, Blue Shield system. There literally were 22 of the original Blue Cross plans, over time merged to form Anthem, which is in states like California, and Nevada, and New York, Ohio, Indiana and many, many others, of course. And so Anthem is that largest subsidiary of the Blue Cross and Blue Shield Association.

What makes them independent and probably the best example I can give, is certainly we're all familiar with a company like McDonalds. And no matter where you go in the United States the restaurants look the same and the food menu looks the same and that's because their owned by independent people as franchises.

The Blue Cross and Blue Shield plans are literally franchises of the Blue Cross and Blue Shield Association operating under the guidance and oversight of the association.

Q Very good. Now I see you were senior medical director when Independence Blue Cross first acquired your old company, right?

A Correct.

Q Tell the jury how your duties and responsibilities evolved as

an employee of Independence Blue Cross?

A Certainly. Independence Blue Cross after acquiring Keystone Health Plan East, which was that HMO plan also decided jointly with Pennsylvania Blue Shield. Pennsylvania is one of those rare states by the way where the Blue Cross plan and the Blue Shield plan are separate entities; they're two different franchises of the association. That occurs in Pennsylvania and, New York and Oregon I believe is the only states, maybe Idaho at one time. But --

Q Did each one had a different standard of specialties? I mean, how would you have two different plans separate --

A Yeah. The Blue Cross plan typically was developed in the 1930s to cover hospital and hospital related expenses. Blue Shield plans were created somewhat later and those were created to cover outpatient, surgical, physician services, emergency services that type of thing and then they all came together under the auspices of the association.

Q Thank you, Doctor. So continue on, senior medical director, what was your next position there?

A My next position was vice president of patient care management in 1996. And that came about because between the acquisitions of Keystone Health Plan East in 1996, Independence Blue Cross jointly with Pennsylvania Blue Shield launched a PPO plan, which is a different type of managed care plan. It's a more open network plan that has both in and out of network benefits contrasted to an HMO plan, which is a network based plan.

When we launched the PPO in 1995 the company recognized my

work at the Keystone Health Plan East and promoted me to vice president to oversee the operations of both the HMO, the PPO and what residual indemnity business we still had.

Q Do you know what type of insurance contract Mr. Eskew had in this case?

A Yes. I do know he had a PPO plan. An individual PPO plan.

Q And you were involved in the launch of the first plan for Independence Blue Cross in '05?

A I was. I was actually the first PPO plan in the State of Pennsylvania.

Q What were --

A To launch in Pennsylvania.

Q What were your duties as the vice president of patient care management?

A In that case I oversaw, again, the utilization management department, the newly formed medical policy department because I launched the medical policy department for Independence after I became vice president. I was also responsible for our quality management initiatives and had a separate assigned medical director and team of nurses to do that work. And again, I still chaired our pharmacy and therapeutics committee.

Q What was your next position at Independence?

A My next position was to become ultimately vice president of pharmacy and care management and technology evaluation. It was a long and convoluted title. But basically at that point I had become a

senior executive in the health plan. I was responsible for the operations of 30 of your divisions, so we had about 110 divisions, so I managed a large portion of our corporate responsibility. We had about 1200 employees in my various divisions. I had a team of 30 medical directors as well as another team of about 200 consultants that I oversaw. I oversaw our newly formed technology evaluation unit. I oversaw the interface of our medical policy unit with our claims department, which we call our claims payment policy department.

And ultimately our departments were responsible for managing access to care and coverage for over three, almost three and a half million covered lives in Pennsylvania as well as about two and half million covered pharmacy lives in Pennsylvania. Accounting for about $8 billion worth of medical expenses.

And then from there --

Q Did you -- was that with a B?

A B.

Q Eight billion?

A B with a billion, yes.

Q Okay.

A Lots of zeros.

Q You mentioned that Delaware Valley was pretty small. Was Independence fairly small by the time you'd finished growing with it?

A No. When I finished growing with it, it was one of the 10 largest Blue Cross plans in the country, was the largest Blue Cross plan in the Mid Atlantic area. Of course, Empire Blue Cross in New York was

bigger. We were considered one of the more influential health plans insurance carriers in the country.

Q So in your work as a medical director, did you do preauthorization reviews as part of your duties?

A I did. During my work as medical director at Delaware Valley and Keystone, in my work as senior medical director. Once I was promoted to vice president with all of the other management responsibilities my front line duties became fewer. I would get involved in some of the complex cases or cases that required my oversight or experience. But when I became an officer of the company I mostly managed the people who did that type of work.

Q And you mentioned that you oversaw 30 medical directors at Independence --

A That is correct.

Q -- by the end of your career? And did some of those medical directors perform preauthorization reviews that were under your supervision?

A Yes, they did. The vast majority of them did. And of course, by that time we had such a volume of business that I needed to have medical directors in multiple specialties to handle those duties and it was my job to oversee all of them.

Q Thank you, Doctor. The jury's seen something called the UnitedHealthcare proton beam medical policy here. Were you involved in the creation of any similar policies at Independence Blue Cross?

A Yes. As I noted in my opening statement I really formed and

launched the medical policy department at Keystone Health Plan East. We transferred that process and technology over to Personal Choice and ultimately to Independence Blue Cross. Our medically policy department grew with the business, at one point I had about 5 nurses, a dedicated medical director to medical policy, a couple of PhD level analysts in, you know, in medical research. And we ultimately launched our online medical policy program, which allowed all of our policies to be converted to a publicly available website.

Q What is URAC? It's an acronym, U-R-A-C?

A It was an acronym; it is now the official name of that company. It was -- the acronym was utilization review accreditation commission. You can't say that three times without tying your tongue, which is I think the reason everybody referred to them as URAC and they eventually adopted that as the official name of their organization. And it was and still is, an independent review organization that was founded to provide oversight and review at first of health plans, but then it expanded to basically oversee and review other types of health care providers.

Q Were you involved with URAC while you were at Blue Cross?

A Yes. And that became about because of Independence's influence in the national Blue Cross organization. I was appointed to chair at the Blue Cross and Blue Associations national utilization review committee, which was a committee of the Blue Cross plans. Based on that position I was approached by the head of URAC, a gentlemen named Gary Carneal who said, we need a Blue Cross representative on

our board, our standards board. And I was appointed to represent not only Independence Blue Cross, but the association at URAC on the standards committee.

Q Does URAC have standards for utilization review?

A They do, to this day.

Q And were you involved in the creation of those standards?

A I was.

Q Explain to the jury what interrelationship there is between something called prior authorization, which we're dealing here and utilization review?

A It's a subset of utilization review, in other words it is a request for coverage of services that need to meet certain criteria to establish the medical appropriateness or medical necessity of those services. It is applied selectively. Less than probably five or 10 percent of all services covered by an insurance carrier, or a managed care plan go through prior authorization. They typically tend to be either newer technology or they may be technology where there may be documentation of misuse or inappropriate use for instance. So it's part and parcel of what's done in utilization review.

Q So I see you stopped working at Independence Blue Cross in 2006. Why did you leave that company?

A At that time I had also expanded my role to become -- in my vice president duties Independence Blue Cross launched something called a pharmacy benefit manager, a PBM, which many of you may know. You may have coverage under a PBM. Our wholly owned PBM

was called Future Scripts. and I was the senior executive in charge of developing and launching Future Scripts, which we did successfully in 2006.

And in 2006 Independence Blue Cross and Highmark decided to attempt to merge to be one Blue Cross and Blue Shield company. They offered many of us senior executives the option to stay with the new company or take a retirement exit from the company. I chose the second because I really had been planning to do that within the next year or two anyway to go onto the next stage of my career that I had already begun planning for, which was to open my own company and do boutique consulting in medical and pharmacy management.

Q And what was the name of the company you started in 2006?

A A very clever name, it was Gary Owens Associates Incorporated.

Q And --

A I obviously didn't have any creatives in that organization.

Q Has your employment changed since 2007 to today?

A It has not.

Q Are you still involved in the managed care industry as president of Gary Owens Associates?

A I am.

Q Have you continued to write since you retired from Independence Blue Cross?

A I actually probably write more now. I've always had a keen interest in medical education when I was a primary care practitioner. I

was, as I noted vice chair of the department, which is a teaching position for residents. I was a clinical affiliate professor at Thomas Jefferson, which means I taught medical students at Thomas Jefferson.

When I moved onto Independence I began to write articles about health care management and health plans that were published, most of them in peer reviewed journals. I'm happy to say I've continued my writing. As of last month I just had my 130 something article published. Article or some of those were editorial, so not all of them were published in peer reviewed.

I'm also please to say that many of my articles get cited in other publications. There are online websites that we all belong to that actually notify us when your articles get cited in other publications. So some of my work has been pretty widespread.

Q About how many articles have you written?

A It's over 130 and approaching 140 now.

Q Do any of those pertain to the managed care industry?

A I would say more than half, if not three quarters of them pertain to something in the managed care industry.

Q Have you ever done any presentations or lectures? Have you ever been invited to do those?

A Yes. I get frequently invited to do lectures. I've presented over 250 managed care related presentations. Prior to that I had done maybe 30 or so clinical type presentations in my teaching duties. I've presented at national meetings like the National Association of Managed Care Physicians, which is a national service organization for medical

directors such as myself. I've presented at the Academy of Managed Care Pharmacy, which is a similar organization in the pharmacy side of the business. Part of that is the fact that I started that thing that I called the PBM.

And AMCP actually elected me to their board of directors and to date I'm the only physician in the country to have served on this pharmacy related organization board of directors. Everybody else has been a pharmacist or a PharmD. And so I did that duty from 2014 to 2018. So I had occasion to lecture there. In fact I'm leaving Las Vegas tomorrow to go do two presentations at the Academy of Managed Care Pharmacy in Chicago on Wednesday.

Q Thank you, Doctor. So based on your experience and training, are you familiar with industry practices and standards when it comes to managed care?

A I think I'm very familiar having not only worked with them but having actually created many of them over the years. I had really the good fortune to work with literally some of the founding fathers of the managed care movements, such as Paul Ellwood whose work ultimately became United. Peter Kongstvedt who authored one of the preeminent textbooks early on in managed care. So I got to work with some of the literal founders of this type of organization from the beginning.

Q Are you familiar with industry standards and practices when it comes to preauthorization requests?

A I am.

Q And dealing with those?

A I am.

Q Are you familiar with industry standards and practices when it comes to the medical policies like the proton beam policy in this case?

A Yes. I am because of my experience overseeing both the medical policy department and our new technology evaluation unit.

Q So let's talk about your current work and your consulting practice. Do you do all legal consulting now?

A No, I don't.

Q How would you break down the general categories of what you're currently doing with Gary Owens Associates?

A I really can break down my corporate responsibilities into three areas. About a third of my work is still with health plan and health plan related subjects, either through teaching. For instances, I have been now for two years doing a monthly online webinar for the National Academy of Family Physicians. The general theme of that is what managed care needs to know and then you fill in the bank with a particular issue. So I do a presentation monthly for NAMCP. I do similar presentations at the annual meetings for AMCP.

So between my direct consulting to some health plans I've even served as an interim medical director on occasion to health plans who had a medical director resign. For instance, Martin's Point Health Plan up in Portland, Maine, I did that for a few months. So, you know, I keep my hand on the payer side and work with payers literally probably every day. So that's a third of my business.

Q Now when you say payers, what do you mean by that?

A Those are the health plans. Probably the synonyms, insurance carriers, health plans and payers just to ground everybody if I use them interchangeably. It's hard to get out of the vernacular of my business.

Q Thank you, Doctor. So what's the other third?

A The next third is basically my writing. I do work with other organizations, for instance, there -- a couple of large technology review organizations in the country, one called M-C-R-A, MCRA it's not an acronym, that's their name and I serve as an advisor to them and look at clinical trial protocols, basically from the payer or health insurer's prospective to advise their clients on are they developing the right data sets in order to gain coverage for instance.

I work with Icon, which is multinational company with similar duties. They're what's called a CRO. They basically oversee clinical trials. So if you've ever heard of people participating in clinical trials, Icon is one of the largest overseers of them and I evaluate some of their clinical trial protocols as well as some of their interfaces with industry both technology and pharmaceutical. And so that's the middle third.

And then the other third is what I call, pardon the vernacular again, OWAs my other weird arrangements, which is other things that I might be called on to do. And of that legal work is a small slice of that, I estimate five to 10 percent of my total work is spent doing what I'm doing here today.

Q Okay. You mentioned, you know, that in that first third you consulted with insurance carriers?

A Yes.
Q Have you ever consulted for Sierra Health and Life prior to this case?
A I have not.
Q Have you ever consulted for any UnitedHealthcare entity?
A I have not.
Q So our firm retained you as an expert witness this case, right?
A Pardon?
Q Did our firm retain you as an expert witness in this case?
A Yes. I just heard that unfortunately due to the plexiglass. Yes. Your firm retained me as an expert in managed care.
Q You just missed it, that may come down this weekend.
A I heard at the end of the week.
Q So are you being compensated for your time that you spent consulting with us on this case?
A I am.
Q And how much are charging us?
A My standard fee is $525 per hour.
Q Can you estimate how much we've paid you up through today?
A For work completed up through today, probably in the 20 hour range, maybe I bit more than that.
Q Okay. So a little more than 10, what -- how much?
A 10 to $12,000 would be a fair estimate.

Q And you expect to be compensated for your time on the stand today?

A Yes. And the preparation work of course.

Q Is that charged at the same hourly rate?

A It is charged at exactly the same rate.

Q Is that a standard rate or are you charging us more?

A That's my standard rate.

Q Good enough. So sir, what --

MR. ROBERTS: Let's go to the next slide, Audra.

BY MR. ROBERTS:

Q So after we retained you I'd like to -- for you to summarize to the jury what work you performed for us, starting with your engagement. When were you first engaged?

A My engagement letter was signed in the fall of 2020.

Q And do you recall what the deadline was for you to submit your first report?

A It was later in the fall of 2020. I don't recall the specific date, but it was -- you know, rough guesstimate, maybe two months later.

Q In your report did you keep track of every document that you reviewed to prepare your report?

A Yes.

Q And could you summarize the key documents for the jury?

A Yeah. Certainly I can't remember every document that are listed in the attachment to the report for completeness. But I looked at the prior authorization requests and the information that went back and

forth between the reviewer and the nurse reviewer. I looked at medical policies from UnitedHealthcare, including their proton beam policy. I looked at a number of internal operating policies from UnitedHealthcare, such as their UM oversight policies and their medical policy development policies. For instance, I looked at some depositions, in particular the depositions of Dr. Ahmad, Dr. Liao and Ms. Amogawin, I think if I pronounced it correctly and if I didn't my apologies to her.

Q What deposition transcripts did you review again?

A Again, Dr. Ahmad.

Q Uh-huh.

A Dr. Liao and Ms. Amogawin.

Q Okay. So there's another period of time, do you recall when we asked to do a supplemental report after reviewed additional materials?

A I did.

Q And what additional materials did you review to prepare your supplemental report?

A I reviewed some expert reports, Mr. Prater's report, I reviewed Mr. Flood's report, Dr. Chang, a radiation oncologist report. I did some additional investigation in things like other medical policies on proton beam therapy since virtually every health plan in the country now has them publicly available on their websites, among other things.

Q And then did you prepare a second supplemental report at our request?

A I did.

Q And what was that second supplemental report commenting on?

A And again, I reviewed a supplemental report by Mr. Prater and Ms. Holland-Williams, as well as a few other miscellaneous documents and submitted a very brief second supplemental report.

Q Now the jury in this trial has already heard testimony from Mr. Prater, Mr. Flood and Dr. Chang. Have you listened to any of that testimony or read any of the transcripts?

A I have listened to the testimony of Mr. Prater. I have listened to some of the testimony of Mr. Flood. I have listened to testimony, let me think, of not Dr. Chang. There is one more and it's escaping me at the moment. It will come to me at 2:00 a.m.

Q Okay. Thank you, sir. Let's go back. There was one thing I meant to ask you. You know, when you mentioned five to 10 percent of your work was in legal consulting.

A Yes.

Q How many legal cases have you done over the last four years?

A In the last four years including this one, there are four.

Q And out of those four cases, did any of them deal with managed care?

A The -- yes. In essence all of them had something to do with managed care.

Q Okay. And did you work for the insurance companies in all four of those cases?

A In this case I worked for the insurance company. Another case I worked for the insurance company, that was a case where I worked with Cigna, another large national carrier. Yet in another case I actually worked for the Defendant in that case, which was a drug manufacturer because it was an issue of what's called CGMP, which is good manufacturing processes. And it basically based on my expertise in my PBM world and pharmacy and therapeutics. In that case I was actually adverse to the Blue Cross and Blue Shield Association.

Q Have you ever turned down an opportunity to serve as a legal consultant?

A I think I probably turned down more opportunities than I've done. Simply because it's not a major focus of my practice. And literally if I don't think I'm the best fit for use of my expertise I will turn that down.

Q Did you feel that your expertise was a good fit for this case when we offered you the opportunity?

A Absolutely.

MR. ROBERTS: Okay. Audra, could we put up the next slide?

BY MR. ROBERTS:

Q Can you take a look at this and tell us if this slide accurately summarizes your opinions that you'd given us in this case?

A Yes. It really says two things, a review of the PBT request was reasonable and complied with industry standards and the medical policy for lung cancer in 2015 was reasonable and compliant with industry standards. And that's a very concise two sentence summary of

what is a much more comprehensive and complex report than that.

Q Thank you, Doctor.

MR. ROBERTS: Next slide Audra.

BY MR. ROBERTS:

Q Let's talk about your first opinion. The review of the proton beam request was reasonable and complied with industry standards. Could you summarize your findings here for the jury?

A I certainly can. First of all, the question was asked of me, "Was the review conducted by an appropriate person"? The individual who reviewed that case, Dr. Ahmad, was a board certified oncologist, highly trained. I remember somewhere in perusing his credentials he was trained at Mount Sinai, one of the more prestigious hospitals in New York.

Based on all of the standards that our industry operates under, Dr. Ahmad met the criteria for being a peer, which is someone in a same or similar specialty, as typically manages or provides care for a patient with that diagnosis, which, in this case, was squamous non-small cell lung cancer.

Q So there's been some criticism to the fact that Dr. Ahmad was not a radiation oncologist. Does the industry standard of care require that the medical director be that specific for a preauthorization request?

A It does not. In fact, whether you look at URAC regulations, NCQA regulations, CMS, Center For Medicare & Medicaid Services, which is what oversees Medicare and oversees Medicaid, they do not

require identical match specialties. And there are more than 200 subspecialties, so, you know, there is a breadth of -- of those individuals.

And, in fact, in my opinion -- and I've worked with oncologists and lectured dozens of times on oncology issues in managed care -- I typically find that oncologists have a broader understanding of cancer care than anybody in the medical profession. And that's because they're responsible for the longitudinal care from the beginning of when a patient is diagnosed with cancer until literally they are at the end stages of cancer.

So they really provide a holistic approach to cancer care. They will draw in other subspecialists when needed. For instance, a surgical oncologist to perhaps remove the tumor, or biopsy a lymph node. They'll bring in radiation oncologists in -- like in this case in order to determine whether radiation therapy is going to be appropriate.

But, ultimately, when those people are finished doing their jobs, these patients go back to the oncologist for continuation of care. So literally they are the care coordinators and the overseers of this very complex field of oncology, which is changing day to day.

Q Let's look at your next bullet point. Could you summarize your next opinion with regard to the timeliness of the review?

A Yes. The review was done in a timely manner. Based on my review of the medical records, this review came from MD Anderson as an urgent request. And, again, based on our standards, which are the same standards whether it's Medicare, Medicaid, or commercial, so this could be CMS, it could be state regulations, or it could be NCQA or

URAC, health plans are retired -- health plans, insurers, payers -- again, please forgive me -- are required to turn urgent requests around in 72 hours. And typically the industry definition of 72 hours is three days.

Q Thank you, Doctor. What about your opinion -- the next opinion here that you've summarized?

A Accurate and appropriate information was provided to the correct --

Q Well --

A -- party.

Q -- I think you may have skipped one.

A I did skip one. Pardon me. This -- this screen is -- is a bit blurry, either that or my glasses have suddenly gone --

The decision was made in a reasonable manner. In -- in this case, the pertinent medical records were forwarded to -- to United Healthcare by MD Anderson on behalf of Dr. Liao. Those medical records were pre-reviewed by the nurse, Ms. Amogawin. She determined, for instance, that proton beam therapy was a covered benefit, she determined that proton beam therapy required a prior authorization, and she determined that there were medical records to send on to a reviewer.

Again, it's standard in the industry that if something can be approved, a lower level of -- practitioner can approve that, so that if this had been a request for something than didn't require prior authorization or met all of the clinical criteria, the nurse reviewer could have approved it. All denials must go to a medical director. And in this case, it was

Dr. Ahmad, who's a board certified oncologist in the state of Nevada.

Q Let's move on to the next bullet point now.

A The one I've already tried to cover?

Q Yes, Doctor.

A Exactly. Accurate and appropriate information was provided to the correct parties. A summary of Mr. Eskew's case was provided to Dr. Ahmad, including their justification for requesting proton beam therapy. The information contained Mr. Ahmad's [sic] diagnosis, it contained a brief outline of some of his prior therapies, which included chemo immuno oncology treatments, and it outlined the extent of his current disease in both the chest and in peripheral site or sites of the tumor, and it, you know, proceeded to request proton beam therapy for a certain number of treatments.

Q And then the final bullet point is the Process Materially Met the Standards Set by Independent Organizations. And we've got slides to cover that detail. But you mentioned URAC already. What other independent organization or organizations did you look at?

A NCQA, which is probably the most preeminent certifying organization in the country, not only for health insurance carriers but now they certify provider networks, they certify pharmacy benefit managers, those PBMs I talked about, they certify health systems, what are called IBMs, which are integrated delivery networks.

So they have become an overarching white glove certifying body for all of these organizations to the extent that CMS, which is, again, the government, the federal government, deems a certification by NCQA to

have met all of the government's standard to provide services to Medicare and Medicaid at most states.

Q Okay. Let -- let's walk through some of these points step by step.

MR. ROBERTS: Audra, could you go to the next slide?

BY MR. ROBERTS:

Q And I think you've already covered this somewhat when -- when you gave your introduction. Is there anything that you wanted to add to your opinion that a medical oncologist was qualified to review a prior authorization request for radiation oncology?

A I absolutely think that that's a qualification because a medical oncologist, again, understands the cancer care from beginning to under -- end. He or she understands the role of the various modalities of treatment, including radiation oncology. Now, an oncologist is not going to do the radiation oncology. They don't need to understand how to use those tools, but they need to understand to apply those tools.

And let me give you an example to kind of bring this home. I'm a family practitioner. I don't do surgery, or I only did minor surgery on things in the skin. But I was often called upon in my duties early on to review surgical cases. I can get surgical records and understand whether -- when the surgeon was choosing to do, appropriate or not. We had criteria. And if I didn't understand it, I could call the surgeon and say, "What are you going to do and why"? What I didn't ask him was, you know, what type of scalpel are you going to use to make the incision, right? You know, that sort of thing. I didn't ask him what kind

of suture material or even what type of instruments he's going to have on the tray. I just needed to know that he was going to do it and why.

Q So several people in this courtroom have opined that it's obvious that Dr. Ahmad as a medical oncologist could not have actually prescribed and performed radiation treatment. Would you agree with that?

A I agree with that totally.

Q Well, if he's not authorized to perform radiation oncology treatments, how can he be qualified to review a preauthorization request for that treatment?

A Because, again, medical oncologists understand and integrate radiation oncology treatments into their comprehensive plan of care many times. I mean to use lung cancer as an example, if one has a stage 3 lung cancer, one of the standard treatments for that is what's called chemo radiation. We are giving chemotherapy concurrently with radiation.

So the oncologist is working hand in hand with the radiation oncologist to administer chemo while the radiation is being given. In fact, the radiation oncologist actually goes back to the oncologist to make sure that chemo has been started ahead of the radiation, because that literally is known as what's priming the field for the radiation to be more successful.

MR. ROBERTS: Audra, can we look at the next -- go to the next slide, please?

BY MR. ROBERTS:

Q Now, a medical director like Dr. Ahmad in this case, does the American Medical Association have principles and standards which guide medical directors in their work?

A They do.

Q And have you cited some of those in -- in your report?

A I have.

Q Okay. So what is the AMA Code of Ethics?

A It's a code that we all practice by and it basically points out the -- and you might want to blow that up for everyone. But it basically -- you know, we need to use our medical knowledge, our skills, and our interaction with the patient to basically, you know, work on behalf of the patient first. And, in other words, do the right thing medically.

Q How do doctors know about the AMA Code of Ethics?

A Basically it's published in all of the AMA websites, it's published in their AMA journals periodically. If you are a member of the AMA -- now likely not every physician is an AMA member -- I still happen to be one even know I don't actively practice -- we -- you know, we have plenty of ways to understand and know what that code of ethics is.

Q So we've cited here -- or you have cited here, "10.1.1, Ethical Obligations of Medical Directors." Is that a -- is that the type of medical director we're dealing with here in the managed care industry?

A That is correct.

Q Could you read the first part of that, which you've highlighted, for us?

A Yes. "The ethical obligations, physicians core professional

obligations, including acting in and advocating for patients' best interest. When they take on roles that require them to use their medical knowledge on behalf of third parties, physicians must uphold these core obligations."

Q Now, you've reviewed the files in this case, reviewed Dr. Ahmad's deposition, right?

A I have.

Q Is it fair to say --

A And that's actually the other testimony; I watched Dr. Ahmad. I knew it would come to me.

Q Thank you, sir. So I didn't see anywhere in there where he was advocating for Mr. Eskew to receive proton beam therapy. Would you agree?

A Yeah. In terms of writing down, "I'm advocating for this." But he was in terms because he was looking at the information he needed to make the review. He was making that review using the resources provided to him as well as his medical knowledge and expertise in making a determination that was both consistent with the coverage provided by, in this case, Sierra as well as the medical appropriateness the requested service.

Q So how do you relate advocating for the patient's best interest with the scientific evidence of the procedure being medically necessary? How do those things work as a medical director complying with the code of ethics?

A I think they work fairly simply. And, you're right, it's around

in many ways the scientific evidence. Basically medicine, especially in the 21st century, as evolved to what's called an evidence-based approach, which was not always the case. I mean early on in the days of medicine people just bought things up and let's try it. Later on, we move -- that was in the 19th century. We don't put leeches -- well, we do put leeches on people but not for most medical reasons. We don't bleed people when they have fevers. You know, fast forward to the 20th century, we began to -- medical technology began to explode. And many things were tried but not necessarily subjected to rigorous trials. So we learned that they worked over experienced.

The latter half of the 21st century, the gold standard became a clinical trial to prove that something is not only safe and effective but as good or better than existing technology. And then you move into the 21st century, where literally there's been a technology explosion, things that I literally, when I trained with I thought, would have been science fiction. That -- we now need to look at all of the evidence surrounding a technology and make a determination whether that technology has been proven to be safe and effective based on as much of the medical evidence or literature as we can.

Q Is it in the patient's best interest to advocate for treatment that's not scientifically proven?

A No, it wouldn't be because they're unknowns. We -- there's -- you know, as I used to teach my medical directors, and, you know, I had a group of 30 of them, but over my years at Blue Cross, you know, medical directors come and go, I probably trained 50 or 60 medical

directors. My first adage was the old Latin term primum non nocere, which means first do no harm. Right? Second, I would advocate do the right thing medically first. And then third, I would often say, you know, look at the science because what often seems intuitive is not. And, you know, things that seem intuitive and logical may not be until proven.

I can give you an example of that Mr. Roberts, if you'd like, but I --

Q Well, maybe --

A -- don't know --

Q -- we'll get -- maybe we'll get back to that. But I would like you to tell the jury, are leeches still used in medicine today?

A Yes, they are, as a matter of fact. There are a few unusual conditions where leeches can actually cleanse a wound. And as an aside, we occasionally use maggots for that purpose. So, you know, not everything they did in the 19th century was crazy; it's just crazy by today's standards.

Q Okay. Could you tell the jury about the -- the other thing that you've indicated here in the ethical obligation of medical directors, subpart E?

A Yeah. In subpart E, it's basically put the patients' interest over personal interests, financial or others created by the nonclinical role.

Q Have you seen any evidence here that Dr. Ahmad put his own personal interests over the patient's interests?

A I did not. And, in fact, United has a group of policies and

procedures to ensure against medical directors and reviewers doing that. And they're -- and they're a very large group of policies labeled 100.XXX whatever. There's a whole section on the obligation of their reviewers, and the obligation of them is a health plan, what's called an affirmative statement. You know, not to put your interests above those of the patient or --

Q And --

A -- the insurance carrier.

Q And have you reviewed those policies and the affirmative statement which has to be acknowledged by the medical directors?

A I have. All 75 pages of them. Not -- but who's counting?

Q Do those policies comply with industry standards?

A As a matter of fact, they're referenced as to which industry standards they comply with, including NCQA, CMS, and Nevada statutes. I believe they're called

NGS statutes or --

Q What state again sir?

A Nevada.

Q Okay. Thank you.

A My East Coast accent comes through sometimes. I promise I won't let the Philly boy slip into this too many times.

Q And --

A But I can say Yo Rock with the best of them, but just for those of you who know Philly's most famous person who never existed.

Q And then, finally, the acknowledgment that has to be signed

by the medical directors, including Dr. Ahmad, did that meet industry standards?

A That is industry standard. We all had to do that at all of the positions that I worked for.

Q Okay. Let's talk a little bit in more detail about the timeliness of the review.

MR. ROBERTS: Could we go to the next slide, Audra?

BY MR. ROBERTS:

Q Did you review United Healthcare policies on utilization management which dealt with the timeliness of treating preauthorization requests?

A I did. And now we're into that series of policies I just mentioned, that 100, a series of digits. And the most recent version of that medical policy was 10/22/15, which was just a few months before this decision was rendered by Dr. Ahmad.

Q Okay.

MR. ROBERTS: And Audra, can you just blow up the bottom clause there so we can get that as big as we can? Perfect.

BY MR. ROBERTS:

Q Could you tell the jury what you are pointing at here in the medical policies?

A Yes. In that section that you can see with that rather lengthy decimal pointed number, "Urgent preservice decisions are made within 72 hours beginning on the day the request is received for commercial, Medicare, and Medicaid members if no extensions are requested or

needed."

Q And how long did it take Sierra Health and Life to make a decision in this case?

A Approximately 48 hours, give or -- give or take a bit.

Q One thing that came up during the trial was the fact that one of the experts for the Plaintiff pointed out that there's no evidence that Mr. Eskew received a phone call. Did you review the policies and have an opinion about whether the health plan should have called Mr. Eskew as opposed to just sending him a letter?

A I did. And that was actually in their policy 100.07, and it basically -- that's their notification and communication -- pardon me -- let me take a drink of water here --

Q Please do.

A -- and in that policy, you know, it establishes a number of notification requirements. But there's a specific section of that policy that said for urgent precertifications, notification as the provider is adequate as it -- the provider is, in essence, the members' authorized representative for that service. It also goes on to state they will try to reach the member and make at least two outreach calls. But it qualifies that notification with that statement about urgent requests. And, of course, as we saw later, the letter was promptly generated.

Q And was a timely phone call made to the provider, it's agent --

A Yes.

Q -- for the member?

A Yes. That was established in the MD Anderson records, that they had gotten the communication from Sierra Health plan and, in essence, asked Dr. Liao what they wanted to do. And, in essence, said they were going to make an outreach I believe to Mrs. Eskew.

Q Now, looking at this -- just not in the context of the policy that Sierra Health and Life wrote or adopted --

A Yeah.

Q -- but just in terms of industry standards, is a 48-hour turnaround on an urgent preauthorization request like this, does that meet industry standards?

A It does. Again, the industry standard is typically 72 hours. But, again, all of us tried not to use up all of that 72 hours if we have what we think is adequate information to make that determination. We basically will turn that -- you know, if we can turn it around in 24 hours or less -- again, the faster we can turn around a determination, again, that's acting in the patient's interest because then they know where they stand and maybe if there are alternate care plans that need to be established.

Q I'd like to move on to the next bullet point, "Whether the Decision was Reached in a Manner that Complied with Industry Standards."

MR. ROBERTS: If we could go to the next slide, Audra. And let's just blow up those bullet points. Perfect.

BY MR. ROBERTS:

Q So you reviewed the Exhibit 5, which is the communications

with Dr. Ahmad, the urgent -- the preauthorization request, the letters that went out denying the request? Have you reviewed all of that?

A I have.

Q And have you reviewed the medical policy?

A I've reviewed the medical policy for communication and all of the medical policies around their various UM internal operation policies.

Q Okay. Based on your review, did you reach an opinion about whether Dr. Ahmad had read the request and understood that proton beam therapy was being requested for stage 4 metastatic non-small cell lung cancer?

A Yes. That was clearly stated in the request for proton beam therapy. Again, including some -- you know, a brief clinical synopsis of Mr. Eskew's case to date, including his tumor when it was discovered really as a -- as an arm issue to the subsequent -- initially it was determined to be a metastatic tumor of unknown origin, and it was only later that they documented it was a metastatic non-small cell lung cancer. And even there was of squamoid, which means squamous, like origin. And then they established the metastatic, meaning spread, of that tumor into the mediastinum and the lymph nodes that are there, more specifically.

Q And --

A So it met all of the definitions of stage 4 lung cancer.

Q We've heard that word a few times squamoid, squamous. What does that mean?

A It's a cell type. There are really two types of cells in our lungs. There are the -- what are called the cells -- it's all based on how we're actually built from an embryo. And I'm not going to get into that. But the two types of squals [sic] are squamous cells and -- and adenomatous cells. One is glandular origin; the other is kind of skin or tissue. Our skin is squamous cells, for instance. And so it's basically either one of those two cell types in non-small cell lung cancer that we have. Now there are -- to get complicated, there are some tumors that are adenosquamous. They show features of both. But, in essence, this was treated as a squamous non-small cell lung cancer.

Q So based on your review of the file, Exhibit 5, what did Dr. Ahmad rely upon to deny the request for preauthorization?

A Well, first of all, he relied on his knowledge and expertise as a board certified medical oncologist in Nevada. Second, he relied on any information that he may have obtained through any kind of literature search. And he relied on the United Healthcare proton beam medical policy. And that policy was created precisely for things like this, to create a reference for medical directors.

So, in essence, as a medical director, you don't have to reinvent the whole process again because those policies are developed and updated mostly to simulate all of, as much of, the latest medical literature as you can. And so that means I don't have to stop every time I do a review and do a MEDLINE search and try to do my own analysis of the literature. They have professional people who do that and then publish those policies for use in situations exactly like Dr. Ahmad used it.

Q Is it a breach of the standard of care in the insurance industry for medical directors to rely on medical policies created by the company?

A No. In fact, it's a requirement of those standards that they use medical policy as one of the sources of what they do. You know, we are all required to create those medical policies, we are all required to update them as needed or annually, according to things like NCQA and URAC standards, whichever is first. And those are precisely there to give medical directors a framework and at a very quick review, or something called a meta-analysis, which means a higher analysis of the existing medical literature.

Q Do medical directors complying with the standard of care in the industry always need to approve care that's recommended by the treating physician?

A No, they don't, as a matter of fact. And, you know, we all trained our medical directors, you know, you make the right decision medically first, you use the policy as a framework. And we have those policies there to create consistency. So if I review a case or, Mr. Roberts, if you were a medical director reviewing a case, we'd all be looking at the same thing. But at the same time we can always look for and are trained to look for maybe a mitigating circumstance or something unusual that would say, I understand what the medical policy is, but based on my experience, my knowledge, perhaps my interaction with a requesting physician, if I need to do that, I'm going to override the medical policy and approve this care.

MR. ROBERTS: Audra, could we go to the next slide?

BY MR. ROBERTS:

Q I'd like to look here at the denial letter that was sent out to Mr. Eskew, Dr. Liao, and the MD Anderson Center. Did you review that letter in detail?

A Yes, I did.

Q And in your opinion, did that letter comply with industry standards?

A Yes, it did.

Q Is there anything that gave you cause for concern?

A No. It contained all of the elements that -- again, state regulations, CMS and/or NCQA requires to be in a letter to the member -- a denial letter to the member. These letters are highly regulated. They have to have certain language in those letters. In order to do that, health plans create a structure and a process to create those letters. And, in my opinion, as I look at this, everything that should have been included was included.

Q Specifically what big things were you looking for?

A Well, first of all, what was the request for service that shows that the health plan understood what was being asked for. Number two, was the service was denied. Number three, that there was language explaining why the service was denied in an easily understandable type of language. Not medical gobbledygook or technical language. Again, that's a requirement of most state regulations that I'm familiar with. It's certainly a requirement of CMS. CMS actually requires, again, Medicare. It requires that our letters be understandable at a fourth grade reading

level. They ever regular the font size. So for people like me who wear progressive lenses, that font size is comfortable to read.

THE COURT: Thank you, Mr. Roberts. We're going to take our first recess.

You are instructed not to talk with each other or with anyone else about any subject or issue connected with this trial. You are not to read, watch, listen to any report of or commentary on the trial by any person connected with the case or by any medium of information, including, without limitation, newspapers, television, the Internet, or radio. You are not to conduct any research on your own during this case, such as dictionaries, using the Internet, or using reference materials. Do not conduct any investigation, test any theory of the case, recreate any aspect of the case, or in any other way investigate or learn about case on your own.

Do not talk with others, text others, Tweet others, Google issues, or consult any other kind of book or computer research with regard to an issue, party, witness, or attorney involved in this case. You're not to form or express any opinion on any subject during this trial until the case submitted to you.

We'll come back at 10:45.

THE MARSHAL: All rise for the jury.

[Jury out at 10:30 a.m.]

THE COURT: Any issues outside the presence the jury?

MR. SHARP: No, Your Honor.

MR. ROBERTS: Nothing for us, Your Honor.

THE COURT: Okay. We'll come back at 10:45.

MR. ROBERTS: Thank you, Your Honor.

[Recess taken from 10:30 a.m. to 10:45 a.m.]

[Outside the presence of the Jury]

THE CLERK: Back on the record.

THE COURT: Thank you. Please be seated, Counsel.

Are the parties ready for the jury?

MR. ROBERTS: Yes, Your Honor.

MR. SHARP: Yes, Your Honor.

THE COURT: Thank you.

[Pause]

THE MARSHAL: All rise for the jury.

[Jury in at 10:47 a.m.]

[Within the presence of the Jury]

THE MARSHAL: Your Honor, all the jurors are present.

THE COURT: Thank you. Do the parties stipulate to the presence of the jury?

MR. ROBERTS: Yes, Your Honor.

MR. SHARP: Yes --

THE COURT: Thank you.

MR. SHARP: -- Your Honor.

THE COURT: Thank you. Please be seated.

Mr. Roberts, please proceed.

MR. ROBERTS: Thank you, Your Honor.

DIRECT EXAMINATION CONTINUED

BY MR. ROBERTS:

Q Okay. Picking up where we left off on the denial letter, based on your experience, did it leave out any pertinent information that was required to be in it by industry standards?

A No, it did not.

Q Well, it didn't contain a copy of the full medical policy, did it?

A No, it did not.

Q Was that required to be attached by industry standards?

A It is not required to be attached by industry standards. Again, the requirement is that the explanation and be -- of the reason for denial be presented in a language that's easily understandable by a layperson.

Q Now, the jury has heard testimony that this letter was actually prepared by Gustavo Guerrero and not by Dr. Ahmad. Are you familiar with that testimony?

A I am.

Q You're familiar with the fact Mr. Guerrero is the one who prepared this letter?

A I am.

Q Does that give you any cause for concern under industry standards?

A Not only no cause for concern but it would have been an expectation, because, again, my industry standard, we are required to have very specific information and formatting of these letters. And, in essence, in order to meet that standard, every health plan that I've ever

been affiliated with has developed a letter generation process and system to do that to be sure we're compliant not only with industry standards but often with CMS and state regulations.

Q So do medical directors typically type up their own letters?

A My quick answer to that, I would hope not, because the variability that might be created by that would be almost impossible to meet the standards, number one. Many of my medical directors were very, very brilliant physicians, but I wouldn't say their prose writing was as good as it should be.

So in order, again, to meet those standards, NCQA, for instance, and other organizations require us to develop a process, and United has that policy, that 100.7 communication policy that sort of lays out what is needed to do to generate member communications.

Q And you talked about having a dedicated unit. You know United had an adverse determination group here, right?

A That is correct.

Q And is that standard in the industry?

A It is. We all have different names of -- you know, Independence Blue Cross, we were just our letter generation, a unit. But because when you issue a denial, aka, the adverse determination, you are required to meet all of those standards that go in the letter. Hence, the reason for having a process and to -- in essence, you don't want to have to reinvent each letter and have each person sit down and try to read the standard and write the letter. Among other things, you would never enforce consistency. And the second one, from an operational

standpoint, it would be very inefficient.

Q So the jury's also heard about the denial library that Mr. Guerrero used to put this letter together. Do you recall that?

A I do.

Q And is it unusual in the industry for a company to have a library of denial forms for specific requests?

A It's not only not unusual, it is the standard in every industry, again, that I've seen, because, again, you want to make the language as consistent as possible. And the number of things that you make determinations on is somewhat finite. And so you can create that library. Now, that library's not static. It's dynamic. And circumstances change and as rationales change and as scientific evidence changes, that denial library evolves with that.

So it's constantly evolving. But it's a very necessary thing in order to ensure these communications have the right language at the right reading level at the right level of understandability before they go out to the individual subscribed.

Q Now, we haven't heard any evidence. Sierra Health and Life has an approval library. Is that unusual in the industry for a company not to have an approval library?

A Absolutely not, because if your request is approved, why does that need to be justified? It implies it met all the requirements for approval. I don't think anybody's ever going to appeal an approval. So you wouldn't need appeal rights in that. And basically, again, the standards require us to notify members of the approval, but it's a very

simple, short letter. "Your request for such and such of service has been approved. You know, provider has been notified, et cetera."

Q Thank you, Doctor.

MR. ROBERTS: Audra, could we go to the next slide?

BY MR. ROBERTS:

Q Now, we've talked about the NCQA briefly this morning. But tell the jury what NCQA stands for.

A It stands for the National Committee for Quality Assurance.

Q Mr. Prater alluded to the fact that this was an industry organization. Is NCQA accreditations something easy to get if -- as long as you pay the money?

A No, it is not.

Q Tell the jury a little bit more about how rigorous this process is.

A Yes. NCQA was actually founded in the early 1990s, again, by a group of visionary people led by another person I happened to get to work with in the early days of managed care, Margaret O'Kane, who to this day is still President of that organization. And some of those visionaries began to understand that with the emergence of managed care that there needed to be some oversight of that managed care industry, some standards by which we all should adhere to.

Many of you may have heard of a similar organization called -- for hospitals called the JCAHO, the Joint Commission on Accreditation of Hospitals [sic], known briefly as the Joint Commission. And do they a similar thing to review hospitals and make sure they meet those

standards.

So NCQA was formed, and it has literally grown over the years not only to certify insurance companies and health plans, but to certify provider organizations, to certify accountable care organizations, to certify hospital networks and integrated delivery systems, and -- and many other things.

The NCQA review of itself is almost a yearlong process for a health plan. Literally. You first have to start by applying for NCQA certification. When you apply, you do pay a fee for that application. And then NCQA sends you, in essence, which is a request for proposal, but it's a whole list of things that they need to begin the review. And so they have pages and pages of documentation about your policies, your policy development process, your affirmative statements, just to name a few. And you literally have to forward them all of those policies and procedures. The last time I did that with Independence Blue Cross, it was literally a collection of binders or, back in those days, big CD ROM that -- that we sent them.

NCQA performs what's known as a bench review. And if you don't meet the basic criteria for review in that bench review, you're given a letter telling you what you're deficient in and a time period to correct those deficiencies.

Q But what's another word for bench review?

A It's a desktop review. They review your documents to make sure that they're in compliance with the standards as promulgated.

Q Okay. And if the bench review determines that your policies

are within standards, what happens next?

A Next they come to do what's on -- on site review. The same -- send a team of reviewers to your health plan, and that on site review basically asks you to pull a random number of policies, a random number of denial letters, a random number of cases that had been reviewed. And those reviewers actually review those. So that's a bit of a white glove inspection, isn't it? You don't know which cases they're going to ask for, you don't know which policies they're going to ask for, you don't know which letters they're going to ask for. And so you actually pull all of that documentation, and they review that.

They also interview key people in the health plan, the director of quality management, the vice president of care management, like myself, the chief medical officer, sometimes even the CEO of the organization. And there they're looking for consistent of understanding of your knowledge in adherence to that policy. So they just don't want to make -- they want to make sure you just don't put it on paper, that people who are in the organization live and breathe and understand that and intellectualize that. And -- and, again, you know, not every health plan passes those reviews.

Q So in requesting random documents in this onsite inspection, are preauthorization requests and the -- are responses to those requests part of was randomly selected?

A That is correct. They -- they select that to make sure, number one, you know, that you reviewed a complete as possible record. And I should point out, we're held to HIPAA to a standard called TPO. And if

you're not familiar with that, it's -- we are allowed to get as much information to review medically as is necessary for treatment, payment, or operations. And, you know, we can't necessarily say send every medical record on this person or everything they've ever had. We need to be specific about what we need. It has to be the minimum necessary for TPO treatment, payment, and operations.

Q Have you ever been involved in an NCQA review?

A I've been involved in several. The 22 years at Independence, our first review was in 1992. That was just after NCQA got off the ground. And we had peer -- typically your certification is for three years. So as soon as you finished your three years cert, you start on the next certification. I will say our first certification at Keystone Health Plan East was a negative determination. We got a provisional accreditation and had to actually have a rereview in a year to get the rest of our standards up. After that, we were fully accredited throughout the rest of my tenure there. But nothing succeeds like failure and knowing what you didn't do in order to pass the first review.

Q And are there health plans that pay all this money for accreditation and then don't get it?

A Yeah. Maybe up to a quarter of them.

Q Up to 25 percent?

A That is correct.

Q So let's look first at the slide you prepared.

MR. ROBERTS: And Audra, if you could blow up the accreditation summary report.

BY MR. ROBERTS:

Q And could you tell the jury what this is?

A Okay. This is a summary of -- of the various areas that NCQA reviews in order to accredit it a health plan. And it points out, first of all, that Sierra Health and Life on the date you see at the top was accredited by NCQA, effective 8/25/16, correct? Or at least that's the date the report was generated. The effective date was 8/12/2014, which was actually the date the accreditation was completed. Sierra Health and Life was accredited. They basically scored above 85 points on all of the domains that NCQA reviews and received a full accreditation from NCQA.

Now, NCQA gives you star ratings from one star through five stars. It's -- you're, graded, just like for teachers used to do, on the bell curve. So if you're a three star plan, you're kind of right in the middle of that bell curve, the majority of health plans. And then, of course, the standardized bell curve. There are fewer and fewer percentages who get four stars and five stars. That's -- about five percent of the plans get five stars. And then down to the other side, if you're a one to two or zero star plan, you don't get accredited. So it -- you know, basically you did everything that was necessary if you're a three star plan.

Q Thank you, Doctor.

MR. ROBERTS: The block on the right-hand side of the page, Audra, right in there --

BY MR. ROBERTS:

Q This talks about the beginning of 1999 NCQA integrated HEDIS into its accreditation process. What is HEDIS?

A This is something that the largest customers of health insurers was looking for a long time. When you really think about, in the United States, we're a bit unique because most of us have health insurance through our employers, right? So -- with the exception now of the Accountable Care Act -- you know, Affordable Care Act, I should say -- I misspoke -- Affordable Care Act, and there are now 10 or 12 million individual subscribers. Most of us are -- if we have private insurance, are insured through our employers.

And employers are beginning to ask of insurers, "I'm paying a lot of money for this healthcare. In fact, it's one of my biggest not operating expenses." You've probably heard that, you know, in some years General Motors paid more for healthcare than they did for steel. So they became myopically focused on what -- so NCQA decided, we're going to look at health plans and basically grade them on how well their members get certain services.

So they created what's called the -- as you can see here, to be very specific, the Health Plan Employer Data Information Set, or better known as HEDIS, H-E-D-I-S. Right? And it basically looks at things like what proportion of your female members over the age of 45 are getting a screening mammography, what proportion of your members are over the age of 50 are getting a screening for colorectal cancer, what proportion of your diabetic patients are in control as defined by a -- a laboratory parameter called hemoglobin A1C, what proportion of your patients with high blood pressure have achieved control then defined as a blood pressure of 140 over 90 or less? And there are dozens and

dozens of these parameters. So basically what they are doing was requiring health plans to reach out to their membership to make sure this stuff was done.

A good example -- I don't know if any of you have seen the commercial that's all over the networks from a major health plan, Humana, encouraging colorectal cancer screening, that you get it, you do it, and you send it in. That's the result of HEDIS. Basically them meeting the standards. And this is where health insurance differs from any other insurance you buy. You don't buy car insurance planning to wreck your car. You don't buy homeowners insurance planning to flood your basement. But if it does, it's there.

Health insurance is a mixture of insurance for those catastrophic things that we have no control over. I walk out of this building and get hit by a bus on the street or I have a heart attack and need ICU. But it's also a prepaid benefit. Most of us buy health insurance expecting to use it, right, at least to go the doctor to have a checkup or perhaps if I get the cold or flu, to get the care I need or maybe planning to have a baby and want to make sure that's covered.

So insurance is a mixture of a prepaid benefit plan. You're paying money up front, but you know you're going to get some benefits. And health insurance plans even encourage using those benefits to meet -- or as he described here, we send letters to people who are diabetic to say, "You know, have you been to your doctor and are you having your blood work done"?

And so that's basically the -- what HEDIS began to generate, was

that outreach so that health insurers were doing more than just taking premiums and paying claims and reviewing services. They were actually proactively engaging their membership to improve the net health outcome of the population. And that's really what I've spent my life -- why I transitioned from primary care to managed care. I could improve the net health outcomes patient by patient, maybe influence 2 or 3,000 people. I moved to managed care so I could influence and improve net health outcomes for millions of people.

Q Thank -- thank you, Doctor. It was mentioned by Mr. Prater that NCQA accreditation can be used for marketing?

A It can.

Q Does the State of Nevada recognize this certification -- or accreditation for anything?

A They do. You can actually go on the NCQA website and click state by state, and it tells you what that state does in terms of recognizing NCQA accreditation. And in the state of Nevada, if you are NCQA certified, you are deemed, which means you get a pass from state regulations, to provide care and services to Medicaid enrollees. Now, Medicaid is our most vulnerable population. Isn't it often poor, underserved area, underserved communities, women with children? And the state of Nevada has deemed NCQA certification adequate to be able to serve that very vulnerable population.

Q So when you say deemed it to be adequate, you mean they deem that to be compliant with all the Nevada laws governing managed care?

A That is my understanding. I can't interpret all those laws, but my understanding of deeming, just like CMS deems NCQA certification to be adequate to provide care to Medicare enrollees, I'm assuming state deeming is the same thing for Medicaid. And I believe there are 40 -- almost 45 states that use NCQA certs to deem Medicaid acceptability.

Q Is it -- do you have a professional opinion on whether NCQA accreditation is evidence that a company's meeting industry standards?

A I believe it's the strongest evidence you can possibly have. Again, think about that desk review, the yearlong process, the white glove inspection, and the fact that it's not a pass/fail system, and it's not pay your money and get certified. It's pay your money and go through a very intensive and arduous process to achieve that certification.

MR. ROBERTS: Audra, could we go to the next slide?

BY MR. ROBERTS:

Q All right. Let's talk now a little bit about URAC, which you mentioned to the jury. And you were involved in setting some of their initial standards, right?

A I was, yes.

Q And over here on the right-hand side, "Utilization Review Accreditation Commission," that was the old name before they went with --

A Before they --

Q -- URAC?

A -- went with URAC. Because that's what everybody called them anyway.

Q So are you familiar with current URAC guidelines and standards?

A Yes. URAC was formed and organized almost in parallel with NCQA. In fact, they got out of the gate a little bit faster with their standards than NCQA did. But they only focused on utilization review. They didn't focus on the more comprehensive health plan standards that NCQA did. And a lot of health plans will get double certified in NCQA and URAC. It's like getting a second seal of approval on your health plan.

MR. ROBERTS: Could you blow up the bottom left box, Audra?

BY MR. ROBERTS:

Q So in addition to reviewing NCQA accreditation, did you also look to see if the review of the preauthorization request in this case met URAC standards?

A And yes. And we put actually the URAC standard PM 24 up there to show that for noncertifications, and again, noncertifications are a special case because in this case you're not only explaining to the member why, but then giving them a number of subsequent rights, correct?

Q And as used in this URAC standard, is a noncertification the same or something different than denied or adverse determination?

A The same thing. All synonyms. Adverse determination, noncertification, denial. Everybody uses slightly different language.

Q So what's required under the URAC standards for a denial?

A Well, as you can see there, you need to notify the patient, the attending physician, or ordering provider, or the facility rendering service. You need to explain the principal reasons for the determination. Again, we're getting back to that plain language. The statement provides that the clinical rationale used in making the noncertification will be provided in writing. Which means if you want to request the policy or policies, that that can be provided if requested. And basically, it has to include the rights of appeal and, you know, basically how to do it.

Q Okay. So under B, "A statement that the clinical rationale used in making the noncertification decision will be provided in writing upon request," did the denial letter you reviewed from Sierra Health and Life do that?

A Yeah. I think they met all of that requirement because of that paragraph, again, that explained why and what went into not approving the proton beam therapy request for Mr. Eskew.

Q What's those for?

A It's a footnote, and I honestly don't remember what the footnote referred to.

Q Okay. All right. Let's go to C, "Instructions for one initiating an appeal of the noncertification." Did the denial letter do that?

A It did. And it also explained how -- beyond that, how to contact the health plan to initiate that appeal.

Q And did the letter give instructions for how to request a clinical rationale for the noncertification?

A It did.

Q So based on your review of the all the URAC standards and all the NCQA standards and not just general accreditation of random files, but on what was done in this case, did it meet these industry organization standards?

A It did. And that's why -- you know, NCQA is the organization -- it has become the -- really the standard for certifying health plans. But the reason I reviewed both the -- did -- and, of course, Sierra's not -- and United's are not certified by URAC. They don't need to be. But I did that as a double-check to make sure that they met the two preeminent certifying organizations, not just NCQA.

MR. ROBERTS: Audra, could we go to the next slide, please?

BY MR. ROBERTS:

Q So let's talk about this specific proton beam radiation therapy policy at issue here.

[Marshal and Counsel confer]

MR. ROBERTS: Oh, we've lost our --

UNIDENTIFIED SPEAKER: And it keeps flashing.

MR. ROBERTS: -- display again.

THE COURT: Okay. Can we push that one forward, closer to the jury?

THE MARSHAL: Yeah.

THE COURT: Counsel, try and move that one around to see if it will make up.

UNIDENTIFIED SPEAKER: [Indiscernible], is there a blue box in that corner?

THE MARSHAL: It's back on now.

MR. ROBERTS: I'm not sure.

UNIDENTIFIED SPEAKER: Well, click the input change first. I can [indiscernible]. It's very strange.

MR. ROBERTS: All right. Well --

THE MARSHAL: I think it's okay.

THE COURT: Yes.

MR. ROBERTS: All right.

BY MR. ROBERTS:

Q You've reviewed the agreement of coverage in this case as well as other materials, correct?

A I have, yes.

Q You would agree with me that there's no specific exclusion for proton beam therapy for lung cancer in the agreement of coverage?

A There is not.

Q Should that have been in there specifically to meet industry standards?

A No. That's not required by any industry standard.

Q Well, why not?

A Well, because the evidence of coverage -- you know, health insurance, again, typically you don't get most of the time the policy itself because the policy's written between your employer and the member. In this case, Mr. Eskew did because it was an individual PPO coverage policy. But, again, you're trying to create the evidence of coverage in a -- in a relatively short and understandable way that could be readable by

the end user or the consumer. If literally one were required to put every medical policy and operational policy, that document would turn into thousands of pages or turn into, you know, some sort of web linked document that practically -- I don't know that anyone would ever need it, want to access it, or to be practical to distribute several of these binders to each enrollee with all of those policies.

Q If someone wanted to research what the policy was for specific treatment, could they do that?

A Publicly available. Yes.

Q What do you mean by publicly available?

A Health plans, again, are required to have transparent medical policies. That was actually the result of many decisions made back in the -- in the 1990s that as we began to develop medical policies, both the providers that we work with as well as the members who might be affected by that needed a way to view those medical policies. So most of us have made them available on a website.

Now, that website, for the most part, is publicly available, which means if you're interested in an Independence Blue Cross medical policy, you can go to ibx.com and click on medical policies, type the policy or the issue you might be interested in in the search bar, and it will lead you to the policy. Some health plans do have member sites and provider sites where you have to log in to your member or provider site just like you do at Amazon or AT&T or whatever, and get the policies that way.

Q Mr. Prater called the proton beam policy for United

Healthcare a hidden policy. Do you agree with that?

A I do not, based on the reasons I just put forth.

MR. ROBERTS: Could we have the next slide, please?

BY MR. ROBERTS:

Q Okay. Did you look specifically at the proton beam radiation policy in existence at the time the adverse determination was made on Mr. Eskew's preauthorization request for proton beam therapy?

A I did. That was provided to me.

Q Okay. And I -- you've highlighted here the information that was highlighted in the claim file, correct?

A That is correct.

Q And it's from Exhibit 5?

A That is correct.

Q And it says, "Proton beam radiation therapy's unproven and not medically necessary for treating all other indications, including, but limited to," and then there's lung cancer listed. Did I read that correctly?

A You did read that correctly.

Q And then going on to the next highlighted portion, "Current published evidence does not allow for any definitive conclusions about the safety and efficacy of proton beam therapy to treat conditions other than those noted above as proven and medically necessary." And then it's referring to a section above for --

A The section above of the ones that have been shown to be proven.

Q Okay. But what is efficacy?

A Efficacy is, you know, does it work, right, under what circumstances does it work, and for which specific patients and conditions does it work?

Q So this talks about current published evidence. Did you review the entire policy, including the summaries of evidence contained in the policy for lung cancer?

A Yes, I did read the entire proton beam policy. Now, I did not then go to the list of extensive references and look all of those up and review them. I'd probably still be reviewing that medical literature. But it was extensively referenced. It was referenced in standard MEDLINE type of, you know, AMA required format for the references, including where it was published, you know, volume, pages, et cetera.

Q As a former medical director who was involved in creating policies like this, do you believe that the evidence cited in this policy supported this general conclusion shown on page 2?

A I do.

Q Was this a reasonable policy based on the cited peer reviewed literature?

A It was because what you do when you create a medical policy is you actually do a comprehensive analysis of the medical literature that's available to you at the time. And, as we know, science is evolving, and science is often contradictory. We've all lived through COVID and the multiple contradictory things that have come out as we've learned more and more about that virus in just two years. Medical literature's the same way. There will be some studies that are positive,

some studies that are negative, and basically you have to wait until those studies evolve and you've got enough of that positive evidence, particularly evidence that's generated by clinical trials.

And I'll give you a good example of that. In the drug industry, they do three phrases of trials to get to the FDA. Phase one is just to make sure that human beings can tolerate the drug. Phase two, they're trying to determine the safety and a little bit of efficacy. And those trials can often be pretty positive and look like they're groundbreaking, you know, break-through products. Then they do a randomized clinical trial with an experimental group and a control group to compare. And often they'll do this with thousands, sometimes in diseases like diabetes, tens of thousands of subjects.

And at the end of that, they may show that there's no difference between what looked like to be a promising treatment and standard of care. And so the gold standard is to prove new technology by randomized clinical trials or at least by something similar to and with a similar level of evidence to a randomized clinical trial.

Q And when you say it's the gold standard, is that just for insurance companies to authorize treatment?

A No, it's not really for insurance companies. It's really for the medical community. Basically those of us who were practicing, as I was, you basically want to make sure that what you're using is, inasmuch as possible, has been proven in clinical trials. For instance, the FDA won't approve a drug until it -- unless it's an orphan drug, until it is actually -- had two parallel positive phrase three clinical trials simply because they

don't even trust one; they need two to make sure that the first one wasn't a fluke.

Q And when you say phrase three, is that randomized or not randomized?

A That's a randomized control clinical trial.

Q Thank you, Doctor.

A And also what's called double-blinded, which means neither the patient nor the doctor administering the treatment is aware of which treatment. Now, that's very hard to do in radiation oncology, so you do a proxy to that. You do open label clinical trials where patients are randomized into the treatment versus standard of care or an alternative. So you can't always blind them, but it's still a randomized trial.

MR. ROBERTS: Audra, could you go to the next slide?

BY MR. ROBERTS:

Q So you've read the section of the proton beam policy on lung cancer?

A I have.

MR. ROBERTS: And could you go to the next slide, Audra?

BY MR. ROBERTS:

Q So let's first look at this summary of the AHRQ.

MR. ROBERTS: Can you blow that up as big as we can get it?

BY MR. ROBERTS:

Q What is the AHRQ?

A The AHRQ is a government agency created very close -- or expanded, I should say, not created, but expanded with the Affordable

Care Act, the legislation that approved what we effectually call Obamacare, right? And they expanded the role of AHRQ, which is the Agency for Healthcare Research and Quality, hence, you know, the AHRQ. Again, it's easier to say. And they're basically the government agency that's been charged with doing comparative effectiveness research; comparing treatment A to treatment B or they don't do the research themselves, they go through the public scientific literature and do what's called -- again, I'll bring that term up -- a meta-analysis, which is they really analyze all of the studies in a rigorous scientific way to say what do these studies support or not support. And that's the highest level of evidence. We call clinical trials -- randomized clinical trials level 1 evidence. Meta-analytics are level 1A evidence. It's the peak of the evidence pyramid.

Q And you're referring now to, what, the hierarchy of evidence?

A I am.

Q So the -- the very top is this --

A Meta-analysis

Q -- meta-analysis?

A Correct.

Q And is a systematic review the same thing as a meta-analysis?

A It is. It is.

Q So it's basically a study of all of the studies?

A It's a study of the studies. And big health plans like United or the Blues, we typically have fairly high-level individuals, sometimes

Ph.D.s and other people, who are skilled at doing these analytics in our medical policy departments. We have physicians in our medical policy, we have nurses.

Q Okay. So going back to AHRQ, you --

A Yeah.

Q -- put that sort of toward the top --

A I do.

Q -- of the hierarchy?

A Yes.

Q And right below that you said it would be randomized clinical trials?

A That is correct.

Q Where do nonrandomized clinical trials fall in the hierarchy of evidence?

A They're usually considered level 2 or 3 evidence, depending on the structure of the trial, the size of the trial. Small trials obviously result in variability because randomness can take over a lot more in a small group than in a large group. So, again, I don't want to get in -- the teacher will probably come out in me here, and that's unfortunate I think.

But you have to do what's called power your trials in such a way that what you determine from them couldn't happen or only has a five percent chance of happening by randomness. It's what's called a P value, and I won't explain. But, in other words, if your trial doesn't produce a statistically significant result, it can only happen 95 percent of the times, it's considered a failed trial.

There's a real high bar for those. Where when you get down the hierarchy, very often you only have one arm in the trial, you have nothing to compare it to, so there's nothing to give you a statistically significant outcome because you're not comparing it against anything. You just look at it and say, it appears to work.

Q And where on the hierarchy of evidence would be the opinion of a single physician?

A Opinions are evidence driven. But because they're opinions, they're actually considered level 4 to 5 evidence. Not because we don't value physicians, their knowledge, and their expertise, but it's, "Show me your data." You know, one of the -- you know, one of the mantras of our technology evaluation reviewers was "In God We Trust;" everybody else brings data. And, you know, that's what they were looking for.

Q And what have you highlighted here as far as the conclusion of the AHRQ meta-analysis?

A It basically concluded that -- and I'll read it verbatim. "The evidence was insufficient to reach conclusions about the relative effectiveness and safety of the interventions in terms of overall survival." Did it make you live longer? Okay, "Cancer specific survival," did it prevent your disease from progressing, right? "Local control," did it mean it stopped the growth of the tumor that was radiated? "Quality of life, can I do things, can I get up in the morning and brush my teeth and get dressed, and, you know, take care of my children, et cetera? "Symptomatic relief," can it take me out of pain and toxicities? And that's the negative effects.

So they didn't say it was good or bad; they just said there isn't enough evidence to know how this compares to other modalities of care.

Q Would esophagitis fall into any of these categories?

A It could. It's a toxicity.

MR. ROBERTS: Audra, could we see the next slide?

BY MR. ROBERTS:

Q In addition to this AHRQ study, the next summary in the medical policy --

MR. ROBERTS: If you could blow that up, Audra.

BY MR. SMITH:

Q -- is a Blue Cross Blue Shield technology assessment. "Evaluated health outcomes." You used to work for the -- for the Blues?

A Yes.

Q Are you familiar with this type of assessment that was done by the Blues?

A Yeah. The Blue Cross Blue Shield Association, because it is the overseeing body and did try to create consistency in the Blues organizations, created what they call TEC, the TEC assessment committee. TEC had five principles of technology evaluation. I won't go into them, but it basically looked at hierarchy of evidence. And basically they do technology reviews. In essence, a meta-analysis of the literature. For many, many years I was actually an adviser to them and consultant to TEC.

Q So this is another per --

A Analytical --

Q -- analytical --

A -- group.

Q Reviewing all of the evidence?

A That is correct.

Q And where again would this be on the hierarchy of evidence?

A Again, this is equivalent to that meta-analysis. So it's an analytic of the studies. So it's at the peak or near the peak of that evidence hierarchy.

Q And at this time, in 2015, what was indicated that the Blue Cross Blue Shield technology assessment found following proton beam therapy compared to stereotactic body radiotherapy?

A And again, I will read. "The report concluded that overall evidence is insufficient" -- again, that -- you know, there's not any evidence, but the evidence has not yet reached a significant level -- "to permit conclusions about the results of proton beam therapy for any stage of non-small cell lung cancer. All PBT studies are case series." That's that level 3 and 4 evidence.

"There are no studies directly comparing PBT and stereotactic radio" -- "body radiotherapy. In the absence of randomized control trials, the comparative effectiveness in proton beam and SBRT is uncertain." Again, the meta-analysis came to the same conclusion that AHRQ came to. So a review of the study of studies.

Q Stereotactic body radiotherapy. Is IMRT a type of that, or --

A I'm not a radiation expert, so I won't --

Q Okay.

A I won't get into those nuances.

Q Thank you, Doctor. So now let's go to one of the citations at the end, which I believe it was Mr. Prater who looked at it.

MR. ROBERTS: Next slide, Audra.

BY MR. ROBERTS:

Q So toward the end of the lung cancer section, there's the citation, the NCCN. And did you review this?

A Yes.

Q And first tell the jury what it says, because I know these boards are hard to read.

A They are -- NCCN, just to tell you what that is, that's the National Comprehensive Cancer Care Network. It is a group of 20 some cancer care centers that put forth their version of standards of care for cancer care.

Q So this would be a center like MD Anderson, for example.

A MD Anderson is an NCCN center, much like Fox Chase and Jefferson University of Penn in Philly.

Q Okay. So the NCCN is a group of the centers rather than being a single group of radiation oncologists?

A That is correct.

Q And the NCCN states that, "The use of more advance technologies such as proton beam therapy is appropriate when needed to deliver curative radiation therapy safely in patients with non-small cell lung cancer. Nonrandomized comparisons of using advanced technologies versus older techniques demonstrate reduce toxic toxicity,

and improved survival." Mr. Prater says that, because that's in here in the summary, that you shouldn't ignore the meta-analysis and go with this NCCN statement? Do you have an opinion about that as far as reasonableness in the industry as a medical professional?

A Well, to me, that's very impressive, because they not only included in their analysis, they included the negatives, they also included the positives. So full disclosure, here's everything we looked at. But you noticed the NCCN study qualified, they say nonrandomized comparisons. So basically, what they were doing there is looking into studies that compare PBT to historical controls. So that was done on a whole different group of patients at a different time, no randomization.

And it's fair game when you first start out to compare to historical controls. But we all know that the population treated three years ago, going forward compared to a population treated now going forward may not be the same population, and may not have derived the same benefit from whatever the control was historically.

So they qualify that by saying it's supported by a lower level of evidence. In fact, NCCN grades the evidence to support their statements. I don't have the evidence grading for this, but their level one evidence is randomized, controlled trials, or a meta-analysis. Level two is just a bit lower than that, and they qualified in 2-A and 2-B levels of evidence, and 2-B are typically those that are nonrandomized and noncontrolled.

Q So you reviewed all of these summaries. Did you see any meta-analysis supporting the fact that proton beam therapy at this point in time had been proven to be safe and effective for non-small cell lung

cancer?

A Let's go through the three; AHRQ, no. United, no. BlueCross and BlueShield Association, Tech, which also, by the way, supports Kaiser Permanente, one of the largest, you know, kind of network based payers in the country, so Kaiser relies on them. The answer to that was no.

Q What about randomized clinical trials? Any support there?

A They didn't quote any.

Q Now, the jury is saying that they saw Exhibit 30, which was a 2018 version of the United proton beam policy, which contained a new exception. Does the fact that the 2018 policy had a new exception, prove that this one was incomplete or inaccurate or didn't meet industry standards?

A No, three years ago by between 2015 and 2018, new literature is emerging. And what that does is created some flexibility for individual decision making. And in fact, it's very consistent with their UN policy, that 100.1. Because in Section 3.1.1, they point out our medical policies need to be objective based on evidence, but flexible enough to allow deviations as necessary, giving individuals medical directors experts, like Dr. Ahmad, to deviate from the policy.

So that statement was actually consistent with their own internal policies about creating some flexibility, most likely, although I can't know what was in the heads of those who created the policy based on some changing medical literature.

Q Dr. Liao, the jury heard her say, oh, come on, everyone

knows proton beams kills cancer. If it works for ocular cancers as recognized by the United policy, don't we know we all know it works from lung cancer too? I mean, isn't that just common sense? Do you agree?

A It seems intuitive, right? It seems like common sense. We certainly know proton beams have the energy to kill cancer. Nobody disputes that. We know that proton beams have been proven in the ocular cancer, because the eyes are a very unique structure. It's very small. The area that enables us to have good vision, which is called the macula, is very tiny, teeny tiny, less than the size of my fingertip. And when that goes, you can't see. Literally, you're legally blind. And so there because you can precisely aim the proton beams, you know, you can work with ocular cancer.

Now, does that mean that when you look at will it kill other cancers? Sure it will. But the dispute is not this proton beam potentially kill cancer. The dispute and what's the essence of these policies is, do we know that it kills cancer better and less toxically than other modalities? And until we have data to compare those, the answer to that is this remains a hypothesis, and if you remember from seventh grade science, hypothesis is something you think is right, but you now have to test it in the investigational world.

Q What's the difference in your mind between a theoretical benefit versus one that's been proven clinically?

A Two hundred proven versus unproven.

Q And you mentioned we know what kills cancer. In your

experience, have you seen where a technology that worked for one application when everyone thought it would work somewhere else, actually caused harm?

A I have.

Q And I believe you said you wanted to give us an example earlier, and not particularly down the road.

A Yeah. No, this is good, I think pushing it. This is something very near and dear to my heart, because I was involved in many of these policies.

In the 1990s, the technology in cancer was exploding. And we learned for certain cancers of the bloodstream, leukemia, for instance, that if you gave people super massive, meaning very large doses of chemotherapy, in essence, large enough doses to kill the patient, right? And then you rescue them by transplanting bone marrow.

You've all heard of bone marrow transplants, that you could wipe out the cancer cells in the bloodstream and put the bone marrow cells back in from another donor, or perhaps the patient themselves before you did the treatment. Those cells would grow, and you get rid of the cancer. And so we learned very quickly, from good, controlled trials that you could cure -- especially children, and children with a certain type of leukemia. In essence, we learned to cure many of them in the 1990s from bone marrow transplants.

Now, it seemed logical that people with solid organ tumors; tumors of the lung, tumors of the liver, kidney, for instance, if you did the same thing to them and gave them bone marrow transplants, that you

would accomplish the same thing, you'd basically give them enough chemotherapy to kill them, but you'd rescue them with a bone marrow transplant. And a lot of centers started doing these procedures, mostly on women with metastatic breast cancer. Many of the payer policies were it make sense, but we don't have any data to show, and we didn't cover these. This was the subject of great controversy. I was actually interviewed on Channel 6 news in Philadelphia, about this controversy.

Fast forward to about a year later, Dr. Russell Stadtmauer [phonetic], and his colleagues at the University of Pennsylvania, along with what's called ECON, the Eastern Cooperative Oncology Group, did a randomized clinical trial of bone marrow transplants for metastatic breast cancer. Fast forward two years later, when they unblinded the study, not only did the patients who got the bone marrow transplant not survive any longer, but more of them died than the patients who didn't get the bone marrow transplant.

So this was a good example of something that seemed logical, common sense would say it ought to work, yet the clinical trial proved the exact opposite. Everybody stopped doing BMTs, bone marrow transplants in that situation.

MR. ROBERTS: Thank you, Doctor. So let's go to the next slide, Audra.

BY MR. ROBERTS:

Q And you heard Mr. Prater's testimony, right?

A Yes, I did.

Q And could you blow up 1366? And Mr. Prater talked about

the definition in the contract of medical necessity. And did you hear him say that the second bullet point, the most appropriate level of service which can be safely provided to the insured, that dealt with a clinical setting?

A Yes, I remember him saying that.

Q Okay. And before we go into this before, is medical necessity, something unique to Sierra Health and Life versus the standard?

A No. In fact, again, every health insurance policy that's ever written has a definition of medical necessity. And that definition also has evolved over time as the subject has gotten more complex. But every one of them has a definition of medical necessity. They tend to contain the elements you see here, although the verbiage can be much, much different.

Q In application, is this different than a standard industry medical necessity policy?

A No, this is very consistent with a medical necessity policy.

Q And do you agree that in a medical necessity definition, the most appropriate level of service means the clinical setting, like inpatient or outpatient hospital or surgery center.

A That's only one component of it. It can mean a level of care. For instance, a good example of that, you know, I'll give it to you. Diabetes. The American Diabetes Association puts forth guidelines for the treatment of diabetes. And the standard of care for people with Type 2 diabetes, unless they have heart disease, or a few other things, is to

start with a very common drug called Metformin. It's readily available, well tolerated, highly effective, and inexpensive. And the standard of care is to start unless there's a contraindication, with Metformin, and then you move up the ladder to drugs that are now branded drugs and they cost 10 or even 100 times what Metformin is. And even those standards, graduate levels of service, in this case, level of drug administration.

So it's not confined to that very narrow, is a hospital versus a skilled facility versus an outpatient or home care. It's a much broader definition accepted and just a standard in the health insurance industry.

Q Is an expensive treatment an appropriate level of service if there's a less expensive treatment that works just as well?

A No. That's exactly what we need. That's the Metformin example. The IMRT versus proton beam example.

Q Is a level of service appropriate if it hasn't been proved even to be safe and effective in a randomized clinical trial?

A I think I've answered that, but clearly, no.

Q Let's go and this is the last slide. So you mentioned earlier that you've done some research about the proton beam medical policies available online from different insurers. Tell us what you did.

A Yes. And to do that, I had to do their current medical policies, because you can't get a historical archive of their medical policies in existence in 2015 or '16. So I went online because these policies aren't publicly available online that we've listed here. And I looked at what their medical policy for proton beam therapy for lung

cancer was. And they do a similar process, right? They analyze the literature, they look at the same sources at United and I can't verify they're exactly the same because I didn't, but the references. But they're doing in essence their admitted analytics are relying on organizations like AARQ or TEC.

There are actually two other companies in the country called Hayes Incorporated and ECRI that do technology evaluations. They're a service that smaller health plans can purchase to do the sophisticated work for them if they don't have the internal capabilities. And as you can see, every one of these health plans in 2021 basically said, your proton beam therapy for lung cancer was unproven, and/or not medically necessary.

So if one assumes the growth of medical literature, and/or were there new information available, probably grew between 2015 and 2021. I can't again verify that because I didn't do a comprehensive literature search. But even today, medical policies from these insurers, representing almost 170 million covered lives in the United States, all these policies are consistent with what Sierra's and United's policy was in 2015.

Q So how did you go about picking? How many companies are these that you looked at? About a dozen?

A About a dozen. I picked mostly the largest carriers. You'll notice that United Healthcare is on here because they're a large one. Aetna of course. Anthem, which is the largest Blue Cross plan. Cigna and Centene. Centene is a very large national plan that focuses on Medicaid.

MR. ROBERTS: Audra, could you blow that up bigger? Just the chart? Yeah.

BY MR. ROBERTS:

Q Okay. And goes through the companies you looked at after United Healthcare. And explain to the jury what you were looking at specifically --

A Yep.

Q -- and what the covered loss is.

A I'll walk you through each one of them. Look at the Aetna policy effective in May of 2020. Basically, that policy for about almost 23 million covered lives, was that proton beam therapy was not medically necessary. And they use the term experimental and investigational. That doesn't mean there's some guy in the lab cooking this stuff up. What it means is the evidence is insufficient. Some health insurance carriers equate unproven with experimental. I think it's a poor choice of terms and we abandoned that a while back for unproven, but be that as it may, it's the same thing.

Q But experimental there's nothing wrong with doing research and clinical trials to try to prove these things, right?

A Not at all.

Q Do you have any criticism of that?

A No, no. It's just their verbiage as opposed to unproven or not medically necessary.

Q Okay. Thank you, sir. And covered lives, what does that mean again?

A The number of people that are health plan insurers.

Q Okay. Thank you. And what was the next one after Anthem?

A Anthem, of course, is the largest Blue Cross plan, probably familiar with many people here in Nevada, California and surrounding states. This one was effective June 1st of 2020. And Anthem -- you want to go up one. You're at Blue Shield.

MR. ROBERTS: Go right up on to Anthem, he's talking about, Audra.

THE WITNESS: Yeah. And basically, they defined it as not medically necessary, which means it was unproven and did not meet that level of service requirements. And that affects almost 43 million insureds. Now, we go to Blue Shield of California. California is one of those other states where the Blue Cross plan is Anthem. The Blue Shield plan is separate. California is the largest state in the country. They insure almost 3.6 million people. In their case it was -- they have a very different policy. It was not in the list of things that are covered. So it was not in the list -- lung cancer is not in the list of covered indications for PBT.

Q So it was one of the ones like the United policy that says it is covered for the following cancers.

A Correct.

Q And lung cancer was not included.

A Was not in that list.

Q Okay. Thank you, Doctor. What about the next one, Cigna?

A Cigna insurers 17 plus million lives and again, not medically

necessary.

Q And what do you have in parentheses there?

A Investigational. That's the other word they use in their policy.

Q And that came from their policy?

A That did.

Q What about the next one, Centene Corporation?

A Centene insurers both commercial, and they have a very large Medicaid branch called Molina. So again, their population is again, a highly vulnerable population Medicaid enrollees. Not medically necessary except when needed to deliver curative radiation therapy safely. So again it created some of that flexibility in decision making much like United's updated policy.

Q Much like the 2018 policy for --

A The updated one.

Q Okay. Florida Blue.

A Florida Blue, one of the larger regional Blue Cross plans, insuring 4 million people. Not medically necessary when the disease is metastatic. Metastatic means it's spread beyond the primary tumor. In this case, we were looking at disease in the mediastinum in the arm at least, so it met the definition of metastatic.

Q What is the next one?

A The next one is Healthcare Services Corporation, HCSC. It's a group of six Blue Cross plans including Texas, Oklahoma, New Mexico, Illinois, Montana. There's one more, but I can't remember what -- New

Mexico. There we go. Again, a big insurer. 16 million covered lives. Not medically necessary.

Q Highmark Group.

A Highmark, which is Blue Shield of Pennsylvania, and the remainder of the Blue Cross Plains in Pennsylvania, other than Independence, also is Blue Cross and Blue Shield of northwestern New York; Buffalo, Syracuse and the like. Almost 6 million enrollees. Not medically necessary.

Q What about Humana?

A Humana. Again, another large national plan, and they are the largest Medicare Advantage, meaning Medicare managed care insurer in the country. Almost 17 million covered lives. Not medically necessary or experimental or investigational.

Q The next to last one?

A Independence Health Group. That's my old employer. We own health plans outside of Pennsylvania called AmeriHealth plan. So Independence Blue Cross is still the Blue Cross plan in southeastern, but this includes all of our other plans outside of Pennsylvania, such as New Jersey, Delaware, et cetera. And the number of Medicaid plans under our affiliate Caritas Mercy Health Plan. Almost eight million covered lives, again, a lot are vulnerable Medicaid enrollees.

And then finally, Molina which is now a subsidiary of Centene, but they still have separate policies. Their policy is consistent with Centene as not medically necessary and again, affecting about three million individuals.

Q And why did you stop here?

A After that, we've exhausted about 75 or 80 percent of the covered insureds in the United States that are commercially insured. And so I thought this was an adequate sample to show that the 2015 policy was not inconsistent, in fact, very consistent with the policies as they're written today.

Q Did you research find where proton beam therapy for lung cancer was covered and considered medically necessary and just decided to leave it off the chart?

A No. I haven't found one. I had gotten that far and had not yet found one and stopped my search because I'm now up to hundreds of millions of covered lives. And can I say with authority there isn't one out there? No, because I didn't look at -- there are over 200 health plans in the country, and being somewhat parsimonious with time, I thought it was time to stop.

Q But at least as far as the fact it may exist, if it does exist, it would be a smaller company with fewer covered lives?

A And it would be a bit of an anomaly, wouldn't it? Yes.

Q Yes. So one thing that we heard here in the courtroom from Mrs. Eskew, was that if the proton beam therapy had been specifically excluded in the agreement of coverage that she would have gone and found a plan that did cover it. In your opinion, is it likely she would have been able to do that?

A Well, based on this analysis, and even though these plans may have looked different, because these reflect mergers and other

acquisitions, I would think it would have been highly unlikely that that could have or would have happened. All of those policies are going to say proton beam therapy is covered, but then they have to meet all the other terms and conditions such as medical necessity.

Q And it's the consensus in the industry that proton beam therapy is not medically necessary for non-small cell lung cancer?

A Based on this, and these policies all of which have either done their own analytics or dependent on outside analytics like Hayes and ECRI, or TEC or AHRQ, I think it's safe to say that.

Q And in looking at the claims policy, Exhibit 5, you agree there were clinical -- I mean, clerical errors in there? There were some typos.

A There were.

Q And there were some mistakes.

A There were.

Q And the quality control group had to send it back to be redone, correct?

A That is correct.

Q Were any of those mistakes in the final denial letter that went out?

A They were not. And that's precisely the reason that health plans have those quality control processes. Human beings are human beings. We all make mistakes, right? And because of that, you need a quality control process to make sure that we minimize those. Just like in the auto industry, you have quality control, you know, continuous quality improvement, what's known as CQI. In the health insurance industry, we

adhere to the concept of CQI, continuous quality improvement, to try to make sure our communications with members, our documents to members, everything we do that's member facing, is the best that we can make it at the time. Do we make mistakes? Yes. Do we try to correct those? Yes. Are we perfect? No.

Q So you're also familiar with the fact that, you know, Dr. Ahmad said some things which indicate that he mistook some of the things intended as far as the grades, the dosage, and number of --

A I do.

Q -- grades of radiation, and the interpretation of the IMRT versus the proton therapy in the original medical records?

A I do.

Q And you're familiar with the criticism of his qualifications as a medical oncologist?

A I do.

Q Despite the clerical errors, the typos, the challenges to Dr. Ahmad's qualifications, based on your review of the request, based on your review of the medical policy and the peer-reviewed literature cited there, based on your own experience as a medical director and a creator of medical records, despite all those things, was the decision reasonable?

A It was based on virtually everything I've presented to you today.

MR. ROBERTS: Thank you very much, Doctor. That's all I have. I'll pass the witness.

THE COURT: Thank you. Ladies and gentlemen, we'll take our lunch recess now.

You are instructed not to talk with each other or with anyone else about any subject or issue connected with this trial. You are not to read, watch, listen to any report of or commentary on the trial by any person connected with the case or by any medium of information including without limitation, newspapers, television, internet, or radio. You are not to make any research on your own related to this case such as consulting dictionaries, using the internet or using reference materials.

You are not to conduct any investigation, test any theory of the case, recreate any aspect of the case, or in any other way investigate about the case on your own. You are not to talk to others, text others, Tweet others, Google issues or conduct any other kind of book or computer research with regard to any issue, party, witness or attorney involved in this case. You are not to form or express any opinion on any subject connected with this trial until the case is finally submitted to you. So we'll return at 1 p.m.

THE MARSHAL: All rise for the jury.

[Jury out at 11:59 a.m.]

THE COURT: Do you have any issues outside the presence of the jury, counsel?

MR. ROBERTS: No, Your Honor.

MR. SHARP: No, Your Honor.

THE COURT: Thank you. We'll see you back at 1:00.

[Recess taken from 12:00 p.m. to 1:02 p.m.]

THE MARSHAL: Department 4 come to order. Back on the record.

THE COURT: Okay. Please be seated. Are the parties ready for the jury?

MR. SHARP: Yes, Your Honor.

MR. ROBERTS: Yes, Your Honor.

THE COURT: Thank you.

THE MARSHAL: All rise for the jury.

[Jury in at 1:03 p.m.]

THE MARSHAL: All jurors are present.

THE COURT: Thank you. Do the parties stipulate to the presence of the jury?

MR. ROBERTS: Yes, Your Honor.

MR. SHARP: Yes, Your Honor.

THE COURT: Thank you. Please be seated. Mr. Sharp?

CROSS-EXAMINATION

BY MR. SHARP:

Q Dr. Owens, when you prepared your initial report you were provided two copies of the agreement coverage, correct?

A I don't remember if it was two, I have a copy of the agreement of coverage.

Q And do you remember after reading Ms. Holland-Williams' deposition that one of the agreement of coverages you had been provided was the one that she provided to Mrs. Eskew?

A Yes.

Q Okay.

MR. SHARP: If we could go to Exhibit 3, or Exhibit 2, Jason, at 24. Should be 10.5, right here.

BY MR. SHARP:

Q Sir, I have in front of you Exhibit 3 at page 24, section 10.5 to the agreement of coverage reads, "The laws of the state of issue shall be applied to the interpretation of this plan". Did I read that correctly?

A Yes. You did.

Q And the state at issue is the State of Nevada; is that correct?

A That is correct.

Q And you spent considerable amount of time this morning talking about NCQA and URAC, do you remember that?

A I do.

Q And you would agree with me that both of those accrediting entities have a standard that an insurance company shall comply with the law of the state of issue, true?

A I don't know specifically whether that language is there, I will have to take it from you.

Q Well, you're the expert here on NCQA and URAC, right?

A I am, but I can't quote you every line in --

Q Is there an industry standard under URAC and NCQA to comply with the laws of the state where the policy is sold?

A There is.

Q Okay. And among those laws are statues, regulations, right?

A There are.
Q And Sierra Health and Life is an insurance company, right?
A It is.
Q They get a certificate of authority from the Nevada insurance commissioner, right?
A Yes.
Q And one of those things is a promise to comply with the laws of the State of Nevada, right?
A Yes.
Q So whenever a law in the State of Nevada conflicts with the standard of URAC or NCQA, you would agree with me that the law of the State of Nevada would supersede anything that NCQA and URAC says?
A That is correct. NC QA and URAC standards, they point out that if one of their standards is in conflict with state laws then you are deemed to have met that standard if you met the requirement of the state law.
Q Now in the course of your preparation for today did you review the jury instructions that have been provided by this court?
A I did.
Q Okay.
MR. SHARP: Let's go to jury instruction 3. Go to the one before that, Jason. So it'd be 2. Okay. Can you blow this whole thing up?
BY MR. SHARP:
Q It says, "In every insurance contract there is an implied

covenant of good faith and fair dealing that neither the insurance company nor the insured will do anything to injure the rights of the other party to receive the benefits of the agreement". Do you see that?

A I do.

Q And I reviewed your report and I listened to your testimony, is it fair to say you had no criticism of Mr. Eskew?

A No. I have no basis to have a criticism of Mr. Eskew.

Q Now it says, "The relationship of the insurer or an insured to an insurer is one of special confidence akin to that of a fiduciary". Did I read that correctly?

A You did.

Q "A fiduciary relationship exists when one has the right to expect trust and confidence and the integrity and fidelity of another." Did I read that correctly?

A You did.

Q So in the process of how Mr. Eskew's prior authorization claim was handled, he had the right and expectation that Sierra Health and Life would conform with its fiduciary relationship, true?

A True.

Q "This special relationship exist in part because as an insurance company are well aware, consumers contract for insurance to gain protection, piece of mind and security against calamity." Did I read that correctly?

A You did.

Q And one of the reasons consumers buy health insurance is to

protect them in the event they have a catastrophic illness, true?

A I stated that.

Q And that could be the accident that you talked about in your direct exam, right?

A Yes.

Q And that could be cancer, right?

A Yes.

Q And when in the manner in which Mr. Eskew was treated, he had the right and expectation that the insurance company would act consistent with providing him with piece of mind, true?

A True.

Q "Now to fulfill its implied covenant of good faith and fair dealing, an insurance company must give at least as much consideration to the interest of the insured as it gives to its own interest." Did I read that correctly?

A You did.

Q And in the course Mr. Eskew having had the right and expectation to believe that Sierra Health and Life would have procedures in place to make sure his interests were considered at least equal to the insurance company's interests?

A Yes.

Q Now I looked through your CV yesterday and within the 134 -- is it 134?

A Somewhere around there.

Q I didn't see one article dealing with the duty of good faith and

fair dealing.

A That's because it's such a basic fundamental principle that -- you know, that's not something that I would write about. I write about more specific issues of managed care and health insurance, as well as sometimes clinical issues.

Q I didn't see one paper where you were instructing insurance companies how to fulfill their duty of good faith and fair dealing, true?

A True.

Q And you sat through Mr. Prater's testimony?

A I listened to it, or I watched it on video, yes.

Q And you -- I think you said you had the transcript too?

A No. Just the --

Q Just --

A -- video.

Q And you saw that he's got considerable experience and background in advising insurance companies on how to conform with the duty of good faith and fair dealing?

A That seems to be his fundamental and major role.

Q And you have no reason to disagree with Mr. Prater on the application from an industry standard practice to fulfill the duty of good faith and fair dealing?

A At the high level as he described it, yes.

Q And you saw that Mr. Prater has taught insurance companies on how to interpret insurance policies consistent with the rules and obligations as established by the laws?

A I did.

Q And you have no reason to dispute him in terms of how the standards for interpreting insurance policy?

A That would not be something I would do, no.

Q And in fact it would be fair to say given that Professor Prater has spent many years teaching insurance law, many years studying the duty of good faith and fair dealing and consulting with insurance companies that he probably has more knowledge than you do regarding the standards to interpret an insurance policy?

A I'm not sure that I can say that when it comes to health insurance. I was not clear in any of his things how much of what he does directly applies to the health insurance industry.

Q You're telling this jury there's one standard to interpret an insurance policy for auto insurance and another one for health insurance?

A No. What I'm saying is the health insurance world is a much more complex world. And yes. The good faith and fair dealing principle applies as one of the underpinnings, but all of the levels of complexity above that, I didn't see much in Mr. Prater's testimony that he either understood that or had engaged in that.

Q Okay. I'm just talking about the insurance policy because really that's why we're here, okay?

A You may.

Q In terms of interpreting insurance policy, the standards that Mr. Prater testified about, those same standards apply to a health

insurance company as they do to an auto insurance company?

A They do.

Q Okay. Now let's go to the next one.

MR. SHARP: Next instruction, Jason. Okay. Let's pull up this whole --

BY MR. SHARP:

Q Now these are the four elements for the breach of the implied covenant of good faith and fair dealing, do you see that?

A I do.

Q And you're here to help us determine whether proton beam therapy was a covered service, right?

A Under the terms and conditions of the policy, yes.

Q The -- well, we've been throwing around policies, I want to make sure. Under the agreement of coverage?

A It is a covered service, but there is a larger -- there are other -- I guess what we should say is, portions of that agreement of coverage that qualify when and how proton beam therapy is covered.

Q Okay. You're here to assist us on determining whether proton beam therapy was a covered service under the insurance contract?

A For Mr. Eskew specifically?

Q Yes.

A Yes.

Q And so we can all agree as a base matter proton beam therapy was covered, the question was whether it was medically

necessary?

A That is correct.

Q Now item two, are you here to assist us as to whether or not Sierra Life and Health had no reasonable basis for its February 5, 2016 denial of the prior authorization claim?

A I certainly disagree with that statement, but I'm here to present my opinion of that statement.

Q Yeah. You're here to assist us on element two?

A Yes.

Q And you're here to assist us on element three, whether Sierra Health and Life knew or recklessly disregarded the fact that there was no reasonable basis for the February 5, 2016 denial of the prior authorization claim?

A And again, while I disagree that, I'm here to help you understand that.

Q Help imply -- you understand these are the elements. The jury's going to decide if the evidence meets any of these four elements, okay?

A I understand that.

Q So you're here to assist the jury in understanding the evidence, do you understand that?

A That's what I did this morning.

Q Okay. So you're here for items one, two and three, right?

A That is right.

Q Okay. And let's go -- and it's your opinion, just so I'm clear

that the manner in which Mr. Eskew's prior authorization claim was handled and investigated conforms with items two and three?

A I do.

Q Okay.

MR. SHARP: Now Jason, let's go back to Exhibit 3. JASON: 2?

MR. SHARP: 2. Yes, 2. I keep mixing and intertwining those two. 2, I want to go to page 6. And just blow up section 3, managed care.

BY MR. SHARP:

Q So Section 3 of Exhibit 2, page 6 reads, "This section tells you about SHL's managed care program and which covered services require prior authorization". Did I read that correctly?

A You did.

Q Now I take it that there are different parts to the insurance company, like different departments?

A Many.

Q And you heard kind of Mr. Prater's simplified version of how insurance companies kind of compartmentalize themselves?

A They have departments, yes.

Q How one of them sets the rates, one of them -- I mean, they're -- I understand that there's levels of complexity. But my point is, there is one department at Sierra Health and Life that handles prior authorization requests?

A That is correct.

Q And so that part is different than the people that process the claim, that determine whether something is paid or should be paid?

A Well, yes. And most health insurance claims are processed electronically, submitted online. But there are claims processors at the health insurance company.

Q So we're clear, if proton beam therapy wasn't required to obtain prior authorization for that procedure, following me so far?

A I'm not sure I understand.

Q All right. Let me phrase it differently. Let's assume that proton beam therapy was a procedure that did not require prior authorization?

A Correct.

Q Okay. Following me? Following me?

A I do.

Q Okay. So then the -- let's say then the procedure occurs, the insured has the prior -- has the proton beam therapy. The bills are filed by the provider, that's going to go -- it's not going to go to Dr. Ahmad when it comes into Sierra Health and Life?

A No. Not if it was not a service that either needed to require prior auth or determine medical necessity. Those would simply go through the standard claims process.

Q Kind of more -- at least from your view, more in the line of Mr. Prater's area?

A In terms of?

Q Well, never mind. That was a bad question. I'll just ask the

next one.

MR. SHARP: Let's go to, Jason, to section 3.4. The next page. Right here.

BY MR. SHARP:

Q So this is Exhibit 2, and it's page 7. And then it says, "Services requiring prior authorization," right?

A It does.

Q And the first sentence says, "Please refer to attachment B, services requiring prior authorization." Did I read that correctly?

A This is, yes.

Q And that seems to be plain, ordinary language, right?

A It is.

Q And when you got Exhibit 3 from Mr. Roberts did you call him and say, where's attachment B?

A I don't remember.

Q So you would agree with me that the two policies you reviewed when you prepared your expert report did not contain attachment B, right?

A Yes.

Q Have you since been provided attachment B?

A I have.

Q Okay.

MR. SHARP: Let's go to Exhibit 4, attachment B at 79. Exhibit 4, 79.

BY MR. SHARP:

Q Okay. Do you see where I'm at, laboratory and x-ray services? Do you see that?

A Right.

Q And you would agree with me in the column next to it proton beam therapy does not appear?

A It does not, but you also have to read that first line, complex therapies included but not limited to.

Q Okay. Let's go through that --

A So it qualifies that is not a comprehensive list.

Q Was it CT?

A Pardon?

Q Was -- well, is proton beam therapy a CT?

A No, no, no. What I'm saying is the, the first one says, "complex radiology, included but not limited to."

Q And it gives a list of examples, right?

A That's examples, that is correct.

Q It's not -- I mean, those are all like x-ray type services. Like I'm going in and somebody might think I have tumor, so I get an MRI.

A Yes. Those are advance imaging technologies.

Q I don't go to get an MRI to get therapeutic radiology services?

A No.

Q Okay. So these are all examples of complex radiology that I go to, to get diagnosed with something, right?

A Yes.

Q Okay.

MR. SHARP: Now go -- Jason, could you go back? So get rid of this and let's go to attachment B.

BY MR. SHARP:

Q Attachment B, "The SHL agreement of coverages, services requiring prior authorization". Did I read that correctly?

A Yes.

Q Now you --

MR. SHARP: Go ahead, Jason, we can pull that down.

BY MR. SHARP:

Q You reviewed Ms. Holland-Williams' testimony, right?

A Yes.

Q And within that testimony do you recall there being an inter-exchange between Mrs. Eskew and Ms. Holland-Williams as to whether or not MD Anderson would be an in network provider?

A Yes. They were discussing the coverage of the PPO, individual PPO plan.

Q And they were an in network provider, correct?

A That was what I was led to believe, yes.

Q Well, did you confirm it?

A I didn't confirm it from 2015, no.

Q Okay. So you and I can agree as we sit here today you're under the assumption that Ms. Holland- Williams was truthfully representing to Sandra Eskew that MD Anderson was an in network provider?

MR. ROBERTS: Objection based on the --

THE WITNESS: Yes. I had no reason to believe differently.

MR. ROBERTS: -- Court's motions in limine.

THE COURT: Hold on, hold on, hold. You can't speak when your attorneys make an objection.

Mr. Roberts?

MR. ROBERTS: Yes. Objection. Parole evidence and the Court's motions in limine to the discussion between --

THE COURT: Sustained.

MR. ROBERTS: -- Ms. Holland-Williams and Mrs. Eskew.

MR. SHARP: I'm sorry?

THE COURT: Sustained.

MR. SHARP: Sustained? Okay.

THE COURT: And Mr. Sharp, please let the witness finish answering the question before you interpose.

MR. SHARP: Okay. Section -- can you go back to Exhibit 2 at page 7? 3.3, yeah. Pull that one up.

BY MR. SHARP:

Q It says here, "The medical director and/or SHL's utilization review committee will review proposed services and supplies to be received by an insured to determine". Did I read that correctly so far?

A You did.

Q And then it continues, "If the services are medically necessary and/or appropriate." Did I read that correctly?

A Yes.

Q And medically necessary is the term defined within the insurance contract?

A Yes.

Q And you or -- so the promise is from Sierra Health and Life to Mr. Eskew is that when the prior authorization comes in it's going to be reviewed to make sure -- to see whether it conforms with the definition of medically necessary?

A Yes.

Q And the person who decided to deny the claim was Dr. Ahmad?

A Yes.

Q And he's the medical director?

A A medical director.

Q The medical director in this case?

A Yes.

Q And you're aware that Dr. Ahmad in evaluating the prior authorization claim never reviewed the insurance policy?

A I am.

Q So he never determined whether the services are medically necessary as defined by the contract, true?

A No.

Q Okay. What'd he do, figure it out by osmosis?

A No. Because medical directors are trained on the definition of medical necessity. The medical definition and medical necessity definition is one of those things that are fundamental to the utilization

review process and medical directors get trained --

Q Okay. When --

A -- on that.

THE COURT: Hold on.

MR. SHARP: Sorry.

THE MARSHAL: Hold on, Mr. Sharp.

THE COURT: Please do not interrupt the witness.

MR. SHARP: I'm sorry, Your Honor. I apologize.

THE COURT: Go ahead.

THE WITNESS: I'm finished.

THE COURT: All right.

BY MR. SHARP:

Q When was Dr. Ahmad trained?

A I can't say that because that was not provided in the documentation that I had.

Q Did he testify he was trained?

A I don't remember.

Q So you can say generally people like him were trained?

A Well, I can say that United and Sierra have policies on that. Those policies that control their utilization management policies 100.00 to 100.14. And one of those policies clearly outlines the training supervision and oversight that the UM department goes through.

Q Okay. So does that mean he was trained on the particular day as to what medically necessary meant?

A I have no reason to believe he wasn't trained, but I can't give

you what day.

Q Well, you recall him testifying in response to Mr. Robert's examination on, I think that was Monday of last week?

A It was last week, yes.

Q And you saw him testify that he had reviewed standard policies which were substantially similar to the one Mr. Eskew had?

A Yes. There is similar language in the health insurance policies issued by a carrier. And the typical process is to train our professional staff on those basic definitions.

Q So trained on a standard policy which was substantially similar to Mr. Eskew's policy?

A That would be my understanding.

Q Okay. Let me pose this to you. Let's say Mr. Eskew said, I'm going to pay a substantially similar premium to Sierra Health and Life than I received in the bill. What do you think Sierra Health and Life would do?

A I can't speculate on that.

Q They'd cancel the policy because he didn't follow the contract, right?

A Perhaps.

Q Okay. So we can agree that the contract has to be followed?

A That is correct.

Q Not some version which may be substantially similar, right?

A If the medical necessity definitions are identical, then I'm not sure I understand your point.

Q Well, I'm just talking about what he said. He said they were substantially similarly, he didn't say they were identical, remember that?

A I do.

Q Okay. So -- and have you been provided with the form standard definition that you use for all policies to define medical necessity?

A I certainly have the medical necessity definition from the agreement of coverage from Mr. Eskew's --

Q Okay.

A -- policy.

Q Okay. But I take it you're not critical of Dr. Ahmad for not having reviewed the insurance policy definition of medically necessary before he denied this claim?

A Absolutely not.

Q Okay. And --

MR. SHARP: Well, let's go to the definition of medical necessity. That's section H -- or 13.64, page 37. Yeah, right here. Let's start with this one.

BY MR. SHARP:

Q And this is the portion of the policy that you and Mr. Roberts had gone over; is that right?

A Yes.

Q Now you talked a lot about proton beam therapy, right?

A We did.

Q Would it be fair to say that Dr. Liao knows more about proton

beam therapy than you do?

A Correct.

Q And would it be fair to say that Dr. Liao knows more about what was needed to improve the specific health condition of Mr. Eskew?

A Than whom?

Q Than you.

A I have never seen or examined Mr. Eskew, so I can't make any comments on taking care of his clinical situation.

Q Let me put it this way, Dr. Liao knew more about what was needed to improve the specific health condition and to improve Mr. Eskew's health than Sierra Health and Life did?

A Again, you're asking me to know what Sierra Health and Life knows. I will acknowledge that Dr. Liao is a highly recognized and authority on radiation oncology.

Q Let me try it this way, the reasonable insurer would understand that Dr. Liao would know about more than the reasonable insurer would about what was needed to improve Mr. Eskew's health condition or to preserve his health, true?

A Possibly.

Q Just possibly?

A I don't know what Sierra Health and Life knows.

Q Well, you're here to comment upon their knowledge and whether they acted reasonably.

A No. I am not here to comment on their knowledge. I'm here to comment on whether they followed standard industry processes and

procedures in handling this claim.

Q Okay. Did you read Dr. Liao's deposition?

A I did.

Q Did she testify that proton beam therapy was needed to improve or preserve Mr. Eskew's health, true?

A She did.

Q And she testified proton beam therapy was consistent with the diagnosis and treatment of Mr. Eskew's lung cancer, true?

A I agree with that.

Q And she determined that the most appropriate level of service which could be safely provided to Mr. Eskew was proton beam therapy?

A That was her opinion.

Q And he -- and she testified that she wasn't doing this solely for the convenience of Mr. Eskew or herself or MD Anderson?

A Yes. That would be very obvious.

Q Do you think her analysis of these three elements to medically necessary was unreasonable?

A Certainly she may have missed the most appropriate level of service, because again we've also established there was a lot of scientific evidence out there that did not necessarily establish that it was equivalent to, superior to or inferior to other options and therefore potentially not the most appropriate level.

Q Okay. I understand that you and she -- that you disagree with her, but that wasn't quite my question. My question was, do you

think her analysis was unreasonable?

A No. That was her professional opinion. That is certainly reasonable based on her assessment.

Q So we can go -- you and I can agree as we go forward that Dr. Liao's application of the elements in 13.64, medically necessary was reasonable?

A That was her interpretation, yes.

Q It was a reasonable interpretation, true?

A I can't say what is in Dr. Liao's head.

Q As a person who is an expert in the managed care organization, her analysis regarding medically necessary was reasonable?

A Again, I'll leave my comment, I can't know what was in Dr. Liao's head.

Q Sir, I'm not asking you to know what's in her mind. I'm ask -- you know what reasonable means, right?

A I do.

Q Means a decision based on logic, right?

A It's not always based on logic. It's based on whatever you're thinking at the time.

Q Okay. So let me ask it this way, when you read her testimony that we just went over did you think, man that's unreasonable, she totally missed the ball?

A No. I don't think she totally missed the ball in terms of her clinical assessment.

Q Or her application to the -- of the terms to the insurance contract to Mr. Eskew?

A Yes. Her understanding.

MR. SHARP: Let's go to the next -- well let me -- let's go to the next page.

BY MR. SHARP:

Q And it says, "In determining whether a service or supply is medically necessary SHL may give consideration to any or all of the following."

A Correct.

Q And you saw where Dr. Liao opined that the likelihood of proton beam therapy -- that there was a likelihood that proton beam therapy would produce a significant positive outcome?

A Yes. We understand that proton beam therapy can kill cancer cells.

Q So you have no disagreement with Dr. Liao?

A No.

Q And then you saw Dr. Liao's opinion was that proton beam therapy was supported for Mr. Eskew was supported in the reports and the peer review literature, right?

A I don't remember her exact statement on that.

Q Do you remember her testifying that her recommendation of proton beam therapy was consistent with the evidence based reports and guidelines published by nationally recognized professional organizations that included supporting scientific data?

A I don't recall exactly which organization she specified there.
Q I'm just talking about whether or not she said, yes, my treatment meets this --
A Yes.
Q -- criteria. She said that, right?
A Yes.
Q And then she said that her treatment was consistent with the professional standards of safety and effectiveness that are generally recognized in the United States or the diagnosis care or treatment?
A In her viewpoint, yes. She testified.
Q Okay. Now you talked about -- a lot about the peer review literature, right?
A Yes.
Q And the people at MD Anderson in part are the ones who create the peer review literature?
A Among many other institutions both nationally and internationally, yes.
Q Okay. But MD Anderson is one of those --
A It's one.
Q It's a center of excellence?
A It is.
Q And in fact some of the -- well, let me ask you this. When it comes to proton beam therapy, do you think Dr. Liao knows more about the peer review literature and whether that literature supported using proton beam therapy on Mr. Eskew than you do?

A Yes. Because that's her specialty.

Q And she knows more, you would expect than Dr. Ahmad?

A You're asking me to speculate on what Dr. Ahmad knows.

Q Well, based upon your review of the testimony of Dr. Ahmad and you're seeing him testify before this jury, you would agree with me that it's likely that Dr. Liao knows more about whether the peer review literature supports treating Bill Eskew with proton beam therapy, correct?

A She may, yes.

Q I mean, that's all you're going to say, she may?

A She may.

Q You're not here telling this jury that based upon your review and analysis of Dr. Ahmad's testimony that he anywhere nears the qualifications she does on proton beam therapy?

A No. I'm not saying that. But I am saying that Dr. Ahmad is certainly qualified to understand how proton beam therapy impacts the treatment of cancer and to interpret the request for the therapy.

Q That's different than my question.

A No, I understand that.

Q We're coming now to equal consideration, remember that equal consideration?

A Correct.

Q Okay. When the insurance company applies the concept of equal consideration, you got to give it to me that Dr. Liao, a specialist in radiation oncology for thoracic cancers, head of research at MD

Anderson knows more than Dr. Ahmad does about whether the peer review literature supports treating Mr. Eskew with proton beam therapy, true?

A Again, I can't say what Dr. Liao knows. I can only say that certainly her reputation supports her expertise.

Q Okay. If you just don't want to answer my question, say you just don't want to answer --

A You're asking me what someone knows, I don't know what someone knows.

Q Okay. Based on Dr. Liao's training and expertise as you reviewed in her deposition, you have to give it to me that she knows more about the reports and the peer review literature and whether that peer review literature supports using proton beam therapy for Mr. Eskew than Dr. Ahmad?

A That's very likely, yes.

Q And that would be the same for each of the four -- each of the other three points, right?

A I certainly don't know what type of analysis of that literature. I certainly know what Dr. Liao's credentials are and the fact that she's done primary work in that area. Do I know what her specific analysis of all the literature is? No.

Q Okay. I was trying to just short circuit this. I'm just saying when we're applying equal -- when insurance companies apply equal consideration it stands to reason that Dr. Liao's going to know more than Dr. Ahmad does about whether the proton beam therapy is likely to

produce a positive outcome for Mr. Eskew?

A It's almost an impossible question to answer from my standpoint. I will concede again Dr. Liao's expertise and knowledge, but I really can't compare her expertise and knowledge to anyone else except mine. I know what I know and don't know about proton beam therapy.

Q Fair enough. But you're here testifying as an expert on the reasonableness of Dr. Ahmad's conduct, right?

A Not of his -- did he follow proper health plan process procedures and policies in rendering his decision.

Q Well, I mean, that sounds to me like you're testifying about the reasonableness of his conduct, right?

A Yes.

Q Okay. So you're here as an expert testifying about his reasonableness of his conduct and you never reached an opinion that Dr. Liao likely knows more about whether proton beam therapy would produce a significant positive outcome for Bill Eskew than Dr. Ahmad?

A I don't think that was part of what I was asked to do.

Q Okay. Would you agree with me that Dr. Ahmad or Dr. Liao is an -- would likely know more about whether the evidence based reports and guidelines published by nationally recognized professional organizations that include supporting scientific data would support her treating Mr. Eskew with proton beam therapy?

A Again, she is very -- I am sure very conversant and familiar with the literature and standards.

Q More so than Dr. Ahmad --

A That I don't know.

Q Okay. Dr. Liao likely would know more about the professional standards of safety and effectiveness that are generally recognized in the United States for the treatment of lung cancer through therapeutic radiology services than Dr. Ahmad?

A Yes. That is her specialty. She would be an expert in that.

Q But as I hear you, you weren't really asked to consider any of these applications?

A I was asked to consider those, but in the context was the conduction or the conduct of the review and the process that Dr. Ahmad followed consistent with industry standards.

Q Okay. So the next thing --

MR. SHARP: Just now go to this paragraph, Jason.

BY MR. SHARP:

Q It reads, "Services and accommodations will not automatically be considered medically necessary simply because they were prescribed by a physician." Did I read that correctly?

A That is correct.

Q Nothing within that statement says the insurance company won't consider the opinions of the treating physician?

A No. They do consider the opinions of the treating physician.

Q Those opinions should be given due weight and consideration?

A They do, yes. They are.

Q The industry standard would be to do that?
A That is correct.
Q Okay.
MR. SHARP: Now let's go to section 10.11 at 25.
BY MR. SHARP:
Q So you had testified this morning about the medical policy, remember that?
A That is correct.
Q Corporate policy?
A Corporate policies, corporate medical policies, corporate operational policies.
Q Just to be clear, those corporate policies are not a part of the insurance contract?
A No. They are not.
Q And do you agree that this was a claim for benefit that was being made on behalf of Mr. Eskew?
A This was a request for benefits, yes.
Q In other words a claim?
A It hadn't reached the state -- the status of a claim yet because no claim had been submitted, that's why it's called a preapproval.
MR. SHARP: Let's go to 1385. You need a page number, Jason. Go to 1385.
BY MR. SHARP:
Q Okay. So regardless of your own personal opinion, you would defer to Sierra Life and Health as to how they would view the

prior authorization, right?

A Yes. They define preservice claim.

Q Means any claim for benefit under a health benefit plan?

A Right.

Q Okay. So as you and I go forward, it's fair for me to call this a claim?

A Yes. I mean we can use that as a preservice claim to be more specific.

Q Well, I'm just following the definition, "means any claim". Did I read that correctly?

A You did.

Q Okay. So it's fair to call this a claim for benefits under the policy?

A Yeah. But it's also conditional upon approval of the benefit in advance for obtaining care, so.

Q I understand. I mean, any claim is. Whether it's preservice, post service, it doesn't matter. Any claim is subject to conditions, right?

A That is correct.

Q I'm just focusing you on the word claim.

A Yeah. We'll call this if you insist on calling it a claim. In my industry we call it a preservice claim.

Q Regardless, the preservice claim means any claim for benefits under a health insurance policy?

A Yes.

Q Okay. So you would agree with me since the medical policy,

corporate policy is not part of the health insurance contract it would be improper to deny a claim based solely upon the corporate medical policy?

A No. I totally disagree. That's why we have corporate medical policies, to perform a review of the subject and give the basis and understanding on how to apply that policy.

Q Okay. You're going to have to help me out with this. We've been dealing with an insurance contract, right?

A That is correct.

Q And the terms of the insurance contract are contained within the contract?

A Yes.

Q And you agreed with me that the corporate medical policy is not part of the insurance contract?

A No. But it is used to administer the contract.

Q I understand that, but I'm just -- you following me so far?

A No, I'm not.

Q Okay. So we have an insurance contract that's a legal instrument, do you understand that?

A That I do. I'm not --

Q And part of this legal instrument and then separate we have this corporate medical policy, right?

A You have many corporate medical policies, yes.

Q Fair enough. None of those corporate medical policies are part of the legal instrument, true?

A That is the case, yes.

Q So it would be inconsistent with the industry standards to rely upon the corporate medical policy that's outside the terms of the legal agreement as the sole basis for denying a claim?

A Well, as the sole basis, but remember corporate medical policies are interpreted in the context of the case at hand and interpreted using the knowledge and experience of the person applying that policy.

Q You don't know that when it comes to Sierra Health and Life?

A I only know it with my experience and doing this job for 22 years.

Q But you were aware were you not that there was a policy folder that exists somewhere back in Minnesota I think that would explain to everybody why the corporate policy was adopted?

A I don't know what's back in Minnetonka, no.

Q You weren't aware of this policy folder?

A I know the medical policies, yes. Because those are publicly available.

Q And you didn't read Dr. Bhatnagara's deposition?

A I don't recall Dr. Bhatnagara's deposition.

Q Okay. In any event, I think we can both agree that an insurance company cannot base the corporate medical policy as the sole basis for the denial of the claim?

A No. The corporate medical policy is a tool that's used in reviewing the preservice claim.

Q Okay.

MR. SHARP: So let's go to -- Jason, can you pull up Exhibit 13?

BY MR. SHARP:

Q Sir, have you reviewed the UnitedHealthcare policy and procedure hierarchy of coverage review?

A Yes.

Q Are you sure because I didn't see that on your list of stuff that was given --

A This one, no. I have not seen this one --

Q Okay.

A -- the hierarchy of coverage. I'm sorry.

Q So UnitedHealthcare didn't share this with you?

A I don't remember. I didn't seek it out, no.

Q Okay.

MR. SHARP: Now go to the second page. Well, let's go to the first page first. It says -- right here. Second paragraph.

BY MR. SHARP:

Q It says, "The purpose of this document is to define the hierarchy of coverage review to ensure a transparent and consistent approach within UnitedHealthcare".

A Yes. That is the purpose of establishing medical policies.

Q Okay.

MR. SHARP: So let's go to the next page. Go to the next page. Okay. Pull up this. Here.

BY MR. SHARP:

Q So the hierarchy of coverage review which is used to determine to build these corporate policies, right? It's what happen -- that's what's going on here, correct?

A Yes. That is correct.

Q Okay. Now you would agree with me that the definition of medically necessary within this corporate policy that's used to define medically necessary in the corporate policy is different than the one in Mr. Eskew's --

A Yes. It has some different language, that is correct.

Q And it's got some pretty significant different language, true?

A Yes.

Q Like this third one, take this third bullet point.

MR. SHARP: Oh sorry, Jason. The --

THE WITNESS: Fourth one.

MR. SHARP: Actually this fourth bullet point. Pull that -- can you pull it up further, like --

BY MR. SHARP:

Q The actually form policy that's being used to create corporate medical policy to define medically necessary it has a provision that says, "Not more costly than alternative drugs, services or supply that at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury, disease or symptom", right?

A That is correct.

Q Did I read that correctly? So this provision that's not in Mr.

Eskew's contract would allow UnitedHealthcare to -- or Sierra Health and Life to consider cost of service?

A Yes.

Q And nothing within --

MR. SHARP: Can you pull this back down, Jason? And just pull up medical necessary.

BY MR. SHARP:

Q And nothing within this definition would tell you that you can use level of service to determine that really means the one that's less expensive, right?

A This is a different way of defining level of service I agree than what was in Mr. Eskew's documents.

Q Well, level of service in Mr. Eskew's document is a contract, we call it.

A Contract, yes.

Q Level of service in Mr. Eskew's contract is not defined, correct?

A That says the most appropriate level of service which can be safely provided to the insured and, of course the and's not germane.

Q My questions a little different. The level of service is not defined in the insurance contract?

A Not that I'm aware of, no.

Q Okay. So you said, well, that's another definition. But I just want to point out the contract doesn't have a definition of level of service, right?

A That is correct.

Q So you still believe your interpretation of the contract of level of service means we can decide which one's cheaper is reasonable?

A No. The -- I think your misstating. Which one is most cost effective because there saying least costly alternative if something is likely to produce equal results. And the way that this gets determined, you can't just put cost in the equation. Value is defined as outcome over cost. And if equal outcomes are expected and one cost more, the one that costs more has a lower value. And in essence what they're trying to do there is to find another way to talk about level of service.

Q Is there any document that you've been provided by Sierra Health and Life or UnitedHealthcare that adopts the same definition of level of care that you provided to this jury?

A I'm confused.

Q You've interpreted what the term level of care -- level of service means, right?

A Correct.

Q Is there an internal document that we can go to that's been provided to you by Sierra Health and Life or UnitedHealthcare that adopts your definition of level of care?

A Not that I'm aware of, no. Or not that I can provide --

Q Did you ask for one?

A I didn't ask for one.

Q Are you aware -- well --

MR. SHARP: Go ahead, Jason, you can pull this down.

BY MR. SHARP:

Q You read Mr. Prater's testimony about his view that proton beam therapy met the coverage provisions for medically necessary?

A Yes.

Q And you've been here to criticize or disagree with many of Mr. Prater's opinions, right?

A Yes.

Q Do you think Mr. Prater's analysis that proton beam therapy met the definition of medically necessary is unreasonable?

A I do. I don't think Mr. Prater was qualified to understand the nuances of medical treatments like proton beam therapy and the evidence to support when and how they should be covered.

Q Okay. So Mr. Prater's unreasonable, but you can't tell me whether Dr. Liao is unreasonable?

A Well, Mr. Prater and myself share the same or similar expertise, so I think I'm much more qualified to comment on Mr. Prater's reasonableness than Dr. Liao's.

Q Tell me, what was the standard by which you used to define what level of care means?

A I used the standard that we have with working in the industry, which is the most effective and/or cost effective level of service to meet the individual's needs.

Q And where can I go find that definition?

A That's basically the working premise and definition that we all use in the industry. So that's based on my experience and the fact

that I've literally built some of these plans over the years.

Q Okay. So where can I go? Can I go to NCQA? What piece of paper can I go to that supports your definition of level of care?

A I can't point you to a piece paper without doing considerable research.

Q So it seems to me like what your major point is, is that Mr. Prater being an industry expert who teaches insurance law doesn't understand the medical aspects of things?

A That is precisely my point.

Q So were you aware that in the State of Nevada in determining the meaning of an insurance policy, the language should be examined from the viewpoint of one not trained in the law or in the insurance business. The terms should be understood in their plain, ordinary and popular sense?

A Yes. That's, you know, not only the State of Nevada, but most states have those things that require insurance policy language to be understandable to a reasonable lay person.

Q And it's your testimony that Mr. Prater's coverage analysis is inconsistent with construing terms in their plain, ordinary and popular sense?

A I don't agree with Mr. Prater, no.

Q Okay. No. That was -- my question is a little different, sir.

A Then my answer is, no.

Q Oh.

A I don't agree with Mr. Prater.

Q Now there's a difference between -- I mean, are you basically telling us that level of service means types of service?

A It can mean type of service; it can mean where the service is provided. It means all of those things.

Q So level has all sorts of different definitions?

A Oh, of course.

Q Okay. Now let's move -- okay. What I'd like to do --

MR. SHARP: Your Honor, can I approach the witness?

THE COURT: Yes, Mr. Sharp.

BY MR. SHARP:

Q I'm going to be using Exhibit 5.

A Exhibit 5? Thank you.

Q Now you've been asked by United, by Sierra Health and Life to evaluate the handling of the prior authorization claim; is that correct?

A That is correct.

Q So you've reviewed Exhibit 5?

A Yes, I have.

Q Okay. What I'd kind of like to do with your assistance, is to give the jury a timeline as between the communications between Ms. Amogawin and Dr. Ahmad, okay?

A Okay.

Q So you could go to --

MR. SHARP: Jason, you can pull up that PowerPoint.

BY MR. SHARP:

Q Could you go to Exhibit 5 at page 6 of Exhibit 5?

A Page 6, okay. Is that the one that starts, "Hi, Dr. Ahmad"? Just --

Q Yes.

A -- to be sure I'm on the same page.

Q So when we're referencing exhibits, Doctor, it's right down at the bottom there. So if you start down there at the very bottom. Do you see that's an email -- let's go back -- yeah. This is an email it's February -- it says February 4, 2016 at 1:20:13 a.m. GMT. Do you see that?

A On page what?

Q Down at the bottom, page 5.

A Down on the bottom of page 5 what I'm seeing is, February 5th, 2016 at 10:50 --

Q No. I'm sorry. I'm sorry, sir. It's page 6.

A Okay.

Q Exhibit 5, page 6. That was my fault. The very bottom it says --

A There I'm seeing, February 4th, 2016 at 1:20 a.m. GMT.

Q Yeah. And GMT is seven hours ahead of --

A Right. That's --

Q Okay.

A -- Greenwich Mean Time.

Q So my math is that I believe -- maybe -- my math would be that's 6:20 p.m. pacific, okay?

A Yes.

Q All right. Now the next thing it says, "Correction request

prior -- request-- authorization request for radiation therapy, IMRT versus IMPT radiation treatment."

A That is correct.

Q Did I read that correctly?

A That is correct.

Q So I've got the February 3rd entry at 6:20. Now let's go to --

MR. SHARP: This should say 2016 for everybody. I apparently don't know dates, so when you write that down that's 2016. I apologize for that.

BY MR. SHARP:

Q So now we're on February 4, 2016. If you go to Exhibit 5, page 2.

A Exhibit 5, page 2, all right.

Q And see down there, this an email from Dr. Ahmad to Ms. Amogawin on February 4, 2016 at 3:12 p.m. --

A Correct.

Q -- correct? And down at the bottom it says, "Case summary, lung cancer. The requested procedure does not meet current HPN policy?"

A That is correct.

Q "Decision, proton therapy and all associated codes are not covered and are denied."

A That is --

Q Did I read that is correctly?

A I do.

MR. SHARP: Okay. Blow up the next line. No. Go back.
BY MR. SHARP:
Q Okay. So first thing I want to know, is it your understanding that Dr. Ahmad receives the email through a secure system?
A Yes. I'm assuming there is an internal secured system between United or Sierra in this case and its reviewers.
Q And does it even have to -- so it's like one of these emails comes in your inbox and says you have a secured message?
A It may be or -- and again, it may be. Our process was to actually have a secured log in and then once you logged in. But I can't say --
Q Okay.
A -- which Dr. Ahmad did it.
Q Let's go by your version. The secured message comes in, the medical director would then log into the system?
A Yes. Or maybe logged in and received the secured message. You can't know which.
Q In any event there would be some kind time stamp within the system to identify when the log in occurs?
A Yes. There would be a record for that.
Q And obviously UnitedHealthcare's transmitting health information of Mr. Eskew and many other insurers?
A Right. Which is why you need secured systems.
Q So this isn't a situation where Dr. Ahmad can just download the medical records to his laptop as an example?

A That would be unlikely. Usually there are provisions to prevent dissemination. Again, I can't -- I'm not an IT expert, so I can't speak for --

Q But you do understand HIPA?

A But with -- and that's exactly where I'm going, yeah.

Q So --

A Health plans have to take HIPA seriously and not -- and develop systems to prevent improper dissemination.

Q It would seem likely that a company as sophisticated as Sierra Health and Life and UnitedHealthcare wouldn't be allowing medical directors to randomly download --

A That would be my belief, yes.

Q So you log into the secured system. You'd be able to see the medical records, right?

A Yes. Whatever is provided to him.

Q And then process would be to log out of that system once the medical records are reviewed?

A Maybe. It depends on how many cases he's reviewing at a time.

Q Regardless, at some point --

A At some point he's going to log out, yes.

Q So it could be one of these situations where he receives all of the claims in a secured message, and he logs in and he's got all of them and all of the documentation for all --

A Could be. It could be, I don't know.

Q In any event, my point is there would be a trail that somebody like UnitedHealthcare would reasonably have to tell us when Dr. Ahmad logged into the system, and we logged out of the system?

A Yes.

Q Now I take it when you were a general practitioner you were pretty busy during the day?

A Generally, yes. That was the nature of the practice.

Q Yeah. I mean, you're trying to have appointments so you can see patients, right?

A Yes.

Q And you -- so you can bill -- make a profit by seeing patients?

A That's what the business is about --

Q Certainly.

A -- yeah.

Q I'm not criticizing, I'm just pointing it out.

A No, no. That's what the business is about.

Q And you understood Dr. Ahmad was running a full time practice while he was doing his part time medical reviews?

A Yes.

Q So -- and in oncology I would take it that your expectation that the patient business might be pretty timely because you're dealing -- I mean, taking time because you're --

A They may, yes.

THE COURT: Hold on. We can only speak one a time, so --

THE WITNESS: Sorry.

THE COURT: -- Doctor, if you can just not interrupt him and then Mr. Sharp will not interrupt you either.

MR. SHARP: I hope I've been better. I got the bailiff -- I mean, marshal coming over. Okay.

BY MR. SHARP:

Q So let's go back. In any event the patient business that Dr. Ahmad had, he's a busy practitioner, right?

A He's a practitioner. I can't state busy or not busy because I don't know how many patients he was seeing.

Q And your common expectation would be, he is a qualified oncologist, he's probably busy?

A Yeah. He's a qualified oncologist, yes. So my assumption is he's seeing patients.

Q And he's busy, he's a busy -- I mean --

A Again, you're asking me to speculate on what he was doing.

Q Okay. Well, we know that he responded to the first email in the middle of the business day, 3:12 p.m., right?

A That is 3:12 p.m., yes.

Q Now --

A Middle of the afternoon.

Q We go to the next -- let's go to Exhibit 5 and page 6. Do you see where in the middle page Dr. Ahmad -- it's the middle of the page, second -- it's the first full email on the page. Emails from Dr. Ahmad to Lou Ann Amogawin through a secured message system?

A Yes.

Q So when that message comes in there should be sort of interior time stamp, right?

A Yes.

Q Okay. And that message is another denial where he says, "Case summary, metastatic cancer to lung unknown primary. The requested procedure does not meet current HPN policy. Decision, proton therapy and all associated codes are not covered and are denied."

A Correct.

Q Did I read that correctly?

A I do.

MR. SHARP: Go ahead and pull that up, Jason.

BY MR. SHARP:

Q And just so the jury knows, on my screen is the verbatim quote that I just read to you --

A Yes.

Q -- as written by Dr. Ahmad, right?

A Yes.

Q So like where current HPN is one word, that's not my typo? Well, we'll do it this way. Do you see where I'm following, "unknown primary the requested," there's not period there?

A Yes.

Q Okay. That's exactly as it appears in Exhibit 5, right?

A Yes.

Q Okay. So now he's denied Mr. Eskew's claim the second time towards the end of the workday, right?

A Correct.

Q Now the next day on February 5, 2016 at 8:23 p.m. or a.m. If you could go to Exhibit 5, page 3, the first note from Ms. Pollack [phonetic]. Where it says, 8:23:42 a.m., do you see that?

A Correct.

Q And here, "Ms. Pollack received a call from Adelle at Proton Therapy Center and she --

A I do.

Q -- "informed her of denial reason, informed her of Med/DIR denial reason." Did I read that correctly?

A Yes.

Q Okay.

MR. SHARP: Pull that up, Jason.

BY MR. SHARP:

Q So we can agree that before the denial letter was created Sierra Health and Life had communicated the denial to MD Anderson?

A That is what this says. It was done at 8:23 in the morning via phone, if I read this correctly.

Q Now at 11:57 a.m., if you go down to the next entry. We have Mr. Guerrero indicating at 11:57, "denial letter's hand typed from template with text below." Did I read that correctly?

A I do.

MR. SHARP: Jason, can you pull up the next point?

BY MR. SHARP:

Q Now did you review the IMRT file?

A I did not review the IMRT file.

Q Do you have Exhibit 73 in that -- not the other binder in front of you?

A I do.

Q By the way -- well, let me know when you get to Exhibit 73 or if it's in there.

A Okay. I'm in Exhibit 73.

Q Just -- I'm just curious, tell me what the clinical trial was for IMRT for lung cancer?

A I didn't do the research on that, so I can't answer that question.

Q So if there was a clinical trial for IMRT for lung cancer it would be -- you would expect it to be in the medical policy?

A For IMRT, correct.

Q So if I represented to you that there is no medical literature in the IMRT policy relating to lung cancer period, would that provide you any concern?

A It certainly would be unexpected because you should if there is a comprehensive review of the literature, there should be references.

Q Would you agree with me if the insurance industry is going to hold proton beam therapy to the standard of clinical trials that it should do the same for IMRT?

A Not necessarily because older technologies sometimes weren't held to the level of evidence that newer technologies have been held to. The standards for reviewing new technology, that bar has been

raised over the years. There are many things in medicine still that have not and never will be reviewed in the clinical trial, but they have become standards of care simply by their longstanding and widespread use.

Q So you're aware though that proton beam therapy has been around for a long time?

A It has been.

Q Okay. Been around about as long IMRT?

A I don't know exactly; I can't give you the exact date when they were in common usage.

Q So you say it's okay to say IMRT you don't need a clinical, but for proton beam therapy you do?

A And again, sometimes because of standards of care that does happen all the time.

Q And the person who's in charge of the proton beam therapy policy should be prepared to address that question?

A They could, yes.

Q Okay. Let's go back and over at the IMRT file could you go to page 2? And we get Exhibit 73 of page 2, if you go down to the bottom and it looks like -- do you see where Mr. Gonzalez received a fax from MD Anderson outpatient IMRT?

A And is this on page 2?

Q It should be on page 3.

A 3, okay. I didn't see on page 2. Okay.

Q Or it may be on page 2, I don't know.

A And on page 3 that one starts off with the user ID L. Ann

Amogawin.

Q If you go to -- it was on page 2, sir. I'm sorry.

A Okay. I'll go back to page 2.

Q If you go back, it's the first entry on page 2.

A First entry on page 2 is that Gonzalez at 2:05 -- 2/5/16 at 4:39?

Q Yeah.

A Okay.

Q And he indicates that he received a fax from MD Anderson?

A Correct.

Q And whatever it was --

MR. SHARP: Go to the -- go ahead and go to the next bullet.

BY MR. SHARP:

Q And whatever was received by Sierra Health and Life was not in the file, correct?

A Correct.

Q Now if we go to the bottom of page 2, you'll see the entry at 2:53 by Ms. Amogawin sent to medical director for review.

A Okay.

Q Do you see that?

A I do, at 14:53.

Q Now let's go back --

MR. SHARP: Next file, Jason.

BY MR. SHARP:

Q We're going to back to Exhibit 5. If you go to Exhibit 5 at pages 5 through to 6. So you see at 5 there's an email from Ms.

Amogawin to Dr. Ahmad? At the very bottom of Exhibit 5, page 5.

A At the very bottom, is that at 14:15?

Q Are you on Exhibit 5?

A I'm on Exhibit 5, page 3.

Q No. Page 5.

A Thank you. And that was is on February 5th, 2016 at 10:50 GMT.

Q So 3:50 p.m., right?

A Yeah.

Q And she writes, "This is the case for proton beam, can you please send me an updated denial text with correct protocol? Attached is the UHC-KL protocol. Please send me an edited denial note for documentation."

A Correct.

Q Did I read that correctly?

A Correct.

Q So she actually physically emailed the correct medical policy to Dr. Ahmad?

A Yes. I remember Dr. Ahmad noting that he had put the wrong medical policy number in his original communication to Ms. Amogawin.

Q In the first two denials he referenced the wrong policy?

A That was 006, correct.

Q Yes.

THE COURT: Counsel, we're going to take our 15 minute

recess.

Ladies and gentlemen, you are instructed not to talk with each other or with anyone else about any subject or issue connected with this trial. You're not to read, watch or listen to any report of or commentary on the trial by any person connected with the case or by any medium of information including without limitation newspapers, television, the internet or radio. You're not to conduct any research on your own relating to this case such as consulting dictionaries, using the internet or using reference materials. You're not to conduct any investigation, test any theory of the case, recreate any aspect of the case or in any other way investigate about the case on your own.

You're not to talk with others, text others, tweet others, google issues or conduct any other kind of book or computer research with regard to any issue, party, witness, or attorney involved in this case. You're not to form or express any opinion on any subject connected with this this trial until the case is finally submitted to you.

We'll come back at 2:45.

THE MARSHAL: All rise for the jury.

[Jury out at 2:30 p.m.]

THE COURT: Does counsel have any issues outside the presence of the jury?

MR. ROBERTS: Nothing for the Defense, Your Honor.

THE COURT: And Mr. Sharp, if you keep interrupting the witness we're going to take breaks.

MR. SHARP: What's that?

THE COURT: If you keep interrupting the witness we're going to take a break every time you do, okay?

MR. SHARP: Okay.

THE COURT: Thank you.

[Recess taken from 2:31 p.m. to 2:46 p.m.]

THE MARSHAL: Okay. Department 4 come to order. Back on the record.

THE COURT: Please be seated. Are the parties ready for the jury?

MR. ROBERTS: Yes, Your Honor.

MR. SHARP: Yes, Your Honor.

THE COURT: Thank you.

THE MARSHAL: All rise for the jury.

[Jury in at 2:47 p.m.]

THE MARSHAL: All jurors are present.

THE COURT: Thank you. Do all parties stipulate to the presence of the jury?

MR. ROBERTS: Yes, Your Honor.

MR. SHARP: Yes, Your Honor.

THE COURT: Thank you. Please be seated. Mr. Sharp, please proceed.

MR. SHARP: Thank you, Your Honor.

BY MR. SHARP:

Q So sir, when we left we had gone through the entry from the proton beam claim file, I believe 50. If you could go to Exhibit 73 at 3

and just let me know when you're there.

A Exhibit 73, page 3?

Q Yeah.

A Yes.

Q Are you there?

A I am.

Q If you could go to the note -- email from Dr. Ahmad to Ms. Amogawin.

A And that is the one dated February 5th, 2016 at 4:38?

Q Yes. And if you could read that to yourself.

A Yes.

Q Okay. I'm going to pull up -- so 4:38 p.m. Dr. Ahmad writes to nurse -- to Ms. Amogawin about the IMRT claim, correct?

A Correct.

Q And he writes, "As described below lung and mediastinal tumor the requested procedure meets current HPN policy. Decision, IMRT and all associated codes are a covered benefit." Did I read that correctly?

A You did.

Q And again, the "meets current code," that's not a typo on my end, correct?

A Correct.

Q So now we go -- if you go back to Exhibit 3. And if you go to page 5.

A Page 5?

Q Yes. And if you read that to yourself, it's going to be the email from Dr. Ahmad to Ms. Amogawin at 4:42 p.m. Do you see that?

A I'm sorry, but the tab that I have for Exhibit 3 is health plan benefit information.

Q I'm sorry. I'm sorry. Exhibit 5.

A Okay. All right. And Exhibit 5, the page again, please?

Q It's page 5. And just let me know when you're there.

A And where -- the email from Dr. Ahmad to Ms. Amogawin?

Q Yes.

A Okay.

Q If you could read that, where it says, "case summary," just read the rest of that to yourself.

A Okay. I did.

Q Okay. Thank you. So at 4:42 p.m. Dr. Ahmad is responding to Ms. Amogawin's email about the correct protocol, right?

A It says, "Procedure decision, proton therapy and all associated codes are not covered and are denied".

Q Again, I'm just asking if you go to the next page Dr. Ahmad is responding to Ms. Amogawin's email at 3:50 on February 5.

A That would be the one at -- now that one says February 4th, 2016.

Q I'm sorry. If you start at page 5.

A Okay.

Q At the bottom of page 5 there's an email from Ms. Amogawin.

A Okay. To doctor, yes.
Q And that's at 3:50?
A Yes, 10:50 GMT.
Q Okay. So my point though is that the 4:42 email from Dr. Ahmad is responding to nurse Amogawin, correct?
A It does appear to be, yes.
Q And it's about the proton claim, right?
A Yes.
Q Thank you. And Dr. Ahmad writes, "Case summary, mediastinal tumor, the requested procedure does not meet HPN/UHC policy. Decision, proton therapy and all associated codes are not covered and are denied."
A Correct.
Q Did I read that correctly?
A You did.
Q Just so we're clear, if you could let me finish my question before I respond so it doesn't look like I'm interrupting you --
A Okay.
Q -- in anyway.
A My apologies.
Q So we've gone through three emails from Dr. Ahmad where he communicates the reasons for the denial of the claim, right?
A Yes.
Q And in each of those three emails he refers to the corporate medical policy?

A Yes.
Q There's no reference in any of those three emails regarding peer review literature that he may have considered, right?
A Yes.
Q No reference to an analysis of the medical record?
A Yes.
Q And each of the three emails were sent during business hours?
A Yes.
Q Did you ever in your analysis explore the possibility that Dr. Ahmad may not even have written those emails?
A Of course not.
Q Did you explore the possibility that being in the middle of a workday Dr. Ahmad did not give this claim a fair and objective evaluation?
A I can't speak to that because I don't know what Dr. Ahmad's schedule was for that workday.
Q You had spoken about the NCQA and URAC accreditation process?
A Correct.
Q Do you recall that?
A Yes.
Q Now in that process do the NCQA auditors show up at Dr. Ahmad's office and say, hey, we'd like to check your files to see what you did, for example when you denied Mr. Eskew's claim?

A No. They typically show up at the offices of the health plan and get the files at the health plan, which would be also the files that are entered into the secure system owned by the health plan.

Q So the auditors would review the same thing that's within Exhibit 5?

A That would be the case.

Q And you're aware there's no practice at Sierra Health and Life to actually evaluate what Dr. Ahmad is doing, other than what's in the claim file?

A No. Sierra Health and Life is not likely to be observing what Dr. Ahmad is doing in his outside office.

Q So every file that he evaluates, there's a denial for medically necessary. No one at Sierra Health and Life verifies that he's actually reviewing peer review literature, correct?

A Correct.

Q And no one at Sierra Health and Life actually verifies that he's analyzing the medical records, correct?

A Correct.

Q And no one at Sierra Health and Life actually verifies that he's considering or analyzing the terms of the insurance contract?

A The contract, that is correct.

Q And that's consistent with the standards of NCQA?

A Yes, it is. Because they don't review every case. They do require a review of the process and they do require reviews for such things as interrater reliability testing where reviewers are given

hypothetical cases to review. I believe even Dr. Ahmad if I recall testified that he was subject to IRR or interrater reliability.

Q My question's a little bit different and maybe it wasn't posed correctly. The process of never verifying what in fact the medical director is considering other than what's -- the emails that are in the claim file. That process that you agree to, right?

A That is correct.

Q And that process is consistent with NCQA?

A That process is consistent.

Q So --

A Again, I think it would be very unlikely that one would re-review every review done by a medical director.

Q Again, maybe you and I are talking on a different level. We've seen, we've taken the jury through what Dr. Ahmad documented in his emails, right?

A We have.

Q My question's a little different, okay. I'm talking about the other stuff that Dr. Ahmad claims to have done, like the peer review literature, like the analysis of the records, okay. You with me so far?

A I do.

Q That part of his job no one in Sierra Health and Life verifies that he's doing that job, correct?

A Not directly, no.

Q Directly or indirectly, nobody's going and looking at his files to make sure like in this instance he actually reviewed the medical

records, correct?

A Well, they would have the same reason to wonder if he actually -- you know -- I mean, again you're asking me to speculate on someone's work performance. Again, no one at Sierra Health and Life is going to review every single case that Dr. Ahmad -- I recognize we're on different plains here, but I'm not sure you understand how these processes work.

Q I'm not worried about why, okay. I'm just trying to get agreement and I think we're on the same page. The agreement that you and I have is that no one at Sierra Health and Life has ever gone to Dr. Ahmad's office and asked him to document for them what he specifically did for any one review?

A I don't know that.

Q Okay. Well, in accordance with industry standards as you understand that, would Sierra Health and Life show up at the office of Dr. Ahmad and as an example say, give us all the documentation you have on Mr. Eskew so you can demonstrate to us that you reviewed the medical policy, that you reviewed the medical records, that you reviewed peer review literature?

A That would generally not be a standard process at Sierra or any health plan of which I'm aware of.

Q And that would be the case. And you had a list of different insurance companies and their views on proton beam therapy, do you remember that?

A I did, yes.

Q And by my count that consisted of over a 150 million insureds?

A Yes. Give or take a few, correct.

Q So and all those insurance companies I take it are NCQA accredited?

A The one -- several I know are. I would have to go back and do -- for instance I know Anthem is NCQA accredited. I know Independence is, that's my former employer. I know Signa is. So the ones that I'm very familiar with are NCQA accredited.

Q In other words -- but regardless from the industry standard perspective any one of those 150 million insureds would be subject to the same type of review process that we've seen with Mr. Eskew, correct?

A A similar process, yes.

Q And they would be treated with the same fairness and impartiality that Mr. Eskew was?

A That is correct.

Q And that this process of never verifying to confirm what the medical director actually did, that would be applicable to all 150 of these insureds?

A And you're looking -- I think what you're describing is a detailed audit of what a medical director may or may not have done in making a decision. And that is not part of the standard operating procedure.

Q So all 150 million insureds would be subject to that same fair

and balanced approach, correct?

A I'm not sure what you're referring to by imbalanced.

Q I said balanced.

A Balanced, okay. It sounded like imbalanced. Yes. They do apply those fair and balanced approaches to utilization review.

Q And your -- so let's go now to the denial letter. If you go to Exhibit 5, page 33.

MR. SHARP: Exhibit 5, Jason.

BY MR. SHARP:

Q This is the denial letter that you went over with Mr. Roberts; is that right?

A That is correct.

Q And this denial letter is consistent with industry standards?

A It is.

Q And this denial letter you would agree with me contains no specific reference to the insurance policy?

A That is correct.

Q And the fact that there's no specific reference to the insurance policy is consistent with industry standards?

A It is.

Q And you would agree with me --

MR. SHARP: If we could pull up the basis for denial.

BY MR. SHARP:

Q This is the basis for the claim denial, right? Where is says, "Reason for our determination is?"

A Correct.

Q And the only thing that's referenced is the medical policy for proton beam therapy, correct?

A That is correct.

Q And that too is consistent with industry standards?

A That is.

Q So the consumer reading this denial would conclude that the basis for the denial was the proton beam radiation therapy policy?

A That is correct.

Q And if we picked up 200 different denials by Sierra Health and Life the form would look the same?

A The format would look the same, yes.

Q And to your knowledge or at least to your expectation there would never be a reference to the specific terms of the insurance contract?

A That is my expectation.

MR. SHARP: Jason, do you have the insurance statutes?

JASON: The NRS?

MR. SHARP: Yeah. Before you pull those up though -- Your Honor, I'd ask for the Court to take judicial notice of NRS 686A.310.

THE COURT: Any objection, Counsel?

MR. ROBERTS: Just a second, Your Honor. I have to look it up. What was that section again?

MR. SHARP: The unfair practices in settling claims. NRS.

MR. ROBERTS: NRS?

MR. SHARP: Yes.

MR. ROBERTS: Could I have the citation, Counsel?

MR. SHARP: NRS 686A.310. And before we -- well, let me know if you're --

MR. ROBERTS: Can we approach, Your Honor?

THE COURT: Yes.

[Sidebar at 3:08 p.m., ending at 3:09 p.m., not recorded]

THE COURT: The Court will take judicial notice of NRS 686A.310.

BY MR. SHARP:

Q Sir, before we get to this statute, you've studied the denial letter it seems like for some time?

A Correct.

Q And there was no explanation within -- well, there's nothing -- there was no reference to the insurance policy, you agree with that?

A There is. If you look at the second paragraph on page 2, "Based on the information submitted, your health benefit plan," which basically is a reference to their insurance policy and UnitedHealthcare medical policy, "we determine", et cetera.

Q Maybe I can ask it this way. There's no specific reference to the provision in the insurance policy contract that is being relied upon to deny the claim?

A No. There's no contract specific provision excerpted from the benefit plan.

Q And there's no explanation within the denial letter why the

terms of the insurance policy for defining medical necessity do not apply?

A It doesn't have the definition of medical necessity in it, no.

Q Okay.

MR. SHARP: So if we could back up to the statute, Jason. And its page 3 of the one we're dealing with. Next. Okay.

BY MR. SHARP:

Q So we say, NRS 686.A310, unfair practices in settling claims. It says, "Engaging in any of the following activities is considered to be an unfair practice."

MR. SHARP: Now if we go to the next page, Jason. No, no, no. All right.

JASON: This one?

MR. SHARP: No, no. Strike this out and then just blow up "and." And, next one.

BY MR. SHARP:

Q Okay. I'm going to read this statute for you, okay?

A Okay.

Q It says, "Failing to provide promptly to an insured a reasonable explanation of the basis in the insurance policy, with respect to the facts of the insured's claim and the applicable law, for the denial of the claim or for an offer to settle or compromise the claim." Did I read that correctly?

A You did.

Q And there's no explanation of the basis in the insurance

policy with respect to the facts of the insured's claim in the denial letter, correct?

A Nothing that I can see, but then again I'm not an expert in the statutes of Nevada.

Q Well, you're here as an expert testifying about a case governed by Nevada law, right?

A Right. But I'm not an expert in Nevada law.

Q Well, you were testifying with Mr. Roberts about something about NCQA and Medicaid in Nevada, right?

A That's a very different thing, that's a deeming statute where Medicaid Nevada takes NCQA certification as meeting the Nevada law requirements.

Q Now the contract was between Mr. Eskew and Sierra Health and Life, right?

A That's my understanding.

Q So it's what we'd refer to, as you commonly I'm sure have heard of, as a first party insurer?

A Yes.

Q Okay. If -- now and we've -- when you went through Exhibit 5 did you see anywhere within Exhibit 5 where somebody for Sierra Health and Life contacted Mr. Eskew to disclose to him the pertinent benefits, coverages or other provisions relating to his claim?

A I did not.

MR. SHARP: Your Honor, I'd like the Court to take judicial notice of NAC 686A.660.

THE COURT: Any objection?

MR. ROBERTS: I have to look it up, Your Honor. If Mr. Sharp has any more of these he could provide them in advance; I might be able to do this quicker. NAC 686?

MR. SHARP: A660. Here, let me show my copy.

MR. ROBERTS: That would be great, thank you. No objection, Your Honor.

THE COURT: The Court will take judicial notice of NAC section 686A.660.

MR. SHARP: Page 7, please. And just pull up this and subpart one.

BY MR. SHARP:

Q I'm going to read this section to you, sir. It says, "Each insurer shall fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance contract or policy under which a claim is presented." Did I read that correctly?

A Yes.

Q And you did not find in your review of Exhibit 5 the compliance with NAC 686A.601 occurred; is that correct?

A I really can't answer that, I'm again not qualified to interpret this out of context with the entire statute.

Q Okay. I'll just run through it. Is there anything in Exhibit 5 which would indicate that Sierra Health and Life fully disclosed to Mr. Eskew the pertinent benefits, meaning the definition of medically necessary?

MR. ROBERTS: Objection, Your Honor. This is referring to the contract, not a denial letter --

MR. SHARP: I mean --

MR. ROBERTS: -- or other provisions of an insurance contract.

MR. SHARP: Well, it's talking about when the claim is filed. I'm not dealing with the denial letter right now. That's why I asked him with Exhibit 5.

THE COURT: Overruled.

MR. SHARP: Thank you, Your Honor.

BY MR. SHARP:

Q So when the prior authorization claim came in, did you see any indication that Sierra Health and Life contacted Mr. Eskew and said, the pertinent benefit is proton beam therapy is a covered service as long as it's medically necessary, any indication of that?

A Yes, I believe so. They point out that where you see their request for the proposed proton beam therapy, we've determined it is not covered and then they give the reason for non-coverage, which my interpretation of that meets that requirement.

Q Okay. My question was a little different. I'm talking about before the denial was issued. When the claim was presented, do you see any evidence that Sierra Health and Life disclosed to Mr. Eskew that proton beam therapy is a covered benefit and here's the definition of medical necessity?

A Yes. They provided that in his agreement of coverage.

Q That's it?

A Yes.

Q So I mean, every insurance company gives a copy of their insurance policy to their --

A Of course. That's what they're for.

Q So why -- if all you needed to do to comply with this provision is say, here's your insurance contract, can you explain to me why there's a requirement that each insurer shall fully disclose to the first party claimant all pertinent benefits or coverages or other provisions of an insurance contract or policy under which a claim is presented?

A And my answer is the same. I believe did that with the letter.

Q With the letter?

A With a letter.

Q Okay. After the denial occurred?

A That is correct.

MR. SHARP: Let's pull up Exhibit 4. Back at -- or Exhibit 5 back at 35 -- 34. Go to the previous page, 33. Okay.

BY MR. SHARP:

Q Tell me in the denial letter dated February 5, 2016 where Sierra Health and Life disclosed to Mr. Eskew that proton beam therapy was a covered service?

A Well, it says very clearly, we received a request to cover the proposed proton beam radiation therapy.

Q Okay. So your testimony is this sentence --

MR. SHARP: Jason, highlight this -- it's the last sentence of

paragraph 1. If you could highlight for the jury, please.

BY MR. SHARP:

Q And the highlighting I have in front of the jury, that's your -- well, I guess the sentence above that as well too.

A Yes. You have to take both.

Q So the last two sentences to paragraph 1 of the denial letter, that's your position as to how Sierra Health and Life disclosed to Mr. Eskew that proton beam radiation therapy was a covered benefit?

A Correct.

Q Now tell me, within the denial letter where the insurance company explained to Mr. Eskew the elements to medical necessity?

A Well, it gives a reason for the denial, which includes among other things limited clinical evidence that directly compares proton beam with other types. Current published evidence does not allow for definitive conclusions about the safety and efficacy of proton beam therapy to treat your condition.

And then points out that the request cannot be approved, which is followed by, "based on the information submitted your health benefit plan and UnitedHealthcare's medical policy for proton beam therapy, we determine this service is not covered," which to me is an adequate explanation of why what could have been a covered service was not covered in this instant.

Q Okay. So I just want to be clear I understand this. You're saying first that from there to "plan" is sufficient to inform Mr. Eskew why the terms of medically necessary were not met?

A Yes. It does refer to specifically that evidence-based reports and guidelines provision, professional standards provision and reports and peer reviewed literature provision.

Q And which one is Mr. Eskew supposed to understand amongst those sentences that in your opinion and Sierra Health and Life's opinion this did not involve an appropriate level of service?

A I think it spells it out in clear and plain language in my opinion. I really don't know how it could have been more clear.

Q Okay. So you wouldn't have any idea how somebody could write this any clearer?

A I would not have done a different job, no.

Q Would you give me this, that it might be a little clearer if you quoted the actual insurance policy and said this is why the -- your claim doesn't meet the definition of medically necessary?

A I think this does it adequately, so I won't give you that.

Q And you understand this is basically a quote from the medical policy?

A Yes.

Q Okay. Let's -- so you've agreed with me that there's no specific reference to the definition of medically necessary in the denial letter, right?

A Not in the denial letter, no.

Q Okay. So --

MR. SHARP: Your Honor, I'd like to take -- have the Court take judicial notice of NAC 686A.675.

THE COURT: Any objection, Mr. Roberts?

MR. ROBERTS: 686 -- thank you. Court's indulgence.

THE COURT: Of course.

MR. ROBERTS: No objection, Your Honor.

THE COURT: The Court will take judicial notice of NAC 686A.675.

BY MR. SHARP:

Q Just so we're all on the same page, we're going through Nevada statutes and regulations, right?

A Correct.

Q And these are the same Nevada statutes and regulations that you agree NCQA says you have to comply with?

A Or they also say where the statutes conflict with NCQA standards that basically it complies with the regulation is acceptable to NCQA.

Q Okay.

MR. SHARP: Jason, if you could pull up page 11, which is -- and pull up subpart one.

BY MR. SHARP:

Q And NAC 686A.675 says, "Standards are applicable to all insurers." Did I read that correctly?

A You did.

Q And then if we go to the second sentence. And I'm going to read this second sentence to you, sir, and I'm just going to ask if you agree I read it correctly, okay? Do you understand me?

A I do.

Q It says, "No insurer may deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to that provision, condition or exclusion is included in the denial." Did I read that correctly?

A You did.

Q Now you would agree with me that an insurance doctor like Dr. Liao is likely not going to familiar with the terms of the insurance policy?

A You referred to Dr. Liao as an insurance doctor, I think that was not what you meant.

Q I'm sorry. Let me rephrase the question. You would agree with me that doctors like Dr. Liao are generally not going to be familiar with their patients' insurance contract?

A No. They deal with too many patients and too many different contracts to do that.

Q And that would be the same with MD Anderson?

A I don't know that I can speak for MD Anderson, that's a very large corporate structure and they may have more ability to assess that than in an individual practitioner.

Q Does that make sense to you?

A Yes, it does. These entities have finance and management organizations that do explore and verify insurance coverage and the exact provisions of that coverage when they take on patients.

Q So you're saying -- how many patients does MD Anderson

have?

A I don't know.

Q So are you here to tell us that when check into MD Anderson you bring your insurance contract and say, here's my insurance contract just in case we need it?

A No. That's not what happens at all. They have what are called coverage investigators that investigate, especially those things that require prior authorization, so that in essence they can comply with what's -- I'm sure Dr. Liao had no idea that Sierra needed to prior authorize proton beam therapy, but their staff I'm sure informed her that that was the case.

Q I mean, you didn't see anything in attachment B that would give UnitedHealthcare or Sierra Health and Life the ability to do preauthorization, did you?

A Yes. The medical necessity definition and the fact that they state that they can do preauthorization for medical necessity.

Q Consistent with attachment B, right?

A Attachment B, yes.

Q And attachment B, we went through it, does not say anything about proton beam therapy?

A It did not.

Q So based upon a fair reading of the insurance policy Sierra Health and Life didn't even have the authority to conduct the prior authorization?

A Again, you left out the part about the -- you know, in essence

I'm paraphrasing it, but included but not limited to.

Q So just so I understand, even though attachment B doesn't exclusively refer to proton beam therapy, you're relying upon the provision relating to diagnostic radiology service to conclude that also means proton beam therapy?

A No. I'm relying on the definition of medical necessity that's provided to justify prior authorizing proton beam therapy.

Q Okay.

MR. SHARP: Can we go back to Exhibit 30 -- Exhibit 3 -- or Exhibit 2 at page 37. We'll just pull up definition of medical necessary.

BY MR. SHARP:

Q So just confirming, there's nothing in the definition of medically necessary that defines what procedures are subject to prior authorization, correct?

A That is correct.

Q Throughout the reference that we went over this afternoon said, you can only conduct prior authorization reviews of those conditions in Attachment D, correct?

A Correct.

Q Is your interpretation that --

MR. SHARP: Stop. Strike that.

BY MR. SHARP:

Q Now, wouldn't a better way, more reasonable way -- wouldn't a more reasonable way be for an insurance company to put all its cards on the table and say, here's the definition of medicine

necessary, this is why we don't think it applies in writing?

MR. ROBERTS: Objection, Your Honor. What's more reasonable is irrelevant. Prejudicial.

MR. SHARP: Let me rephrase it, Your Honor.

THE COURT: Yes.

BY MR. SHARP:

Q Would you agree with me that a reasonable way, consistent with the fiduciary-like duty that Sierra Health and Life owed to Mr. Eskew, that Sierra Health and Life could put in the denial letter, here's the definition of medically necessary. This is our analysis of why proton beam therapy is not medically necessary?

A Well, hypothetically they could have put that in the letter. I believe the letter expressed all of the elements necessary to explain their decision.

Q Isn't it fair to suggest when you don't put your cards on the table that somebody can come in six years later and say, oh, the real reason why this claim was denied is there wasn't the most appropriate level of service which can be safely provided to the insured?

A I think that's one interpretation.

Q One of many interpretations, right?

A Well, it's your interpretation.

Q Wasn't that why you're now denying the claim?

A That was not medically necessary, and it was not supported by peer review literature. It was not supported by the preponderance of current evidence, and it was not the most appropriate level. So there

were multiple reasons.

Q Wait a second. Peer review is not within the three elements defining medically necessary.

A It is in the elements below those three.

MR. SHARP: Jason, could you pull of that element?

BY MR. SHARP:

Q Okay. In determining whether a service or supply is medically necessary --

A Correct.

Q -- SHL may give consideration to any or all of the following.

A That is correct.

Q Okay. So these elements don't define medically necessary, right?

A They define how one determines medically necessary so in essence they define how one interprets medical necessity.

Q How one may interpret, right?

A Correct.

Q Okay. So I'm coming back to the three elements for medically necessary. You testified today that the reason why it wasn't medically necessary is the second element, the most appropriate level of service which can be safely provided to the insured.

A That is correct.

Q And can you tell us before today who in Sierra Health and Life who told Mr. Eskew that?

A No.

Q And you're okay with that?

A Yes.

Q Now, you talked a lot about an appeal. The fact is you and Mr. Roberts talked about the appeal, remember that?

A I do.

Q Wouldn't you think a reasonable way, consistent with the fiduciary like responsibilities is to explain to the insured we don't think this service is the most appropriate level of service which can be safely provided to the insured, in that language?

A That's another way to do it.

Q A reasonable way, right?

A It's a possible way.

Q Okay. But you would agree with me if those cards were put on the table and if Sierra Health and Live really believed the second bullet point gave them a basis to deny the claim, and they disclosed that to Mr. Eskew, that somebody like Dr. Liao would be in a position to respond and say, no?

MR. ROBERTS: Objection to form. Referring to what they really believe that's him to speculate.

THE COURT: Overruled.

THE WITNESS: Dr. Liao was asked if she wanted to appeal the case and stated, no.

BY MR. SHARP:

Q Okay. I understand the message that you're trying to deliver. My question's different. My question is, wouldn't it be a reasonable way

for Sierra Health and Life to just say 4.2 is why we're denying this claim and then Dr. Liao can respond to that position?

A From a medical professional standpoint I think that would be totally un-understandable, if that's a word.

Q I thought that you were interpreting this provision from a medical standpoint.

A I am, but Dr. Liao would appeal based on whether she thought any alternatives would not be reasonable in her opinion.

Q So somebody like that Dr. Liao, I'm just taking that given her background, she's pretty smart, give me that?

A I'll give you that, sure.

Q So somebody as intelligent as Dr. Liao, would read this quote: The most appropriate level of service which can be safely provided to the insured, and she wouldn't understand what that means?

A I don't think that would make any difference in what she would do to choose to appeal or not appeal. I think, again, I'll stand by the fact that I think the letter that Sierra Health and Life provided was within industry standards and provided all of the information that Dr. Liao needed to know whether to appeal or not. Or for that matter, that the member needed to do the same.

Q Okay. And now, when M.D. Anderson was orally told of the denial, did anybody tell them here's the provision within medically necessary that we're claiming does not apply?

A I don't know because we don't have a full record of that oral conversation.

Q Well, you've read the records that exist.

A Well, it said that M.D. Anderson would contact given the reason for the denial.

Q Based upon what you viewed in the file, is there any evidence that Sierra Health and Life told M.D. Anderson the reason why we're denying this claim is we believe that the most appropriate level of service which can safely be provided to the insured is IMRT?

A I don't think United or in this case Sierra made any suggestions to Dr. Liao what to do next.

Q And you're okay with that?

A I am.

Q Okay. So now let's look at the timing. Let's go back to Exhibit 5. And let's go to page 33. And I'm getting this right, to pull up the address, I'm understanding the position for Sierra Health and Life, they mailed this letter; is that right?

A That is correct.

Q And you're fine with that?

A That is required, so yes, I am fine with that.

Q And your testimony, I think, was if it's an urgent health care situation, Sierra Health and Life only needs to contact the doctor to inform them of the denial.

A No, that's not what I said. You're mischaracterizing. Sierra Health and Life's policy says they make attempts to contact the member, but also they contact the physician and because it's an urgent request they understand the physician is the agent for the member in that case.

Q Where did you get that?
A It's right on their operational policy. To be more specific, it' is Policy 100.07 §3.3.5.1.
Q I'm not talking about that, the word urgent, that's not a medical, that's not a doctor order.
A Well, that's in the case of somebody representing a member in a prior authorization, it is.
Q You sure somebody told you to say the word agent, because that is a legal connotation, right?
A The term that I used in the insurance industry forever.
Q Okay. But what I'm not clear about is somebody trying to pick up the phone and call Mr. Eskew say we're denying your claim here's why.
A That's part of their standard procedure.
Q And that never happened.
A Not that I'm aware of, no. I saw no documentation.
Q And so that decision not to contact Mr. Eskew was unreasonable, agreed?
A It was overlooked.
Q Well, I mean even talking about how important it is to follow these policies, we have one that was clearly not followed, right?
A It sounds like it, yes.
Q Involving treatment for cancer, right?
A Yes.
Q So you would agree with me that it was unreasonable to not

at least pick up the phone and try and call Mr. Eskew?

A And again, I don't know whether that was done. There's no documentation, so I can't say if it was done or not.

Q Well, you're here to evaluate the documentation from the insurance viewpoint, right?

A Right.

Q If it's not in the documentation, it didn't exist?

A That's essentially the way we operate, yes.

Q And that's the way we can look at Exhibit 5 from your viewpoint. It's not documented, it didn't happen.

A Yes.

Q Okay. So we can go forward with the assumption, well, the conclusion that nobody tried to bother to talk to Mr. Eskew, right?

A Correct.

Q And they all knew in the policy they were supposed to, right?

A Correct.

Q So the decision not to call Mr. Eskew is unreasonable, correct?

A The decision not to call Mr. Eskew is an oversight.

Q How do you know?

A Well, I don't know, but I also don't know if it was intentional.

Q I didn't say it was intentional.

A You said unreasonable.

Q Yes.

A Those are your words, not mine.

Q You would agree it's unreasonable?
A No.
Q Okay. Just another mistake, right?
A It could be.
Q Okay. Now, let's just go to page 2.
A Are we still on Exhibit 5?
Q Yes.
MR. SHARP: I'm sorry, Jason, it's page 2 of the trial letter, it's at page 34.
THE WITNESS: Okay. Page 34?
BY MR. SHARP:
Q Yes.
A Thank you.
Q I'm all there. Okay. So let's go to compliance. Get there, do compliance. It says, "compliance by the member with SHL advantage care program is mandatory." Do you see that?
A Yes.
Q If Prof. Prater's interpretation of Attachment B is correct, then that's not the first sentence I have highlighted as incorrect statements, correct?
A You didn't ask a question.
Q I'm just saying, it's correct. You agree with me?
A Please ask it in the form of a question.
Q So it says, compliance by member SHL's managed care program is mandatory. You see that?

A Yes.

Q We've gone over Attachment D, right?

A Yes.

Q So if a reasonable interpretation of Attachment D is that it doesn't refer to proton beam therapy, so you can't conduct prior authorization -- you with me so far?

A Yes.

Q

Q Okay. That's a reasonable interpretation this statement is not correct.

A I'm just not sure what you're trying to get at there.

Q Well, proton beam therapy is not subject to prior authorization. Then in Mr. Eskew's case compliance with the SHL managed care program was not mandatory, correct?

A Well, but again they were reviewing for medical necessity, so that part is still mandatory.

Q Okay. Would you go to this paragraph right here where it says a member?

Okay. So now we've got the paragraph from the denial letter that begins the member will be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the request.

A Correct.

Q You see that? So wherein this letter does it tell Mr. Eskew you're just on the website you can find this medical column?

A Well, it doesn't, but you know, you left out the next paragraph down there which says: If you have any questions, contact member services. So all one has to do is pick up the phone, dial that number and ask those questions.

Q Okay. So Jason, can you pull up that paragraph for the referencing? So what you're saying is now this isn't just your everyday treatment, this is somebody who's getting treatment for cancer --

A Correct.

Q -- right? And they get a letter mailed to them and you're saying what this person needs to do is call into member services with some call-in number?

A They could, yes.

Q Wouldn't a reasonable way just be to attach the policy to the letter?

A No, the more reasonable way was with the second part of the letter which gives the patient two pages of appeal rights, including how to do that appeal. And that they can request an expedited appeal.

Q Okay. So you would agree with me, though, that an insurance company isn't allowed to have one free deny, right?

A No, any denial is subject to appeal at multiple levels.

Q No, no, no, no. You're missing my hook here. You're not suggesting -- let's just say, I know that you disagree with me, but let's just say that the denial of the prior authorization was improper. You with me so far?

A I don't agree with that, but I understand your premise.

Q I mean you and I aren't the ones that make that decision. It's the jury.

A That's why I'm telling I don't agree with you.

Q Okay. Just assume for me that the denial of the prior authorization was improper. With me so far?

A Again, your assumption, not mine.

Q The fact that an appeal was not followed does not change that the initial denial was wrong under my hypothetical.

A Right. Your hypothetical and I maintain the initial denial was done according to industry standards.

Q Fair enough. But what I'm getting at is the insurance company, this isn't all put in place, so insurance company gets one free denial, right?

A I'm not sure what you mean by one free denial.

Q Well, in other words, if the jury finds that this denial of a prior authorization was improper, we can just dispense with this issue about the appeal, right?

A That is correct. But that's not for me to say.

Q Understood. Okay. So let's go to the next page and from what I understand you're saying, it's industry standard that the medical director does not review the denial letter before its sent.

A That is correct.

Q You think that somebody like Mr. Eskew, or any other insured would have the right and expectation to believe the person who signed this letter actually reviewed it?

A That could be an understanding. But again, to be efficient, to get these letters out in a timely fashion, they're done in that standardized fashion that I described very completely. And there is a quality review process to make sure the letters are complete and accurate and contain all of the information. And medical directors have really delegated the authority to complete the letter to the letter generation unit.

Q Okay. Are you done?

A I am.

Q Okay. Thank you. So if we go to Exhibit 36 page 5.

MR. SHARP: Next page. Now, I pull up the important information about your appeal rights.

BY MR. SHARP:

Q Okay. First of all, you reviewed the insurance contract and Sierra Health and Life choose to make the appeal -- the insured didn't have to appeal, right?

A Yes.

Q Some insurance policies require people to appeal, right?

A Yes. In this case the provider could be appealing on behalf of the member.

Q You keep jumping ahead of my questions.

My question was simply: Some insurance policies require insurers to appeal denials.

A That is correct.

Q But not this one?

A This one does not.

Q So let me reference something. Because you agree with me that we went through the clinic of the Exhibit 5, the last email dated 4:42 from Dr. Ahmad.

A Yes. I don't remember the exact time, but you're reading it.

Q I'd like you to assume to me February 5, 2016 was a Friday. Okay?

A Correct.

Q Do you know when the batch mail was picked up daily by Sierra Health and Life?

A No. I don't.

Q Do you know -- I mean, I'm assuming all of this is computer generated, right?

A Yes.

Q Do you know where in the country the mail resource center was to disburse mail throughout the country?

A I do not.

Q But you would agree with me that mailing, instead of a phone call, is going create some delay --

A There may be a delay.

Q Okay. Now, it says, "Expedited internal appeal may be available," right?

A Yes.

Q "If the condition is such that the time needed to complete a standard appeal could seriously jeopardize a patient's life, health, or ability to regain maximum function," right?

A Yes.
Q And just so I'm clear, Sierra Health and Life had the fax number for M.D. Anderson, right?
A Yes.
Q But they didn't fax the letter?
A I don't know.
Q When you reviewed the file. Did you see any evidence that they faxed the letter?
A I didn't see any evidence they didn't either, so I can only say I don't know.
Q Okay. Well, I don't think -- we went back, if it's not in the file it didn't occur, right?
A Yes.
Q Okay. It's not in the file that it was faxed, so we can conclude the letter wasn't faxed, right?
A Correct.
Q Okay. Thank you.
Now, it goes on down here, "To request an expedited appeal, you may contact the member service department during normal business hours." Did I read that correctly?
A Yes.
Q Same service department you can call to get the medical policy?
A Correct.
Q And one of the things I want to point out, I think you'd agree

with me, that the fiduciary responsibility runs from United Health Care or Sierra Health and Life to Mr. Eskew, right?

A Yes.

Q So what Sierra Health and Life needs to do is it needs to treat Mr. Eskew fairly and in good faith without regard to what M.D. Anderson may or may not do, correct?

A yes.

Q Okay. Now, let's go to next paragraph, and it says: "Your expedited appeal request should include the following information: an explanation of what you are asking us to reconsider," right?

A Yes.

Q "The specific reasons why you feel the service should be considered for coverage," right?

A Yes.

Q Now, Sierra Health and Life's the one that has the fiduciary-like relationship to Mr. Eskew, right?

A Yes.

Q And we went through all those statutes and regulations that say the insurance company, Sierra Health and Life, need to put -- needs to disclose all the reasons that it's denying the claim, right?

A Yes.

Q Can you tell me how Mr. Eskew could have provided Sierra Health and Life the specific reasons why he feels the service should be considered for coverage without knowing what Sierra Health and Life's position is regarding why the service was not medically necessary under

the terms of the insurance contract?

A And again, it doesn't have to be a detailed response like that. Appeals from members can simply be, I would like to appeal my denial. I believe that I am entitled to the services which my physician provided, and I'd like for that appeal to be expedited.

And that, in effect meets that requirement.

Q So he would be handicapped in not being able to rebut Sierra Health and Life's position.

A Yes. But it also points out, which you have overlooked so far, is after normal hours you can call the customer response and resolution department at any time. That's a 24/7. So again, it makes an opening there for an alternate pathway.

Q So you're aware that Dr. Ahmad is now on the appeals board, right?

A He does appeals work at Sierra.

Q So we, you and I, can agree that Mr. Eskew could expect the same type of fairness and impartiality on appeal that he received when his prior authorization claim was first processed and denied?

MR. ROBERTS: Objection. Misleading and irrelevant. He was not on the appeals board at this time.

THE COURT: Mr. Sharp?

MR. SHARP: I can just reword it, Your Honor.

THE COURT: Okay.

BY MR. SHARP:

Q Let me just get to the point. Can Mr. Eskew or any other

insured expect that the appeals department would handle the prior authorization claim with the same fairness and impartiality that Sierra Health and Life handled Mr. Eskew's prior authorization claim?

A Yes. They would be expected to have a different person than reviewed the initial request to do an impartial review of the appeal.

Q Then the answer to my question is yes?

A Yes.

Q Now, you had referenced some ethical obligations through the AMA, right?

A Yes.

Q And it's true that Dr. Ahmad did not follow those guidelines, correct?

A No. My testimony was that I believed he did follow those guidelines.

Q Okay. One of the guidelines says that he should review plan policies and guidelines.

A Yes. And plan policies and guidelines in this case is referring to the internal plan policies and guidelines.

THE COURT: Counsel, we're going to take a quick recess.

Ladies and gentlemen, you are instructed not to talk with each other or with anyone else about any subject or issue connected with this trial. You're not to read, watch or listen to any report of or commentary on the trial by any person connected with the case or by any medium of information including without limitation newspapers, television, the internet or radio. You're not to conduct any research on

your own relating to this case such as consulting dictionaries, using the internet or using reference materials. You're not to conduct any investigation, test any theory of the case, recreate any aspect of the case or in any other way investigate about the case on your own.

You're not to talk with others, text others, tweet others, google issues or conduct any other kind of book or computer research with regard to any issue, party, witness, or attorney involved in this case. You're not to form or express any opinion on any subject connected with this this trial until the case is finally submitted to you.

So we'll come back at 4:10.

THE MARSHAL: All rise for the jury.

[Jury out at 4:00 p.m.]

[Outside the presence of the jury]

THE COURT: Thank you. Any issues outside the presence?

MR. SHARP: Your Honor, it's only one thing. I notice that the witness had some notes that he's taken in his hand. I'd like to review those notes at the break.

THE COURT: Any objection, Mr. Roberts?

THE WITNESS: You may.

MR. ROBERTS: No, no objection, Your Honor.

THE COURT: Thank you. So it seems we're a bit behind now. Ms. Sweet is here.

MR. ROBERTS: Yes, she is, Your Honor, but I was just about to ask Mr. Sharp if I should release her.

MR. SHARP: No, I think I'm almost done.

MR. ROBERTS: I will have some redirect, and then we need to get, just like Dr. Owens has to get on a plane to go somewhere, our next witness also is not going to be available past tomorrow at 5:00. So I'd like to start with him at nine.

THE COURT: Dr. Bhatnagara?

MR. ROBERTS: No, no, this is Dr. Kumar.

MR. SHARP: Oh, yeah, that's fine.

MR. ROBERTS: So if we're only left 10 or 15 minutes with Ms. Sweet, it might be better, you know, not to have to break her up a second time. But that's --

MR. SHARP: Your Honor, whatever they'd like to do with Dr. Kumar --

MR. ROBERTS: We're still going to finish on Wednesday, Your Honor.

MR. SHARP: Yeah, we'll be fine.

MR. ROBERTS: I promise.

THE COURT: Well, it's up to you whether or not you want to let Ms. Sweet go or not.

MR. ROBERTS: Okay. Well, the reason I'm asking you is that I don't know how upset you might be with me if we finish 10 or 15 minutes early today in the event my cross went quickly.

THE COURT: Of course I'd be upset with you, Mr. Roberts.

MR. ROBERTS: Thank you, Your Honor.

THE COURT: All right, so we'll come back in 7 minutes.

[Recess taken from 4:03 p.m. to 4:11 p.m.]

THE COURT: Thank you, please be seated. Are the parties ready for the jury?

MR. SHARP: Yes, Your Honor.

MR. ROBERTS: Yes, Your Honor.

THE COURT: Thank you.

THE MARSHAL: All rise for the jury.

[Jury in at 4:12 p.m.]

THE MARSHAL: All the jurors are present.

THE COURT: Thank you. Do the parties stipulate to the presence of the jury?

MR. ROBERTS: Yes, Your Honor.

MR. SHARP: Yes, Your Honor.

MR. SMITH: Yes, Your Honor.

THE COURT: Thank you. Please be seated.

Mr. Sharp, please proceed.

CROSS-EXAMINATION CONTINUED

BY MR. SHARP:

Q So I've got a couple of questions for you, sir. If anyone in this court were to say that the denial letter that you and I have been going over is no big deal or suggest that, your response would -- you would disagree with that?

A I would disagree with that, yes.

Q It's a very big deal --

A Yes.

Q -- right?

The second line of questioning is from what I understand you're saying, aside from the couple which you say are mistakes, that your analysis of what happened in this claim and the reasonableness of Sierra Health and Life's conduct, which you say is reasonable, right?

A Yes.

Q And that's what all 150 million-plus insurers, based on your listed exhibit, can expect in fairness.

A I believe that, yes, that Sierra Health and Life acted in accordance with industry standards and in the particular case of -- I'm assuming you're referring to proton beam policies -- that that would be handled in a similar fashion by major national health insurers.

Q And that every insurer in the State of Nevada should expect that their prior authorization for cancer or any other serious medical situation should be handled with the same fairness, impartiality as Sierra Health and Life handled Mr. Eskew's claim.

A And my belief was that Sierra Health and Life did handle it with fairness. So yes, I think what they did can be considered consistent with all standards and was done properly.

Q I understand the speech, but my question was a little bit more specific. Your testimony is that all insurers in the State of Nevada can expect their claim prior authorization involving serious medical issues with the same fairness and impartiality that Sierra Health and Life handled Mr. Eskew's claim.

A Yes, I believe that would be the case.

MR. SHARP: Thank you, Your Honor. No further questions.

THE COURT: Thank you, Mr. Sharp.

Mr. Roberts?

MR. ROBERTS: Yes, thank you, Your Honor.

REDIRECT EXAMINATION

BY MR. ROBERTS:

Q Doctor, Mr. Sharp asked you a series of questions with regard to anyone was checking on Dr. Ahamad's work --

A Yes.

Q -- along those lines. Do you recall those questions?

A I do recall.

Q Doctor, are you familiar with the concept called IRR testing?

A Yes. I did bring that up in my testimony the concept of interrater reliability.

Q Okay. Tell the jury again what interrater reliability is and how that might relate to whether someone's checking Dr. Ahamad's work.

A Okay. Health plans have established interrater reliability to make sure that medical directors or key decision makers are following a similar process in what they do. In fact, United Health, Sierra, actually has a policy establishing the concept of interrater reliability in their UM policies 100 to 114.

And things that can be done in interrater reliability you can have a senior person at the health plan review the documents of the decisions by the medical directors. And that does happen so that there's a bit of an audit of the internal documentation. No, they don't go to the doctor's

office if they're external and pick up everything there. They do it internally.

It can be a quiz, literally a test where medical directors are given five hypothetical cases that can be based around medical necessity and their use of the resources at hand, and you literally have to take the test. And you're sort of graded on your performance on that. We also look at medical directors' performance for approvals, denials, and documentation in comparison to their peers internally. If somebody appears to be an outlier, we can do more intensive reviews. That's just one of the many ways that interrater reliability can be studied.

Q And did you see any evidence that Dr. Ahmad was subject to IRR testing?

A Only in the policies. It was in the United policies in, you now, if it's in the policy it's written down and, therefore, should be something United Health is doing.

Q You were asked a series of questions related to proton beam therapy and whether it was a covered service. I'd like to go back to the contract, the agreement of coverage.

MR. ROBERTS: Audra, could you put up Exhibit 4, page 40 and go into Section 5, covered services, blow that up.

BY MR. ROBERTS:

Q Okay. And you reviewed the agreement of coverage, correct?

A I did, yes.

Q This section tells you what services are covered under the

plan. So this says what a covered service is, right?

A Yes.

Q "Only medically necessary services are considered to be covered services," right?

A You read that correctly.

Q Okay. So is proton beam therapy that is not medically necessary for a specific condition, a covered service under Mr. Eskew's plan?

A No, it is not.

Q And at one point you said proton beam therapy was covered, at one point you said it was potentially covered. Which one was right?

A Potentially because it has to be medically necessary in addition to being, you know, as a requirement of being covered, I should say.

Q So is Exhibit B, the list of services that had to be pre-authorized, is that part of the definition of covered services?

A No, that's a definition of services requiring prior authorization.

Q In order to be covered, right?

A In order to be covered.

Q And does it matter whether something's on Exhibit B if it's not medically necessary?

A No, it does not.

Q And then let's look at a couple of other provisions of the contract.

MR. ROBERTS: Audra, could you go to page 80. And blow up the top in blue for me.

BY MR. ROBERTS:

Q And what does this say, Doctor, here toward the end of the agreement of coverage?

A It says, "In order to be covered, requested services must be medically necessary as determined by the plan and not otherwise excluded under the AOC."

Q Okay. So does this confirm that if something's not medically necessary, it's not covered?

A It does.

MR. ROBERTS: Let's look, Audra, at page 61, and go to the definition at 13.21 over on the left-hand column.

BY MR. ROBERTS:

Q This is in the definition section of the contract, 13.21 power covered services defined.

A It means health services supplies and accommodation for which SHL pays benefits under this plan.

Q Okay. And does SHL pay benefits for services that aren't medically necessary under the plan?

A By the definitions that we've looked at, no.

Q Moving on to a different subject. You were asked about Dr. Liao. You acknowledged that she's board certified, correct?

A That is correct.

Q So where did you put the opinion of an individual treating

physician on the hierarchy of evidence?

A Because it is case based and antidotal is towards the bottom. And really just so everyone knows I'm not inventing this hierarchy of evidence, Tufts University among others have put out the evidence pyramid and many of us follow that evidence pyramid.

Q Okay. And what tier would that be --

A Level four --

Q -- an individual treating physician --

A -- perhaps evidence.

THE COURT: Dr. Owen, just please wait until --

THE WITNESS: Thank you.

THE COURT: -- he's finished.

BY MR. ROBERTS:

Q Okay. And what about randomized peer reviewed -- excuse me. What about randomized clinical trials?

A Randomized controlled clinical trials, they're typically level one evidence.

Q And what about the meta-analysis of all of the studies?

A That's considered level one A evidence.

Q Would that be above or below?

A Above, above. Kind of at the tip of the pyramid if were to view it as that.

Q And what about peer review journal articles?

A That you really can't place in that hierarchy because it depends on the subject. If it's reporting a randomized clinical trial it goes

in level one. If it's reporting a meta-analysis it goes in one A. If it's reporting what we called case control studies which are those randomized non-comparative clinical trials that would probably be a level two evidence. So it depends on what the peer review journal is reporting.

Q Now what about a nonrandomized clinical trial, what level would that be?

A That would be a level two to level three evidence depending on the design, structure and size of the trial.

Q Okay. Did I get that right?

A You did.

Q Was it reasonable for Sierra Health and Life to look at the evidence in front of them and to determine that Dr. Liao's individual opinion was outweighed by the other scientific medical evidence?

A That is entirely the basis of why you do medical review and why you have policies, so the answer is yes.

Q Let's switch over to the IMRT.

MR. ROBERTS: If we could go back to the computer control there. Thanks.

BY MR. ROBERTS:

Q First of all before I put that up, did you hear Mr. Prater say that if you are going to approve a treatment no investigation is necessary?

A I do remember that statement, yes.

Q Do you generally agree with that?

A No. You need to get the facts to approve or deny. You can't know whether to approve something unless you've assessed it.

Q Is there a duty to maintain the same type of file under industry standards if you approve a claim?

A It's a similar file, but you don't necessarily have to give a rationale for approval. But most medical directors will provide a brief rationale, I approved this because it's consistent with our policy or consistent with standard of care.

Q So let's take a look at the IMRT policy, Exhibit 75-5.

MR. ROBERTS: And if we could go to the paragraph right above clinical evidence.

BY MR. ROBERTS:

Q And ask you to read the part right here. Let's see, "It is used to treat tumors in."

A Okay. "It is used to treat tumors in areas of the body that are prone to movement such as lungs as well as tumors located close to critical organs."

Q And that's defining the use of IGRT in conjunction with IMRT, do you understand what that means?

A That is correct. IGRT image guided in conjunction with intensity-modulated --

Q Okay.

A -- RT.

MR. ROBERTS: And Audra, can we then go to the area right below. So into the clinical evidence section, above the second citation.

BY MR. ROBERTS:

Q So at the time that Sierra Health and Life approved the IMRT did their policy cite to, "A systematic review of the evidence behind the use of IMRT for various disease sites," and then continue reading.

A Yes. In other words they point out, "Veldeman et al conducted a systemic review of the evidence behind the use of IMRT for various disease sites. 49 comparative studies on head and neck, prostate, gynecological, CNS, breast and lung cancer were reviewed. The authors reported that the generally positive findings for toxic effects and quality of life are consistent with the ability of IMRT to better control the dose distribution inside, that is dose homogeneity and simultaneously integrated boost, and outside, that is selectively sparing organs at risk knows as OAR, the planning target volume."

Q And sparing selective organs at risk, is that like the esophagus in the case of Mr. Eskew's treatment?

A Its surrounding structures including the esophagus, the heart and other structures that reside in all of our mediastinum.

Q And according to the hierarchy of evidence that you described to the jury, at what level is this on the hierarchy of evidence?

A The systemic review is indeed a type of meta-analysis where they're looking in this case 49 different studies.

Q Was it reasonable for UnitedHealthcare to approve the IMRT request for Mr. Eskew based on this medical policy?

A Based on their policy, yes.

Q In response to one of the questions about notification to Mr.

Eskew --

A Yes.

Q -- of the adverse determination, you mentioned that you thought you'd seen where the treating physician could be considered the agent of Mr. Eskew --

A Yes.

Q -- as I believe the words?

A Yes.

Q But I tried to write down your citation.

MR. ROBERTS: Audra, could you go to Exhibit 14, page 23, article 3.1.10? See if we got it right. If you can blow up that whole paragraph and the subparagraphs.

BY MR. ROBERTS:

Q So 3.1.10 defines urgent care as, "Any request for medical care services where application of the timeframe" --

A Yeah.

Q -- "for making a routine or non-life threatening care determinations could seriously jeopardize the life, health or safety of the member," et cetera, correct?

A Yes.

Q And then can you read 3.1.10.3 to the jury?

A "For urgent care decisions the health plan allows a health care practitioner with knowledge of the member's medical condition, that is the treating practitioner act as the member's authorized representative."

Q So is this what you were thinking of --

A Yes.

Q -- authorized representative?

A Yes.

Q And so you misspoke when you said agent?

A I misspoke when I said agent.

THE COURT: Hold on. Dr. Owens, please the court reporter can only take down one person at a time.

THE WITNESS: Sorry.

THE COURT: In everyday speech we anticipate what someone's going to say, but because we're in a courtroom we can't do that.

THE WITNESS: No. Understood. Sorry.

THE COURT: Thank you.

BY MR. ROBERTS:

Q So in this particular case you reviewed the urgent request for prior authorization, correct?

A Yes.

Q And was that made by the member or by the treating practitioner?

A Of course by the treating practitioner.

Q And when United made the determination -- Sierra Health and Life made the determination who did they try to call?

A MD Anderson.

Q The treating practitioner?

A That is correct.

Q Was that reasonable in your opinion?

A Yes.

MR. ROBERTS: Court's indulgence, just a second I'm trying to --

THE COURT: Of course, Mr. --

MR. ROBERTS: -- read all my notes.

THE COURT: Of course, Mr. Roberts.

MR. ROBERTS: I -- Your Honor, that's all I have.

THE COURT: Thank you, Mr. Roberts. Mr. Sharp, any recross?

MR. SHARP: Yes, Your Honor.

RECROSS-EXAMINATION

BY MR. SHARP:

Q You -- Doctor, you were asked some questions about whether Dr. Liao provided you -- or provided peer review studies to support her opinion, remember that?

A I was asked just now, yes.

Q When did Sierra Health and Life ask her to provide those studies?

A That I don't know.

Q And you're not seriously suggesting to this jury that a doctor of Dr. Liao's experience, over 350 some peer reviewed articles, providing treatment to people at MD Anderson is engaging in medical practices that are not supported by peer reviewed literature, are you?

A I can't say whether she is or isn't because I don't know the total extent of everything she's doing. Could even be participating in clinical trials, which are certainly not yet supported by peer reviewed literature.

Q So is the answer to my question yes or no?

A I don't have any reason, so the answer is, no. I won't suggest that Dr. Anderson has -- or Dr. Liao at MD Anderson has those intents.

Q You've been asked some questions about -- what's this called, interrater reliability --

A Yes.

Q -- about Dr. Ahmad? I mean, regardless because we went through this on cross, you and I can agree that what Dr. Ahmad did in this particular case is reflected in the claim file, right?

A Yes. Dr. Ahmad documented his part of that file.

Q And if it isn't in the file it didn't exist, right?

A Yes. I still --

Q Is that correct?

A Yes.

MR. SHARP: Jason, can you pull up Exhibit 75? Page 5. If you could pull up the same study.

BY MR. SHARP:

Q And you talked about this study with Mr. Roberts, right?

A Yes, just now.

Q But this study isn't comparing IMRT to proton beam therapy?

A No. That's not what this says. It's comparative studies in IMRT, but it's not saying compared to PBT.

Q What's it being compared to?

A I would have to look at the studies to know.

Q Okay. So this really -- you really don't have any opinion about this, right?

A I have the opinion that it's an analysis of 49 studies, yes.

Q And you wouldn't stand to reason that they were -- that what was being compared is conformal x-rays versus IMRT, right?

A That would certainly be one potential.

Q And there's no dispute in your mind that proton beam therapy is better than conformal x-rays?

A I don't know of any studies comparing the two at this point, so I can't opine on that.

Q So you just don't know?

A I don't know.

Q Not willing to concede that point?

A No.

Q Okay.

MR. SHARP: Let's go to Exhibit 24.

BY MR. SHARP:

Q You had talked about the ab with -- Mr. Roberts about the absence in your mind of peer reviewed literature relating to proton beam therapy, correct?

A I wasn't talking about the absence of peer reviewed

literature; I was talking about the absence of well-designed control studies reported in the peer reviewed literature.

Q Okay.

MR. SHARP: So let's go to page 13. And let's go right here in lung cancer.

BY MR. SHARP:

Q This is the -- from Exhibit 4 proton beam therapy and ICER through like a managed care company that you have -- you cited ICER in your report, right?

A They are not a managed care company, no.

Q Well, they're somebody that helps managed care companies review data, right?

A No. ICER is the Institute for Clinical Effectiveness Research. It's a private foundation funded with grant money based in Boston that does comparative effectiveness reviews of new technology.

Q Okay.

A They're independent.

Q And according to UnitedHealthcare, ICER concluded that, "proton beam therapy is comparative to alternative treatment options for patients with lung cancer, strength of evidence is moderate", correct?

A That is what it says.

MR. SHARP: And then if we go to the next page. Pull up this sequel study.

BY MR. SHARP:

Q And this study I have here, "Compared the toxicity of proton

therapy plus concurrent chemotherapy in patients with NC -- NSCLC with toxicity of patients with similar disease given three dimensional conformal radiation therapy plus chemotherapy or intensity-modulated radiation therapy plus chemotherapy."

Did I read that correctly?

A You did.

Q And that's -- was it your understanding Mr. Eskew was getting concurrent radiation -- concurrent chemotherapy radiation?

A It was my understanding he was getting a chemoradiation concurrent therapy.

Q Okay. And then it continues.

MR. SHARP: Right here, Jason.

BY MR. SHARP:

Q Rates grade equal to or more than 3 pneumonitis, esophagitis in the proton group 2 percent and 5 percent were lower despite the higher radiation dose, 3D-CRT 30 percent and 18 percent and IMRT 9 percent and 44 percent, correct?

A Correct.

Q So 44 percent of the people that got IMRT had grade 3 esophagitis 3 or above?

A Yes.

Q And 5 percent of the people in the proton group had grades of serve grade 3 or above esophagitis, correct?

A Yes.

Q And that information was available to Dr. Ahmad, correct?

A Yes. It was.

Q Now --

MR. SHARP: Jason, you can take that down.

BY MR. SHARP:

Q You had mentioned that -- you had reference MD Anderson as the authorized representative of Mr. Eskew?

A Yes.

Q But we can agree that the duty of good faith and fair dealing between Sierra Health and Life and Mr. Eskew, that was owed to Mr. Eskew, right?

A Yes.

Q Without regard to what MD Anderson did or didn't do, right?

A Yes.

MR. SHARP: No further questions.

THE COURT: Thank you, Mr. Sharp. Mr. Roberts?

MR. ROBERTS: Just one follow up, Your Honor.

FURTHER REDIRECT EXAMINATION

BY MR. ROBERTS:

Q Mr. Sharp showed you the ICER summary?

A Yes.

Q Indicating a moderate certainty as the level?

A Moderate level of --

Q The estimate of health benefit.

A Sorry.

Q Sorry. Let me restate.

A Yes.

Q He showed you the summary which included an estimate of health benefit as moderate certainty, right?

A Yes.

Q Under the ICER scale does that includes promising/inclusive?

A Yes.

Q And without more would that justify using that ICER summary as a substitute for a randomized clinical trial?

A No.

Q Okay. Thank you, Doctor.

THE COURT: Thank you, Mr. Roberts. Mr. Sharp, any follow up?

MR. SHARP: No, Your Honor. I'm completed.

THE COURT: Counsel, will you approach?

[Sidebar at 4:45 p.m., ending at 4:46 p.m., not recorded]

THE COURT: Dr. Owen, these two questions are from a juror. Question number one, did you read Mr. Eskew's plan?

THE WITNESS: Did I read Mr. Eskew's plan?

THE COURT: Yes.

THE WITNESS: I read the information that was submitted to Sierra Health and Life outlining Mr. Eskew's plan. Did I read his detailed radiation therapy plan, no. That was not provided to me.

THE COURT: Question number two, if so should proton therapy have even made it to the review process or according to the plan policy should it have been approved, proton therapy?

THE WITNESS: I'm not sure I understand that question, but again my contention is that based on the evidence that they used, the type of reviewer that approving proton therapy was not appropriate. Did that answer the question? I'm not quite sure.

THE COURT: Yeah. Hold on. Counsel, any follow up?

MR. SHARP: Yeah. If I may, Your Honor?

THE COURT: Yes.

MR. SHARP: Or would like Mr. Roberts, it's your witness.

MR. ROBERTS: Thank you. I just have one follow up.

FURTHER REDIRECT EXAMINATION

BY MR. ROBERTS:

Q You answered and interpreted that first question as reviewed his treatment plan, right?

A Yes.

Q If you were asked did you review his insurance policy or agreement of coverage, would your answer change?

A Oh yes. Then the answer is clearly I've reviewed that multiple times.

Q Okay. Thank you, sir.

THE COURT: Thank you. Mr. Sharp?

FURTHER RECROSS-EXAMINATION

MR. SHARP: Okay. So Jason, could you pull up section 3.4 of Exhibit 2, page 7.

THE COURT: Can the jury see that? No. Can you make it a little closer for the jury? That's good. Thank you.

BY MR. SHARP:

Q Okay. So in order to determine whether a service should be subject to prior authorization you have to refer to attachment B, right?

A Yes.

Q And if proton beam therapy is not subject to attachment B, it's not subject to prior authorization, right?

A It's subject to medical necessity review.

Q I understand that. But it's not subject to prior authorization, correct?

A According to that, yes.

Q And according to the plain language of the agreement of coverage that you read?

A Yes. Because it wasn't listed.

Q Thank you.

THE COURT: Mr. Roberts, any follow up?

MR. ROBERTS: No follow-up, Your Honor. Thank you.

THE COURT: Thank you. Are there any additional questions from the jury? Hearing none, thank you. Dr. Owens, you're excused. Thank you.

THE WITNESS: Thank you.

THE COURT: Ladies and gentlemen of the jury, we're going to take our evening recess. We will resume tomorrow at 9:00 a.m. and conclude no later than 5:00 p.m. Wednesday will be the same, 9:00 a.m. to 5:00 p.m. And just as a reminder we will not have trial Thursday and Friday, so it's just three days this week and then we'll resume next

Monday.

During the break, you are instructed not talk with each other or with anyone else about any subject or issue connected with this trial. You're not to read, watch or listen to any report of or commentary on the trial by any person connected with the case or by any medium of information including without limitation newspapers, television, the internet or radio. You're not to conduct any research on your own relating to this case such as consulting dictionaries, using the internet or using reference materials. You're not to conduct any investigation, test any theory of the case, recreate any aspect of the case or in any other investigate or learn about the about the case on your own.

You're not to talk with others, text others, tweet others, google issues or conduct any other kind of book or computer research with regard to any issue, party, witness, or attorney involved in this case. You're not to form or express any opinion on any subject connected with this trial until the case is finally submitted to you.

Thank you. We'll see you tomorrow at 9:00 a.m.

THE MARSHAL: All rise for the jury.

[Jury out at 4:51 p.m.]

[Outside the presence of the jury]

THE COURT: Counsel, any issues outside the presence of the jury?

MR. SHARP: No, Your Honor.

THE COURT: Mr. Roberts?

MR. ROBERTS: We do have some unresolved issues related

to the -- one of the depositions we want to play where there's some relevance objections. And I apologize Mr. Gormley was working on those, so I'm not prepared to argue them now. But I would like to maybe do it at lunch time tomorrow and I can be prepared to argue it -- address it at that time.

MR. SHARP: Are we starting at 9:00 tomorrow, Your Honor?

THE COURT: Yes.

MR. SHARP: I just assume you're at 9:00 ever -- I'm just wondering if you've got -- we can talk to Mr. Roberts to see if we can resolve those objections. There aren't very many, but I'm wondering if we probably can do it in the morning. I mean --

MR. ROBERTS: 8:30? Okay.

MR. SHARP: 8:30 would be fine. If we're not available -- if we don't need you we'll let your staff know.

MR. ROBERTS: Well, we have Dr. Kumar starting at 9:00 and he's guaranteed to go through lunch.

MR. TERRY: Your Honor, we may have some issues outside the presence with regard to the extent that Dr. Kumar is allowed to testify based on your ruling under -- in the motion in limine with regard to after acquired evidence that we may need to take up before the jury comes in as well.

THE COURT: The Court will make itself available before 9:00 a.m. if the parties need the Court.

MR. TERRY: Okay. Thank you, Your Honor.

MR. SHARP: Okay. Thank you, Your Honor.

MR. ROBERTS: Thank you, Your Honor.

THE COURT: Thank you.

MR. ROBERTS: 8:45, Your Honor, just to make sure you all aren't waiting for me. What time would you like us here?

THE COURT: Well, how much time do you need?

MR. SHARP: I would say let's be here at 8:30 just in case.

MR. ROBERTS: Okay.

MR. SHARP: I mean, if you're -- I know you're available. I know you're --

THE COURT: I will be here at 8:30.

MR. SHARP: I can tell by just looking at --

MR. ROBERTS: I don't know what the issues are yet, Your Honor, so I can't give a time estimate, but I'll be here at 8:30.

THE COURT: All right. We'll all be here at 8:30 then.

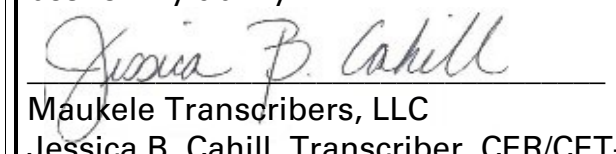
MR. ROBERTS: Thank you, Your Honor.

THE COURT: Thank you.

MR. SHARP: Thank you, Your Honor.

[Proceedings adjourned at 4:53 p.m.]

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



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