No. 85369

# In the Supreme Court of Nevada



SIERRA HEALTH AND LIFE INSURANCE CO., INC.,
*Defendant-Appellant,*

v.

SANDRA L. ESKEW, as special administrator of the Estate of William George Eskew,
*Plaintiff-Respondent*.

Appeal from the Eighth Judicial District Court, Clark County
Case No. A-19-788630-C

## NOTICE OF SUPPLEMENTAL AUTHORITY

Respondent writes to advise this Court of pertinent authority under Rule 31(e):

**1.** In *Acuity Insurance Co. v. Swanson*, No. 85090. at 2 (Dec. 27, 2023), an insurer asked this Court to overturn a jury's verdict of bad faith because the insurer, in its view, "had a reasonable basis" to deny coverage. The standard of review was dispositive: "We will not overturn a jury verdict supported by substantial evidence unless it is clearly wrong." *Id.* (citing *Wohlers v. Bartgis*, 114 Nev. 1249, 1261, 969 P.2d 949, 958 (1998)). Under that standard, "[t]his court is not at liberty to weigh the evidence anew." *Id.* It was sufficient that "Swanson provided evidence that Acuity denied Swanson's claim without a reasonable basis … and that Acuity declined to thoroughly investigate." *Id.*

*Acuity* is pertinent to the standard of review. In its reply (at 4), for the first time,

Sierra urges de novo review. But *Acuity*, and its reliance on *Wohlers*, confirms the law in Nevada: "[T]he insurer's belief that the validity of the insured's claim was fairly debatable" is "a question of fact to be determined by the jury." *Wohlers*, 969 P.2d at 956; *see Salim v. La. Health*, 2023 WL 3222804, at *3 (5th Cir. 2023) ("The decision to deny [coverage for PBT] based on lack of medical necessity" "involves a 'factual dispute' rather than an 'interpretive dispute'"); *Strauss v. Premera*, 449 P.3d 640, 641, 644 (Wash. 2019) ("The trier of fact, not the court, must determine" whether an insurer unreasonably denied coverage for proton-beam therapy (PBT) as not "medically necessary"). This contrasts with judges' rulings on insurer's "*legal* obligations" that "depend[] on *legal* precedent"—like a "duty to file an interpleader action"—which are reviewed de novo. *Allstate v. Miller*, 125 Nev. 300, 317, 212 P.3d 318, 329-30 (2009).

**2.** *Taylor v. Brill,* 139 Nev. Adv. Op. 56, 539 P.3d 1188, 1195 (Dec. 21, 2023) held that it was error to bar counsel from arguing that the jury should "send a message."

*Taylor* is pertinent to Sierra's plea for a new trial because trial counsel here "urged jurors to … 'send a message'" (SHL Br. 61; Reply 30) and described a damages verdict as "the right thing to do" (SHL Br. 52-54; Eskew Br. 40). As in *Taylor*, counsel was "not asking the jury to ignore the evidence." 539 P.3d at 1195. He was "telling the jury that the requested verdict was the right thing to do according to … the evidence," and he "promptly corrected any impression that [he was] conveying a personal opinion." 18-

JA-3652, 3653. In fact, Sierra persuaded the trial court that a special instruction would cure any "issue" of "passion and prejudice" based on "personal opinion." 14-JA-2857–59. The trial court then gave Sierra's requested curative instruction. 14-JA-2875.

**3.** In *Weissman v. UnitedHealthcare Insurance Co.*, 2021 WL 858436, at *8 (D. Mass. 2021), a court considering a challenge to UnitedHealthcare's refusal to cover PBT in 2016 found it relevant that "[o]ne of UnitedHealthcare's affiliates recently pledged over $15 million to construct and operate a proton center in New York City" and that "[m]ultiple cancer facilities," including "the New York Proton Center," "regularly recommend and use" PBT. In denying a motion to dismiss, the court highlighted these facts as support for the claim that PBT is neither "unproven" nor "experimental." *Id.*

*Weissman* is pertinent to Sierra's contention that the trial court here abused its discretion by denying a pretrial motion to categorically exclude the very facts *Weissman* found relevant. *See* SHL Br. 54. That pretrial ruling must be assessed from the vantage point of the time it was made: "An abuse of discretion occurs when no reasonable judge could reach a similar conclusion *under the same circumstances*." *Davitian-Kostanian v. Kostanian*, 534 P.3d 700, 704 (Nev. 2023). At the time of the pretrial evidentiary ruling, United was still a defendant in this case. So the briefing focused on why evidence about United was relevant in a case against United. RA-1-7. The only question on appeal is whether the trial court abused its discretion in declining to categorically exclude this

evidence about United while United was still a party.

Sierra's argument now is different. It centers on Sierra's status as the lone defendant and a "distant" corporate affiliate. SHL Br. 54-56. But "the contemporaneous objection rule required" Sierra to "specifically object on the grounds urged on appeal." *Thomas v. Hardwick*, 231 P.3d 1111, 1120 (Nev. 2010). Sierra never did. Long after United had dropped out of the case, when the court *specifically asked* Sierra if it objected to the key proton-center evidence, Sierra had "[n]o objection." 7-JA-1520–21.

Respectfully submitted,

*/s/ Deepak Gupta*
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January 29, 2024

*Counsel for Respondent*

## CERTIFICATE OF SERVICE

Pursuant to NRAP 25, I certify that on January 29, 2024, I submitted the foregoing notice of supplemental authority for filing via the Nevada Supreme Court's eFlex electronic filing system. Electronic notification will be sent to the following:

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IN THE SUPREME COURT OF THE STATE OF NEVADA

| | |
|---|---|
| ACUITY, A MUTUAL INSURANCE COMPANY,<br>Appellant,<br>vs.<br>GIDGET SWANSON,<br>Respondent. | No. 85090 |
| ACUITY, A MUTUAL INSURANCE COMPANY,<br>Appellant,<br>vs.<br>GIDGET SWANSON,<br>Respondent. | No. 85486 |



*ORDER AFFIRMING IN PART, REVERSING IN PART AND REMANDING*

These are consolidated appeals from a district court judgment following a jury verdict and order awarding attorney fees and costs in an insurance action. Eighth Judicial District Court, Clark County; Gloria Sturman, Judge.

In this case, the jury found appellant Acuity liable for breach of contract, breach of the covenant of good faith and fair dealing, and violations of the Nevada Unfair Claims Practices Act, and granted respondent Gidget Swanson $150,000 in compensatory damages. The jury further found by clear and convincing evidence that Acuity acted with oppression, fraud, malice, or reckless disregard in its conduct and, after the punitive damages stage of trial, awarded Swanson $1,350,000 in punitive damages. The district court's judgment on the jury verdict granted Swanson interest and attorney fees and costs in addition to compensatory and punitive damages. Acuity filed a motion for a new trial, which the district court denied. The

district court issued an amended judgment in the amount of $2,266,338.64 plus post judgment interest. Acuity appeals.

We affirm the jury's verdict that Acuity breached its contract with Swanson, breached the covenant of good faith and fair dealing, and violated the Nevada Unfair Claims Practices Act. We affirm the compensatory damages award of $150,000. We also affirm the jury's finding that Acuity acted with oppression, fraud, malice, or reckless disregard in its conduct, which warrants punitive damages. However, we reverse the punitive damages award and remand to the district court for a new punitive damages hearing. Finally, we vacate the awards of attorney fees and costs, and decline to assign this case to a new district court judge on remand.

Acuity first argues that the jury's finding of bad faith is not supported by substantial evidence because Acuity had a reasonable basis to deny Swanson's claim due to their bona fide dispute. We will not overturn a jury verdict supported by substantial evidence unless it is clearly wrong. *Albert H. Wohlers & Co. v. Bartgis*, 114 Nev. 1249, 1261, 969 P.2d 949, 958 (1998). Swanson provided evidence that Acuity denied Swanson's claim without a reasonable basis, including evidence that there was a third vehicle involved in the crash and that Acuity declined to thoroughly investigate the rear bumper, despite requests from Swanson's attorneys to do so. Although Acuity disputes these allegations, we conclude that there was sufficient evidence for a jury to find that Acuity acted in bad faith and that punitive damages were warranted. *See Yamaha Motor Co v. Arnoult*, 114 Nev. 233, 238, 955 P.2d 661, 664 (1998) ("This court is not at liberty to weigh the evidence anew, and where conflicting evidence exists, all favorable inferences must be drawn towards the prevailing party.").

Acuity next argues that Professor Jeffrey Stempel's testimony violated pretrial orders precluding some of Stempel's proposed testimony. Acuity also argues that Stempel was not qualified to be an expert witness. Violation of an order in limine can warrant a new trial. *See Bayerische Motoren Werke Aktiengesellschaft v. Roth*, 127 Nev. 122, 126, 252 P.3d 649, 652 (2011). Additionally, to testify as an expert, a witness must be qualified as an expert in an area of scientific, technical, or other specialized areas. NRS 50.275; *Hallmark v Eldridge*, 124 Nev. 492, 498, 189 P.3d 646, 650 (2008). In this case, the order in limine at issue explicitly permitted Stempel to testify on the "yardstick" testimony. The district court denied the part of the motion seeking to preclude Stempel from testifying on that subject. Therefore, Stempel did not violate the order in limine. Furthermore, Stempel was qualified to be an expert. As an insurance law professor, Stempel had specialized knowledge of insurance. He has testified in over 97 cases, is a member of the Academy of Insurance, and has written law review articles, treatises, and books on insurance liability. The alleged inaccuracies in Stempel's expert report do not detract from his other qualifications, but instead go to the weight of his testimony. *See Nev. Power Co. v. 3 Kids, LLC*, 129 Nev. 436, 443, 302 P.3d 1155, 1159 (2013) (explaining that concerns about an expert's methodology went to weight, not admissibility). Accordingly, we conclude the district court did not abuse its discretion in this regard.

Acuity next argues that the district court erred in permitting witness Sam Terry to change his opinions at the time of trial. In his deposition testimony, Terry said that the question of whether a red sedan hit Swanson's car was "inconclusive" because he did not know the materials of the two bumpers. At trial, Swanson asked Terry if he could explain what

he meant by "inconclusive," and Terry said that the composition of the paint of the vehicles was inconclusive. He said he could not formulate opinions about contact between a red sedan and Swanson's vehicle because he did not have the red sedan and did not know the material of the bumper or the paint. These two answers are not materially different, and the district court did not abuse its discretion in permitting Terry's testimony.

Acuity further argues that Terry's trial testimony undermined Acuity's defenses, created a trial by ambush, and may have been a significant factor in the jury's bad faith determination. However, Acuity does not identify any authority supporting this claim, and therefore we need not consider it. *See Edwards v. Emperors Garden Rest.*, 122 Nev. 317, 330 n.38, 130 P.3d 1280, 1288 n.38 (2006). Even if Acuity had provided relevant authority supporting this claim, its argument fails because Terry's trial testimony did not materially differ from his deposition testimony, as noted above. Accordingly, we affirm the jury's finding of liability and the compensatory damages award.

Acuity next argues that several errors compromised the punitive damages stage of the trial, requiring reversal of the punitive damages award. To begin, Acuity contends that Swanson failed to timely disclose Attorney Matthew Pfau as a testifying witness. The purpose of discovery is to prevent surprises at trial. *Washoe Cty. Bd. of Sch. Trs. v. Pirhala*, 84 Nev. 1, 5, 435 P.2d 756, 758 (1968). If a witness is not timely disclosed, a district court may nonetheless permit the witness to testify if the failure to disclose is substantially justified or harmless. NRCP 37(c)(1). If the failure to disclose is not substantially justified, the party will not be able to use the improperly disclosed witness or information. *Capanna v. Orth*, 134 Nev. 888, 894, 432 P.3d 726, 733 (2018). Here, the disclosure was

untimely, as Swanson identified Pfau the night before trial. Because Swanson does not substantially justify this late disclosure, we conclude that it was not excused.

Acuity further argues that Swanson's disclosure of Pfau was incomplete as she failed to provide the information required under NRCP 16.1, including the subjects of information known to the witness, the opinions the witness would express, and the basis and reasons for their opinions. Acuity argues that such information must be disclosed during discovery under NRCP 16.1, and that a party must also provide supplemental pretrial disclosure information. NRCP 37(c)(1) provides that if a party fails to timely disclose the information required under NRCP 16.1, the party is prohibited from using the information at trial, unless the failure was substantially justified. We conclude that Swanson's disclosure of Pfau was incomplete because Swanson failed to identify the topics to which Pfau would testify. Although she may have orally disclosed this information, this is not equivalent to the written disclosure required under NRCP 16.1, and she did not show that her failure to disclose the requisite information was substantially justified. Accordingly, we conclude that the district court abused its discretion in allowing Pfau to testify.

Acuity further argues that the district court should have excluded evidence of certain settlement negotiations between Acuity and Swanson which occurred the week before trial pursuant to NRS 48.105(1). Swanson argues that the settlement negotiation evidence was admissible because it falls under the exception that settlement negotiation testimony is admissible when it is used for a purpose other than to prove liability. Swanson argues that Acuity was already deemed liable, so the evidence was instead offered to determine the amount of the punitive damage award.

Settlement negotiation testimony is typically inadmissible. *See* NRS 48.105(1); NRS 48.109(2). Such testimony may be admissible, however, if it is offered for another purpose, such as proving bias or proving an effort to obstruct a criminal investigation. NRS 48.105(2). Here, we conclude that Pfau's testimony that Acuity rejected Swanson's version of the settlement agreement and ultimately withdrew its offer was inadmissible. Evidence illustrating the level of reprehensibility of Acuity's actions during the settlement negotiations is irrelevant to demonstrate Acuity's conduct in denying Swanson's insurance claim. Moreover, a party's decision to withdraw from a settlement agreement is not an indication that a party deserves punitive damages. Therefore, we conclude that the district court abused its discretion in allowing Pfau to testify regarding the pretrial settlement negotiations.

Acuity next argues that the district court abused its discretion when it permitted Pfau's testimony on Acuity's prior lawsuits, which was irrelevant and highly prejudicial. It further argues that Pfau improperly testified as an expert witness on these cases because he was only permitted to testify as a lay witness. Swanson argues that Pfau properly testified to his involvement in Acuity's prior lawsuits, including the case *Humes v. Acuity* where his law firm represented the plaintiff against Acuity.

Evidence is inadmissible if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury. NRS 48.035(1). A lay witness generally may only testify on a matter if the witness has personal knowledge. NRS 50.025(1)(a). Further, lay opinion testimony must be "[r]ationally based on the perception of the witness." NRS 50.265(1). We conclude that the district court should have excluded evidence of Acuity's six prior cases. These other

cases, including *Humes*, were irrelevant. *Humes*, in particular, lacked a factual connection to Swanson's case. Further, Pfau's testimony regarding the amount the jury awarded Humes in compensatory and punitive damages, was also unfairly prejudicial because it suggested an outcome.

Pfau's testimony on *Humes* also exceeded the scope of lay witness testimony because Pfau had no personal knowledge of the case. Similarly, Pfau only knew about Acuity's five other cases through Acuity's written discovery responses. The evidence of Acuity's prior lawsuits suggests that Acuity was a serial violator, which is unfairly prejudicial and substantially outweighs any probative value. *See* NRS 48.035(1); NRS 48.045(1). Therefore, we hold that the district court abused its discretion in allowing Pfau to testify regarding Acuity's prior cases.[1]

Acuity further argues that Pfau exceeded the scope of a lay witness when he testified about a typical punitive damages award. Pfau, a purported lay witness, testified as to the formula the jury should use to calculate punitive damages against Acuity (suggesting that the jury should multiply the compensatory damages award by a factor of nine). Unsurprisingly, the jury awarded Swanson the exact amount of punitive damages suggested by Pfau. As a lay witness, Pfau should not have been permitted to testify as to a typical punitive damages award. Because this testimony exceeded the scope of lay testimony, we hold that the district

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[1]Acuity also argues that Pfau's testimony regarding *Humes* violated a pretrial order. Acuity failed to object on this basis when Pfau testified and therefore waived this objection. *See Old Aztec Mine, Inc. v. Brown*, 97 Nev. 49, 52, 623 P.2d 981, 983 (1981) ("A point not urged in the trial court, unless it goes to the jurisdiction of that court, is deemed to have been waived and will not be considered on appeal.").

court abused its discretion when it allowed Pfau to testify as to the typical punitive damages award.

Acuity next argues that the court should have allowed supplemental defense discovery due to Swanson's untimely disclosure of Pfau. We agree. Nevada's discovery rules grant broad powers to litigants by allowing those litigants an adequate means of discovery during the period of trial preparation. *See Club Vista Fin. Servs. v. Eighth Judicial Dist. Court*, 128 Nev. 224, 229, 276 P.3d 246, 249 (2012). Generally, discovery matters are "within the district court's sound discretion, and we will not disturb a district court's ruling regarding discovery unless the court has clearly abused its discretion." *Id.* at 228, 276 P.3d at 248. Failure to provide reasons for denying the reopening of discovery may result in an abuse of discretion. *Pickett v. McCarran Mansion, LLC*, No. 77124-COA, 2019 WL 7410795 (Nev. Ct. App. Dec. 31, 2019) (Order of Reversal and Remand); *see also* NRCP 52(a)(3). Here, due to Swanson's untimely and incomplete disclosure, Acuity was unable to conduct any discovery as to Pfau, even after Acuity asked to depose him. Acuity's multiple requests for such discovery were ignored by the district court. Accordingly, we conclude that the district court abused its discretion in disallowing supplemental discovery.

Because of the numerous errors in the punitive damages stage of trial, we reverse the punitive damages award and remand for a new punitive damages hearing. Because we reverse and remand the punitive damages award for further proceedings, we necessarily vacate the award of

attorney fees and costs for further consideration by the district court after the new punitive damages hearing.[2]

Finally, Acuity argues that this case should be assigned to a different district court judge because Judge Sturman has seen inadmissible evidence and expressed opinions on the strengths and weaknesses of the evidence. However, there must be a compelling reason to warrant disqualification or recusal of a judge, such as an extreme showing of bias. *Matter of Dunleavy*, 104 Nev. 784, 788, 769 P.2d 1271, 1274 (1988). A judge must also not make statements on the ultimate merits of the case. *FCH1 LLC v. Rodriguez*, 130 Nev. 425, 435, 335 P.3d 183, 190 (2014). We do not discern evidence of bias in the record. None of Judge Sturman's comments are remarks on the ultimate merits of the case. Instead, her comments relate to the admissibility of evidentiary matters. Furthermore, this was a jury trial rather than a bench trial, meaning that Judge Sturman did not serve as the factfinder. Therefore, we see no reason why she would have difficulty taking a fresh approach to the case, free from any previously expressed views or from bias.

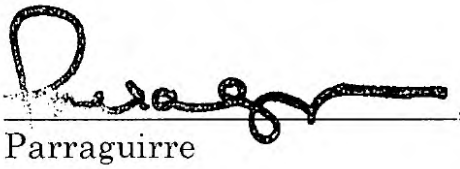
[2]Acuity argues that the district court's "erroneous rulings" necessitate reversal due to cumulative error. We do not reach the issue of cumulative error because relief is warranted on other grounds.

Accordingly, we

ORDER the judgment of the district court AFFIRMED IN PART AND REVERSED IN PART AND REMAND this matter to the district court for proceedings consistent with this order.

_____, J.
Herndon

_____, J.
Lee



_____, J.
Parraguirre

cc: Hon. Gloria Sturman, District Judge
Kristine M. Kuzemka, Settlement Judge
Resnick & Louis, P.C./Las Vegas
Lemons, Grundy & Eisenberg
H&P Law, PLLC
Eighth District Court Clerk

# United States Court of Appeals for the Fifth Circuit

United States Court of Appeals
Fifth Circuit
**FILED**
May 3, 2023
Lyle W. Cayce
Clerk

No. 22-30573

ROBERT L. SALIM,

*Plaintiff—Appellee*,

*versus*

LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY, *doing business as* BLUE CROSS AND BLUE SHIELD OF LOUISIANA,

*Defendant—Appellant*.

Appeal from the United States District Court
for the Western District of Louisiana
USDC No. 1:19-CV-442

Before HIGGINBOTHAM, SOUTHWICK, and WILLETT, *Circuit Judges*.

PER CURIAM:[*]

Robert Salim purchased health insurance from the Louisiana Health Service & Indemnity Company ("Blue Cross"). Salim later sought coverage for proton beam therapy to treat his throat cancer. Citing an internal guideline, Blue Cross denied coverage, deeming proton therapy not medically necessary. Salim sued, arguing that the guideline relied on a third-

[*] This opinion is not designated for publication. *See* 5TH CIR. R. 47.5.

party source that had since been updated to specifically approve proton therapy for exactly his condition. The district court held that the denial was an abuse of discretion, and it ordered Blue Cross to provide coverage. We AFFIRM.

## I

Salim is a business owner who bought a health-insurance plan from Blue Cross to cover himself and his employees (the "Plan"). While the Plan was in effect, Salim was diagnosed with throat cancer. His medical provider requested preauthorization for "proton therapy" from AIM Specialty Health, a company that helps Blue Cross administer the Plan. AIM denied the treatment as "not medically necessary." AIM reasoned that Salim had no history of cancer, and that proton therapy is used only "when the same area has been radiated before." AIM also denied Salim's appeal. AIM's denials cited only one source: the "clinical appropriateness guideline titled Radiation Oncology: Proton Beam Therapy" (the "Guideline").

Salim appealed to Blue Cross, which denied the appeal. Relying solely on the Guideline, Blue Cross explained that "proton beam radiation therapy is not considered medically necessary in adult patients with head and neck cancer." Salim then initiated a second-level appeal with Blue Cross by requesting that an independent medical organization review the denial. As part of that appeal, Dr. Clifton Fuller, who is Salim's physician, described three flaws in the Guideline that AIM and Blue Cross had relied on.

Dr. Fuller first argued that the Guideline relied on an outdated and superseded policy issued by the American Society for Radiation Oncology (the "ASTRO Policy"). According to Dr. Fuller, the ASTRO Policy "ha[d] been updated . . . to specifically include proton beam therapy as both appropriate and medically necessary for exactly Mr. Salim's diagnosis, advanced head and neck cancer." Second, Dr. Fuller argued that the

Guideline "glaringly omitted" reference to a separate source, the National Comprehensive Cancer Network Head and Neck Guidelines (the "NCCN Policy"). *Id.* Dr. Fuller viewed that omission as questionable because Blue Cross *did* rely on NCCN recommendations for "other disease sites." Third, Dr. Fuller pointed out that the Guideline cited only three articles related to head and neck cancer, and that all three "specifically endorse the use of proton therapy" for head and neck cancer.

After describing the AIM Guideline's three flaws, Dr. Fuller went on to explain why he viewed proton therapy as medically necessary for Salim's condition. He cited over a dozen evidence-based publications as support for his conclusion that proton therapy was medically necessary. He also explained that the ASTRO Policy and the NCCN Policy each "consider proton beam therapy the standard of care."

Blue Cross referred Salim's second-level appeal to an independent reviewer, the Medical Review Institute of America (the "Institute"). The Institute denied the appeal, giving two reasons. First, citing several articles, the Institute explained that "most investigators recommend additional study . . . before adopting [proton therapy] as a standard treatment option for patients with head and neck cancer." Second, the Institute concluded that the ASTRO Policy and the NCCN Policy support proton therapy for head and neck cancer only when the patient has "a lesion with significant involvement of structures at the skull base." According to the Institute, Salim "d[id] not have significant macroscopic disease involvement in the region of the skull base," and therefore the ASTRO and NCCN Policies did not support proton therapy as medically necessary to treat his cancer.

The Institute's decision operated as a final denial of coverage. Despite that denial of coverage, Salim chose to undergo proton therapy.

Salim sued Blue Cross in Louisiana state court, but Blue Cross removed to federal court. There, the parties stipulated that ERISA (the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001–1462) governs the Plan and preempts all state-law causes of action. They also stipulated that Blue Cross has full discretion "to determine eligibility for benefits" and "construe the terms of the Plan." Salim argued that Blue Cross's denial was an "arbitrary and capricious" abuse of discretion because it relied on "outdated literature," and he asked the district court to "reverse[]" the denial of coverage. The district court assigned the case to a magistrate judge.

The magistrate judge agreed with Salim. Because the Plan gives Blue Cross full discretionary authority to make determinations regarding benefits, the judge reviewed Blue Cross's denial of coverage for an abuse of discretion. The parties agreed that the Plan covers only "medically necessary" treatments, and they agreed on that term's plain meaning. Accordingly, the magistrate judge framed the question as whether "[Blue Cross] abused its discretion in finding that [proton therapy] is not the accepted standard of care for [Salim's] head and neck cancer—a fact related to coverage." After reviewing the overlapping denial explanations from AIM, Blue Cross, and the Institute, the magistrate judge found that "substantial evidence does not support [Blue Cross]'s finding that [proton therapy] was not medically necessary for treatment of Salim's cancer." Accordingly, the magistrate judge concluded that Blue Cross "abused its discretion in denying coverage."

The district court adopted the magistrate judge's report and recommendation, and it entered summary judgment for Salim "on the issue of coverage" for proton therapy. The court also ordered Blue Cross "to pay Salim's medical bills stemming from his receipt of the subject [proton therapy] treatments." Blue Cross timely appealed.

## II

We review "summary judgment de novo, applying the same legal standards that controlled the district court's decision." *White v. Life Ins. Co. of N. Am.*, 892 F.3d 762, 767 (5th Cir. 2018) (citing *Robinson v. Aetna Life Ins. Co.*, 443 F.3d 389, 392 (5th Cir. 2006)). In other words, we "review the plan administrator's decision from the same perspective as the district court." *Foster v. Principal Life Ins. Co.*, 920 F.3d 298, 304 (5th Cir. 2019) (quoting *Meditrust Fin. Servs. Corp. v. Sterling Chems., Inc.*, 168 F.3d 211, 214 (5th Cir. 1999)).

Blue Cross argues that the district court should have treated proton therapy's medical necessity as a legal question (rather than a factual question). In the alternative, Blue Cross argues that substantial evidence supports its decision to deny coverage for proton therapy. We disagree on both fronts.

### A

Because the Plan "lawfully delegates discretionary authority" to Blue Cross, judicial review "is limited to assessing whether the administrator [that is, Blue Cross] abused that discretion." *Ariana M. v. Humana Health Plan of Texas, Inc.*, 884 F.3d 246, 247 (5th Cir. 2018) (en banc) (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, (1989)). A plan administrator can abuse its discretion by denying claims "based on legal *or* factual grounds." *Id.* at 248 (emphasis added). Legal grounds include "interpretation" of a plan's terms, whereas factual grounds include "application" of a plan's terms. *Rittinger v. Healthy All. Life Ins. Co.*, 914 F.3d 952, 956 (5th Cir. 2019) (per curiam) (emphasis omitted).

For legal disputes—that is, disputes about a plan's *meaning*—the abuse-of-discretion analysis has "two steps." *Encompass Off. Sols., Inc. v. La. Health Serv. & Indem. Co.*, 919 F.3d 266, 282 (5th Cir. 2019). The first step

asks whether the administrator's reading is "legally correct." *Id.* "If so, the inquiry ends, and there was no abuse of discretion." *Id.* But if not, then we proceed to the second step, which uses several factors to determine whether the administrator's legally erroneous interpretation of the plan's terms still falls within the administrator's discretion. *See id.*

For factual disputes—that is, disputes about a plan's *application*—the abuse-of-discretion analysis asks whether the administrator relied "on evidence, even if disputable, that clearly supports the basis for its denial." *Nichols v. Reliance Standard Life Ins. Co.*, 924 F.3d 802, 808 (5th Cir. 2019) (quoting *Holland v. Int'l Paper Co. Ret. Plan*, 576 F.3d 240, 246 (5th Cir. 2009)). "If the [administrator]'s decision is supported by substantial evidence *and* is not arbitrary and capricious, it must prevail." *Id.* (emphasis added) (quoting *Killen v. Reliance Stand. Life Ins. Co.*, 776 F.3d 303, 307 (5th Cir. 2015)). "Substantial evidence is more than a scintilla, less than a preponderance, and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Id.* (quoting *Ellis v. Liberty Life Assur. Co. of Bos.*, 394 F.3d 262, 273 (5th Cir. 2004)). "A decision is arbitrary only if made without a rational connection between the known facts and the decision or between the found facts and the evidence." *Id.* (quoting *Foster v. Principal Life Ins. Co.*, 920 F.3d 298, 304 (5th Cir. 2019)). In sum, "we must uphold the determination if our review 'assures that the administrator's decision falls somewhere on a continuum of reasonableness—even if on the low end.'" *Id.* (alterations adopted) (quoting *Holland*, 576 F.3d at 247)).

The district court correctly concluded that this case involves a "factual dispute" rather than an "interpretive dispute." *See Rittinger*, 914 F.3d at 956. Blue Cross and Salim agree that the Plan covers only "medically necessary" treatments, and they agree on that term's definition. Because the parties agree about what the Plan means, their dispute involves only the "*application* of the [P]lan terms." *Id.* Thus, the question is whether proton

therapy was medically necessary to treat Salim's cancer. "[T]he decision to deny benefits based on lack of medical necessity involves a review of the facts." *Meditrust Fin. Servs. Corp.*, 168 F.3d at 214; *see Katherine P. v. Humana Health Plan, Inc.*, 959 F.3d 206, 208 (5th Cir. 2020).[1]

Blue Cross's contrary arguments are unavailing. For instance, Blue Cross argues that a court should look for an abuse of discretion "[o]nly if the court finds the administrator did not give the plan the legally correct interpretation." Similarly, Blue Cross argues that the "interpretation of the Plan is necessarily in dispute" because "the only place 'medically necessary' is defined is the Plan." This line of argument errs by trying to replace the "substantial evidence" factual analysis with the two-step legal analysis for interpretive errors. *See Rittinger*, 914 F.3d at 956 (distinguishing between "(1) an interpretive dispute and (2) a factual dispute" (quotations omitted)); *Meditrust Fin. Servs. Corp.*, 168 F.3d at 214 (rejecting the standard-of-review argument that Blue Cross advances here).

Blue Cross also argues that the district court erred by drawing "a distinction between a claim for coverage for medical services . . . and a claim for benefits." We disagree. The district court used the words "eligibility for benefits" when referring to the Plan's meaning (a question of law), but it used the word "coverage" when referring to the Plan's application (a question of fact). In context, the district court was distinguishing factual questions from legal questions; it was not distinguishing coverage from benefits. The district court was therefore correct that "the test for a legally

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[1] Medical necessity is not *always* a question of fact. For example, a question of law arises—and the two-step abuse-of-discretion framework applies—when the parties' dispute requires a court to "interpret[] the term 'medically necessary' as expressly defined in the insurance contract." *Dowden v. Blue Cross & Blue Shield of Tex., Inc.*, 126 F.3d 641, 643 (5th Cir. 1997) (per curiam). Here, however, the question is one of application—not interpretation.

correct construction of the Plan is not applicable in this case." Instead, the "substantial evidence" standard governs. *See Nichols*, 924 F.3d at 808.

B

We also agree with the district court that "substantial evidence does not support" Blue Cross's decision. In this ERISA case, substantial evidence "is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Rittinger*, 914 F.3d at 957 (citation omitted). Blue Cross is "not legally obligated to weigh any specific physician's opinion more than another's." *Holland*, 576 F.3d at 250. Rather, if there is "more than a scintilla" of evidence supporting denial, then Blue Cross prevails—as long as its decision "is not arbitrary and capricious." *Nichols*, 924 F.3d 808 (citations omitted); *cf Michael J. P. v. Blue Cross & Blue Shield of Tex.*, 2021 WL 4314316, at *9 (5th Cir. 2021) (Oldham, J., concurring) ("ERISA's 'substantial evidence' is radically different from 'substantial evidence' elsewhere in law."). That is because a court is "not supposed to weigh and balance the evidence." *Rittinger*, 914 F.3d at 960. Still, even under this highly deferential scheme, "a plan administrator 'may not arbitrarily refuse to credit a claimant's reliable evidence.'" *Schexnayder v. Hartford Life & Acc. Ins. Co.*, 600 F.3d 465, 469 (5th Cir. 2010) (quoting *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003)).

Under the Plan, a treatment is "medically necessary" if it is (A) "in accordance with nationally accepted standards of medical practice," (B) "clinically appropriate," and (C) "not primarily for the personal comfort or convenience of the patient, or Provider, and not more costly than alternative services . . . that are as likely to produce equivalent therapeutic or diagnostic results." Blue Cross argues that the record contains substantial evidence showing that proton therapy is not "in accordance with nationally accepted standards" (element (A)). Blue Cross also argues that there is "no evidence" regarding whether proton therapy was "clinically appropriate," primarily for

"personal comfort," or "not more costly than alternative services" (elements (B) and (C)). We disagree.

Start with AIM's denials and with Blue Cross's first-level appeal denial. Each cited only one source for denying coverage for proton therapy: the Guideline. The Guideline, in turn, relied on the ASTRO Policy as a nationally accepted standard. Yet as Dr. Fuller pointed out, the ASTRO Policy "has been updated . . . to specifically include proton beam therapy as both appropriate and medically necessary for exactly Mr. Salim's diagnosis, advanced head and neck cancer." Indeed, the ASTRO Policy designates proton therapy as "medically necessary" both for "[t]umors that approach or are located at the base of the skull" and for "[a]dvanced . . . head and neck cancers."

The updated ASTRO Policy is not *competing* evidence that requires a court to weigh one policy against another. Rather, the updated Policy is *superseding* evidence showing that ASTRO—a source which AIM and Blue Cross treated as reliable—in fact classifies proton therapy as medically necessary for Salim's condition. A plan administrator "may not arbitrarily refuse to credit a claimant's reliable evidence." *Schexnayder*, 600 F.3d at 469; (quoting *Black & Decker*, 538 U.S. at 834). Perhaps Blue Cross has discretion to ignore ASTRO altogether. But it does not have discretion to deny Salim's claim by attributing to ASTRO a view that ASTRO does not hold.

The Institute's review does not cure Blue Cross's decision. Consider the Institute's statement that "most investigators recommend additional study . . . before adopting [proton therapy] as a standard treatment option for patients with head and neck cancer." This generic claim about unnamed investigators does nothing to address the problem that Dr. Fuller highlighted, which was that the investigator that Blue Cross trusted—ASTRO—in fact viewed proton therapy as medically necessary for Salim's diagnosis. Nor did

Dr. Fuller recommend proton therapy as a "standard" treatment. Just the opposite: "I am not advocating for the routine treatment of head and neck cancer; Mr. Salim has massive oral disease." Given the ASTRO Policy that Blue Cross relied on, the Institute's generic claim is not "such relevant evidence as a reasonable mind might accept as adequate to support" the denial. *Rittinger*, 914 F.3d at 957 (citation omitted).

Nor do we see substantial evidence in the Institute's conclusion that the updated ASTRO Policy and the NCCN Policy support proton therapy for head and neck cancer *only* when the patient has "a lesion with significant involvement of structures at the skull base." Relevant excerpts from both Policies are in the record. The ASTRO Policy designates proton therapy as "medically necessary" for "tumors . . . at the base of the skull" *or* for "[a]dvanced head and neck cancers." "[A]dvanced head and neck cancer" was Salim's exact diagnosis. The Institute did not address this aspect of the ASTRO Policy. The NCCN Policy says that proton therapy is "especially important" for tumors that "invade . . . the skull base." According to the Institute, Salim "d[id] not have *significant* macroscopic disease involvement in the region of the skull base," and therefore the NCCN Policy did not apply. But the NCCN Policy requires only that the disease "invade" the skull base, not that the invasion be "significant." Salim's cancer involved "skull base invasion." Again, then, the Institute did not address the full range of diagnoses that the NCCN Policy refers to.

Finally, Blue Cross argues that "there is no evidence in the [record] that [Salim] met his burden as to parts B and C" of the Plan's definition of "medically necessary." Blue Cross also complains that "the District Court d[id] not discuss the B and C provisions." That silence is not surprising given that Blue Cross did not make this argument in the brief that it submitted to the magistrate. But Blue Cross did present this argument in its objection to

the magistrate judge's report and recommendation, albeit in only a few conclusory sentences. Assuming this argument is preserved, it lacks merit.

Dr. Fuller explained at length that proton therapy was appropriate "in this scenario" (element (B)), and that proton therapy was also "less cost[ly]" than and otherwise "[s]uperior" to other treatment options (element (C)). That explanation satisfied Salim's "initial burden of demonstrating entitlement to benefits under an ERISA plan." *Perdue v. Burger King Corp.*, 7 F.3d 1251, 1254 n.9 (5th Cir. 1993). Blue Cross had a chance to rebut Dr. Fuller's view with substantial evidence, but it focused instead on element (A). On appeal, Blue Cross has identified no evidence in the record that favors its view of elements (B) and (C), nor do we discern any such evidence. As a result, Blue Cross's final argument fails.

## III

The district court used the correct standard of review, and it correctly held that Blue Cross abused its discretion by denying coverage even when substantial evidence did not support that decision. We AFFIRM.

# IN THE SUPREME COURT OF THE STATE OF WASHINGTON

JOHN STRAUSS and MICHELLE STRAUSS, husband and wife, and their marital community,

Petitioners,

v.

PREMERA BLUE CROSS,

Respondent.

NO. 95449-6

EN BANC

Filed OCT 0 3 2019

STEPHENS, J.—John and Michelle Strauss challenge the Court of Appeals decision affirming summary dismissal of their action against Premera Blue Cross, which arises out of the denial of coverage for proton beam therapy (PBT) to treat John Strauss's prostate cancer. At issue is whether the Strausses have established the existence of a genuine issue of material fact regarding PBT's superiority to intensity-modulated radiation therapy (IMRT), thereby demonstrating that proton beam therapy is "medically necessary" within the meaning of their insurance

contract. We hold that they have, and we therefore reverse the Court of Appeals' decision and remand for a jury trial on the disputed facts.

## FACTS

John Strauss was diagnosed with prostate cancer in September 2008. He is insured under a Premera health insurance policy that covers "medically necessary" treatment, defined as treatment conducted "[i]n accordance with generally accepted standards of medical practice . . . and not more costly than an alternative [treatment] . . . at least as likely to produce equivalent therapeutic or diagnostic results." Clerk's Papers (CP) at 212. After consulting with Dr. David Bush, Strauss elected to pursue PBT. Dr. Bush recommended PBT over IMRT because, although no clinical trials directly compared the two forms of treatment, he believed that PBT resulted in fewer adverse side effects for the majority of patients.

On November 12, 2009, Strauss sought preauthorization from Premera to undergo PBT rather than IMRT, but Premera denied the request on the ground PBT was not "medically necessary" within the meaning of the policy. CP at 243. Strauss twice unsuccessfully pursued internal appeals of this decision with Premera. At Strauss's request, Premera sought an external review in July 2010, which upheld the denial of coverage. Meanwhile, Strauss completed PBT in April 2010.

The Strausses subsequently filed this action in superior court, seeking recovery for the cost of PBT, as well as insurance bad faith damages and treble damages for violation of the Consumer Protection Act, chapter 19.86 RCW. The parties stipulated that PBT is costlier than IMRT and is at least as effective in treating prostate cancer. But Premera moved for summary judgment on the ground that the Strausses could not meet their burden to show PBT was "medically necessary" under the insurance plan. CP at 37-38. The parties agreed that PBT would qualify as "medically necessary" if it resulted in fewer adverse side effects compared to IMRT; Premera argued that the Strausses had failed to raise a genuine issue as to that fact. CP at 40.

Acknowledging the absence of clinical studies directly comparing the two therapies, the Strausses relied on declarations from two board-certified radiation oncologists who opined that PBT would likely lead to fewer side effects because it irradiates a smaller amount of healthy tissue. Premera responded that these expert opinions did not constitute "credible science" and that, in the absence of "randomized controlled trials," the Strausses' arguments about side effects "rely entirely on conjecture, theory, and inadmissible cross-study comparisons." CP at 19. Premera did not move to exclude any of the Strausses' expert declarations, however. Instead, it discounted those declarations on their merits, arguing that, even

if one were to credit nonrandomized studies, some of those studies show that PBT may be equivalent to or worse than IMRT in terms of side effects. Premera admitted that developments in radiation therapy, generally, have been aimed primarily at reducing incidental radiation to healthy tissue. But it cited publications, by the National Comprehensive Cancer Network and two other professional organizations, stating that there is currently no clear evidence that PBT has any advantages over IMRT. When it moved for summary judgment dismissal, Premera relied solely on these publications and the federal district court's decision in *Baxter v. MBA Group Insurance Trust Health & Welfare Plan*, 958 F. Supp. 2d 1223 (W.D. Wash. 2013), which it characterized as involving facts "almost identical" to this case. CP at 37. The superior court granted Premera's motion.

The Court of Appeals affirmed, even though it acknowledged that the record contained conflicting evidence on the question of side effects, the sole issue before the superior court on Premera's motion for summary judgment. Specifically, the court stated, "[T]he record establishes there are peer-reviewed medical studies that show the side effects of PBT may be superior to IMRT and other peer-reviewed medical studies that show the side effects of IMRT may be superior to PBT." *Strauss v. Premera Blue Cross*, 1 Wn. App. 2d 661, 683, 408 P.3d 699 (2017). It then concluded that, because the record contained conflicting evidence on this issue, PBT

and IMRT were equivalent treatments as a matter of law, "absent clinical evidence directly comparing [them]." *Id.* at 683-84. We granted Strauss's petition for review. *Strauss v. Premera Blue Cross*, 190 Wn.2d 1025 (2018).

ANALYSIS

We review summary judgments de novo. *Ranger Ins. Co. v. Pierce County*, 164 Wn.2d 545, 552, 192 P.3d 886 (2008) (citing *City of Sequim v. Malkasian*, 157 Wn.2d 251, 261, 138 P.3d 943 (2006)). "'Summary judgment is appropriate when "there is no genuine issue as to any material fact and . . . the moving party is entitled to a judgment as a matter of law."'" *Id.* (alteration in original) (quoting *Locke v. City of Seattle*, 162 Wn.2d 474, 483, 172 P.3d 705 (2007) (quoting CR 56(c))). "When determining whether an issue of material fact exists, the court must construe all facts and inferences in favor of the nonmoving party." *Id.* (citing *Reid v. Pierce County*, 136 Wn.2d 195, 201, 961 P.2d 333 (1998)).

As noted, there is no dispute that PBT costs more than IMRT and is equally effective in curing prostate cancer. Nor is there any dispute over the meaning of the insurance contract provision at issue here: for purposes of this appeal, the parties agree that PBT is "medically necessary" if it results in fewer side effects than IMRT. Thus, the sole question presented in this case is whether the Strausses raised a

genuine issue of material fact as to PBT's relative superiority, in terms of side effects, to IMRT.

Generally speaking, expert opinion on an ultimate question of fact is sufficient to establish a triable issue and defeat summary judgment. *Eriks v. Denver*, 118 Wn.2d 451, 457, 824 P.2d 1207 (1992) (citing *Lamon v. McDonnell Douglas Corp.*, 91 Wn.2d 345, 352, 588 P.2d 1346 (1979)). However, "speculation and conclusory statements will not preclude summary judgment." *Volk v. DeMeerleer*, 187 Wn.2d 241, 277, 386 P.3d 254 (2016) (citing *Elcon Constr., Inc. v. E. Wash. Univ.*, 174 Wn.2d 157, 169, 273 P.3d 965 (2012)). "The expert's opinion must be based on fact and cannot simply be a conclusion or based on an assumption if it is to survive summary judgment." *Id.* (citing *Melville v. State*, 115 Wn.2d 34, 41, 793 P.2d 952 (1990)).

Evaluating the declarations on summary judgment, the Court of Appeals concluded that the record contained conflicting evidence on the issue of side effects: "the record establishes there are peer-reviewed medical studies that show the side effects of PBT may be superior to IMRT and other peer-reviewed medical studies that show the side effects of IMRT may be superior to PBT." *Strauss*, 1 Wn. App. 2d at 683. Yet, it concluded that PBT and IMRT were therefore equivalent treatments as a matter of law, "absent clinical evidence directly comparing [them]."

*Id.* at 683-84. In other words, the Court of Appeals held that the Strausses were required to provide evidence in the form of randomized clinical trials in order to defeat summary judgment. *Id.*

This holding was error. Requiring expert medical opinion testimony to be based on a specific type of research goes beyond the court's limited role at the summary judgment stage, which is simply to decide whether a trial is unnecessary. *See Reese v. Stroh*, 128 Wn.2d 300, 307, 907 P.2d 282 (1995) (trial court erred by excluding medical expert testimony solely because it was not based on "statistically significant studies" directly supporting expert's opinion). Indeed, Premera seems to concede this point in some of its briefing. *See* Premera Blue Cross's Resp. to Amicus Br. of Wash. State Ass'n for Justice Found. at 4 ("[i]t is correct . . . that head-to-head clinical trials are not *required* as a basis for medical opinion testimony [and that a] doctor . . . could opine based on his own observation"). There is no dispute that the Strausses' experts were qualified to testify, only a dispute as to the weight or credibility of their opinion testimony. The credit to be given to any witness's testimony, including expert opinion testimony, is quintessentially a matter for the trier of fact to determine. *Grove v. PeaceHealth St. Joseph Hosp.*, 182 Wn.2d 136, 146, 341 P.3d 261 (2014); *see also Anderson v. Akzo Nobel Coatings, Inc.*, 172

Wn.2d 593, 606, 260 P.3d 857 (2011) ("Evidentiary rules provide significant protection against unreliable, untested, or junk science.").

Premera urges this court to embrace the United States District Court's decision in *Baxter* and uphold summary dismissal. The insurance contract at issue in *Baxter* had a "medical necessity" definition identical to the provision at issue in this case. *Baxter*, 958 F. Supp. 2d at 1228-29. Like the Strausses, the plaintiff in *Baxter* argued that the plan covered PBT "despite the lack of randomized clinical trials comparing [PBT] to other forms of radiation therapy for treatment of prostate cancer," because observational studies and theoretical models supported PBT's superiority. *Id.* at 1232. The defendant-insurer countered that PBT was definitely costlier than IMRT and had not been proved more effective. *Id.* at 1230. The court ultimately agreed with the insurer, finding that, where "[n]o study cited by either party provides statistically significant evidence that one therapy is superior to the other," the plaintiff had not met his burden to prove PBT was "medically necessary." *Id.* at 1238.

While the Court of Appeals found *Baxter* persuasive,[1] we do not. The *Baxter* court, considering cross motions for summary judgment on very similar facts,

[1] *See Strauss*, 1 Wn. App. at 683-84 (citing *Baxter* as the sole source of authority for the conclusion that "reasonable minds could only conclude that absent clinical evidence directly comparing PBT and IMRT, the treatments are equivalent").

acknowledged that the evidence before it, in the form of observational studies, theoretical models, and expert opinion, supported both parties' arguments. 958 F. Supp. 2d at 1236-38. From this conflicted record, it erroneously concluded that PBT and IMRT are therefore *equivalent* treatments as a matter of law, neither superior to the other in terms of side effects or secondary malignancy. *Id.* at 1237 ("the Court concludes that the record demonstrates that IMRT and [PBT] provide equivalent cancer treatment with comparable side-effects"). In reaching that conclusion, the court weighed the credibility of conflicting medical studies and essentially rejected all of them:

> While Plaintiff points to observational studies demonstrating that proton therapy may slightly reduce certain side-effects in some situations, it appears that it is just as likely to increase other side effects. . . . Plaintiff focuses on studies involving mathematical modeling that show that the long-term risk of developing a secondary malignancy may be higher with [PBT]. . . . Defendants focus on comparative studies that show that other side-effects, including gastrointestinal side-effects may be slightly more severe with [PBT]. . . . No study cited by either party provides statistically significant evidence that one therapy is superior to the other.

*Id.* at 1237-38. This analysis reflects a weighing of conflicting evidence and is exactly what the Court of Appeals did in this case.[2] This is inappropriate at the

[2] *See id.* at 683 (holding Dr. Laramore's expert opinion is insufficient to create a genuine issue of material fact because "Dr. Laramore admits his opinion that PBT is superior for the risk of contracting secondary cancers is 'theoretical' . . . [and he] based his opinion on the side effects from radiation to the rectal wall on one medical study"). It is not clear why the court believed that an expert's inferences are insufficient if drawn from a single study, but the questions begged by that conclusion—e.g., how many studies are

summary judgment stage. *Grove*, 182 Wn.2d at 146. We decline to follow *Baxter* and instead adhere to settled summary judgment principles under Washington law. The trier of fact, not the court, must determine whether PBT has a superior side effect profile, making it "medically necessary" within the meaning of the insurance policy.

## CONCLUSION

Because there is conflicting evidence in the record regarding the "medical necessity" element of the Strausses' coverage claim, the trial court erred by granting Premera's motion for summary judgment dismissal. We reverse the Court of Appeals and remand to the trial court for further proceedings consistent with this opinion.[3]

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required to make an inference credible?—illustrate the manner in which the court assumed the fact finder's role.

[3] The Strausses have also requested attorney fees on appeal, but until coverage is determined, this request is premature.

Stephens, J.

WE CONCUR:

Fairhurst, C.J.

Johnson, J.

González, J.

Gordon McCloud, J.

139 Nev., Advance Opinion 56

IN THE SUPREME COURT OF THE STATE OF NEVADA

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| KIMBERLY D. TAYLOR, AN INDIVIDUAL,<br>Appellant,<br>vs.<br>KEITH BRILL, M.D., FACOG, FACS, AN INDIVIDUAL; AND WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA-MARTIN PLLC, A NEVADA PROFESSIONAL LIMITED LIABILITY COMPANY,<br>Respondents. | No. 83847 ✓ |
| KEITH BRILL, M.D., FACOG, FACS, AN INDIVIDUAL; AND WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA-MARTIN PLLC, A NEVADA PROFESSIONAL LIMITED LIABILITY COMPANY,<br>Appellants,<br>vs.<br>KIMBERLY D. TAYLOR, AN INDIVIDUAL,<br>Respondent. | No. 84492 |
| KEITH BRILL, M.D., FACOG, FACS, AN INDIVIDUAL; AND WOMEN'S HEALTH ASSOCIATES OF SOUTHERN NEVADA-MARTIN PLLC, A NEVADA PROFESSIONAL LIMITED LIABILITY COMPANY,<br>Appellants,<br>vs.<br>KIMBERLY D. TAYLOR, AN INDIVIDUAL,<br>Respondent. | No. 84881 |





23-41426

Appeals from a judgment following a jury verdict in a medical malpractice action, a post-judgment order granting in part and denying in part a motion to retax and settle costs, and a post-judgment order denying attorney fees. Eighth Judicial District Court, Clark County; Monica Trujillo, Judge,[1] and Joseph T. Bonaventure, Sr. Judge.

*Reversed and remanded.*

McBride Hall and Heather S. Hall and Robert C. McBride, Las Vegas, for Kimberly D. Taylor.

Breeden & Associates, PLLC, and Adam J. Breeden, Las Vegas, for Keith Brill, M.D., FACOG, FACS, and Women's Health Associates of Southern Nevada-Martin PLLC.

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BEFORE THE SUPREME COURT, STIGLICH, C.J., and HERNDON and PARRAGUIRRE, JJ.

*OPINION*

By the Court, HERNDON, J.:

In these appeals, we consider whether defendants to a medical malpractice action may defend by arguing, or otherwise present evidence concerning, the plaintiff's informed consent or assumption of the risk when the plaintiff does not raise a claim based on lack of informed consent. We conclude that assumption-of-the-risk evidence may be relevant in certain

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[1]While Judge Carli Lynn Kierny signed the final judgment, the district court case was assigned to, and the trial was presided over by, Judge Monica Trujillo.

instances where a plaintiff's consent to the procedure is challenged. But neither the defense itself nor evidence of informed consent is proper in a medical malpractice action, like this one, where the plaintiff's consent is uncontested. Thus, the district court erred in allowing such arguments and evidence at trial here.

We also consider whether a plaintiff must use expert testimony to show that the billing amounts of the medical damages they seek are reasonable and customary. While an appropriate expert can testify as to the reasonableness of the amount of damages, we hold that expert testimony is not required when other evidence demonstrates reasonableness. The district court abused its discretion by prohibiting such evidence. Based on these errors, and others discussed herein, we reverse the district court's judgment and remand this matter for further proceedings.

*FACTS AND PROCEDURAL HISTORY*

Kimberly Taylor, the plaintiff in the lawsuit below, had a hysteroscopy performed by the defendant, Dr. Keith Brill. Dr. Brill perforated Taylor's uterus and bowel during the procedure. Taylor reported escalating pain after the surgery and was twice transported to an emergency room via ambulance. On the second trip, the attending doctor concluded her symptoms were consistent with an uncontrolled bowel perforation and performed an emergency surgery to remove any contamination and to correct what turned out to be a three-centimeter perforation.

Taylor then filed a medical malpractice action against Dr. Brill and the Women's Health Associates of Southern Nevada-Martin PLLC, amongst others. Taylor alleged that Dr. Brill had breached the standard of care by piercing her uterine wall and small intestine during surgery. Taylor

also alleged Dr. Brill continued surgery after observing her uterine perforation, failed to evaluate and diagnose her intestine perforation, failed to inform the post-anesthesia care unit of the uterine perforation and instruct the post-anesthesia team to observe her for specific concerns requiring further examination, and failed to apprise her of these complications. The matter proceeded to a jury trial. Before trial, Taylor sought to exclude any references to known risks or complications, as well as hospital documents regarding her informed consent and educating her on the risks of the procedure to be performed. The district court ultimately ruled that Dr. Brill could introduce evidence of Taylor's knowledge of the risks and complications associated with the procedure but not her informed consent form. At the conclusion of trial, the jury unanimously found in favor of Dr. Brill and denied all of Taylor's claims. Taylor appeals from the final judgment in Docket No. 83847. Dr. Brill and Women's Heath Associates appeal from certain post-judgment orders in consolidated Docket Nos. 84492 and 84881.

*DISCUSSION*

We first address Taylor's challenge to the district court's admission of evidence regarding her knowledge of the risks associated with the procedure Dr. Brill performed. We then address Taylor's other evidentiary challenges, including to the district court's decisions to prohibit her from presenting nonexpert evidence in support of her damages claim and to allow evidence of insurance write-downs. Finally, we address Taylor's remaining challenge concerning the rejection of a portion of Taylor's proposed closing argument.

*Evidentiary decisions*

We review a district court's decision to admit or exclude evidence for an abuse of discretion and will not disturb such a decision

"absent a showing of palpable abuse." *Las Vegas Metro. Police Dep't v. Yeghiazarian*, 129 Nev. 760, 764-65, 312 P.3d 503, 507 (2013). But when an evidentiary ruling rests on a question of law, we review it de novo. *Davis v. Beling*, 128 Nev. 301, 311, 278 P.3d 501, 508 (2012).

*Informed consent and assumption of the risk*

Taylor first challenges the district court's decision to admit evidence of her knowledge of the risks and potential complications of her surgery through witness testimony, Taylor's hospital discharge instructions, and associated paperwork. Taylor asserts that such evidence is irrelevant in this case because she did not allege that she was not informed of the risks associated with her procedure or that Dr. Brill failed to obtain her consent. Dr. Brill contends that the evidence is relevant because the complication she experienced was a known risk of the procedure and the evidence demonstrated that such a complication could occur in the absence of negligence.

Only relevant evidence is admissible. NRS 48.025; *see also Desert Cab Inc. v. Marino*, 108 Nev. 32, 35, 823 P.2d 898, 899 (1992). Relevant evidence is "evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more or less probable than it would be without the evidence." NRS 48.015. But relevant evidence is "not admissible if its probative value is substantially outweighed by the danger of unfair prejudice, of confusion of the issues or of misleading the jury." NRS 48.035(1).

To succeed in a professional negligence action, a plaintiff must prove that, in rendering services, a health care provider failed "to use the reasonable care, skill or knowledge ordinarily used under similar circumstances by similarly trained and experienced providers of health care." NRS 41A.015. The plaintiff must establish three things: "(1) that the

doctor's conduct departed from the accepted standard of medical care or practice; (2) that the doctor's conduct was both the actual and proximate cause of the plaintiff's injury; and (3) that the plaintiff suffered damages." *Prabhu v. Levine*, 112 Nev. 1538, 1543, 930 P.2d 103, 107 (1996).

We have not previously considered whether evidence of informed consent is relevant, or if an assumption-of-the-risk defense is proper, in a professional negligence action. Generally, the first two elements of such an action—deviation from the standard of care and medical causation—are shown by evidence consisting of "expert medical testimony, material from recognized medical texts or treatises or the regulations of the licensed medical facility wherein the alleged negligence occurred." NRS 41A.100(1). An assumption-of-the-risk defense, on the other hand, requires proof of "(1) voluntary exposure to danger, and (2) actual knowledge of the risk assumed." *Sierra Pac. Power Co. v. Anderson*, 77 Nev. 68, 71, 358 P.2d 892, 894 (1961) (quoting *Papagni v. Purdue*, 74 Nev. 32, 35, 321 P.2d 252, 253 (1958)). As the defense "is founded on the theory of consent," a party may seek to present evidence of a plaintiff's informed consent to support it.[2] *Id.* We conclude that such evidence and argument is irrelevant to demonstrating that a medical provider conformed to the accepted standard of care or to refute medical causation when defending against a medical malpractice claim. *See* NRS 41A.100(1). Indeed, informed consent evidence "does not make it more or less probable that the physician was negligent in . . . performing [the surgery] in the post-consent timeframe" and is therefore inadmissible to

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[2]Dr. Brill argues he did not present such a defense, but his answer to the complaint includes the affirmative defense that Taylor "assumed the risks of the procedures, if any, performed."

determine whether a medical professional breached the standard of care. *Brady v. Urbas*, 111 A.3d 1155, 1162 (Pa. 2015); *see also* NRS 48.025(2) (deeming irrelevant evidence inadmissible).

Even if a plaintiff gave informed consent, that would not "vitiate [a medical provider's] duty to provide treatment according to the ordinary standard of care" because "assent to treatment does not amount to consent to negligence, regardless of the enumerated risks and complications of which the patient was made aware." *Brady*, 111 A.3d at 1162. Other jurisdictions are in accord. *See, e.g.*, *Hayes v. Camel*, 927 A.2d 880, 889-90 (Conn. 2007) ("[E]vidence of informed consent, such as consent forms, is both irrelevant and unduly prejudicial in medical malpractice cases without claims of lack of informed consent."); *Baird v. Owczarek*, 93 A.3d 1222, 1233 (Del. 2014) (concluding that once the plaintiff dismissed their informed consent claim, any signed consent forms "became irrelevant, because assumption of the risk is not a valid defense to a claim of medical negligence, and because [such evidence] is neither material [n]or probative of whether [the doctor] met the standard [of] care" (citation omitted)); *Wilson v. P.B. Patel, M.D., P.C.*, 517 S.W.3d 520, 525 (Mo. 2017) (concluding that such evidence would mislead the jury that the plaintiff consented to injury); *Waller v. Aggarwal*, 688 N.E.2d 274, 275-76 (Ohio App. Ct. 1996) (recognizing that informed consent evidence is generally irrelevant because it does "not grant consent for the procedure to be performed negligently [or] waive appellant's right to recourse in the event the procedure was performed negligently" and that it has the potential to confuse the jury); *Wright v. Kaye*, 593 S.E.2d 307, 317 (Va. 2004) (holding that when a plaintiff does not place consent in issue, "evidence of information conveyed to [the plaintiff] concerning the risks of surgery in obtaining her consent is neither

relevant nor material to the issue of the standard of care . . . [or] upon the issue of causation").

Despite the foregoing, certain evidence that may support an assumption-of-the-risk defense, such as evidence of the known risks and complications of a particular procedure, may help inform a jury as it evaluates whether there has been a breach of the accepted standard of care. *See Mitchell v. Shikora*, 209 A.3d 307, 318 (Pa. 2019) ("[R]isks and complications evidence may assist the jury in determining whether the harm suffered was more or less likely to be the result of negligence."). Other courts have distinguished between inadmissible informed consent evidence—such as consent forms or communications between a physician and patient regarding the purpose, nature, and risks of procedures—and admissible evidence of the risks and complications of surgery. *See id.* at 316-18. However, evidence of a procedure's risks must still fall within the ambit of NRS 41A.100(1). And courts must analyze on a case-by-case basis whether the evidence should still be excluded because its potential to confuse the jury substantially outweighs its probative value. *See* NRS 48.035(1).

Since expert witness testimony may establish the standard of care and breach, the testimony regarding risks and complications of the procedure by Taylor's and Dr. Brill's retained experts was admissible. *See* NRS 41A.100(1). However, lay witness testimony and hospital literature are generally not suitable for this purpose, making the testimony by Taylor and Dr. Brill, as well as portions of Taylor's discharge instructions and associated paperwork about this same subject, inadmissible. *Id.* Accordingly, the district court abused its discretion by allowing evidence of Taylor's knowledge of the procedure's risks and consequences and evidence

probative of Taylor's informed consent. And we are not convinced that the limiting instruction given to the jury cured the prejudice resulting from this error.

*Special damages*

Taylor sought special damages as renumeration for the medical services she underwent following her injury from the surgery performed by Dr. Brill. To be entitled to special damages, Taylor had to demonstrate that the amounts she was billed were reasonable and necessary. *See Pizzaro-Ortega v. Cervantes-Lopez*, 133 Nev. 261, 266, 396 P.3d 783, 788 (2017). The necessity of the medical services Taylor received after Dr. Brill's allegedly negligent surgery was not contested in the trial court. Taylor's retained expert, Dr. Berke, clearly testified that the medical services Taylor received were reasonable and necessary and were caused by the perforations that arose from Dr. Brill's surgical procedure. The district court excluded the bulk of the evidence Taylor sought to admit in support of her special damages claim—including medical bills, testimony from health care industry witnesses about those bills, and testimony from Taylor herself, who had worked in the medical billing industry with both physicians and hospitals for over two decades. The district court relied, in large part, on its finding that testimony about the reasonable and customary nature of medical charges was beyond the knowledge of a layperson and required an expert. Since Taylor proffered no expert to testify that the charges for the medical services she received were usual, customary, or reasonable, the district court excluded them. In doing so, the district court relied on *Curti v. Franceschi*, which held that an award for medical services was supported by substantial evidence where the attending doctor testified as to the amount that the patient was charged, that he believed such charges were reasonable, and that he had no usual and customary fee. 60 Nev. 422, 428,

111 P.2d 53, 56 (1941). But that case does not stand for the proposition that evidence of the reasonableness of the damages sought can *only* be proven by an expert witness or physician. Here, Taylor presented three witnesses—the CFO of the charging hospital, a health care billing representative, and a health care customer service billing manager—all of whom would have testified regarding the charges for the medical treatment provided to Taylor. Taylor also sought to testify herself on the issue based in part on her experience working in the medical billing industry for over two decades. This information was relevant and therefore admissible. NRS 48.015; NRS 48.025. The district court thus abused its discretion in excluding this evidence, *see Yeghiazarian*, 129 Nev. at 764-65, 312 P.3d at 507, which affected Taylor's substantial rights, as it prevented her from proving a prima facia case for damages, *see Brown v. Capanna*, 105 Nev. 665, 672, 782 P.2d 1299, 1304 (1989) (holding that an appellant's substantial rights were affected by the exclusion of testimony that would have helped prove their prima facie case).

*Insurance write-downs*

Although the district court excluded the vast majority of medical billing evidence related to Taylor's proposed special damages, it did admit evidence related to two lower-cost items of medical billing. Taylor challenges the district court's decision to permit Dr. Brill to present evidence of insurance write-downs in defending against this aspect of her damages claim. The district court based its decision on its interpretation of NRS 42.021(1); therefore, the issue presented is one of law that we review de novo. *See Zohar v. Zbiegien*, 130 Nev. 733, 737, 334 P.3d 402, 405 (2014) (recognizing that statutory interpretation questions are issues of law); *Davis*, 128 Nev. at 311, 278 P.3d at 508.

NRS 42.021(1) abrogated the common law collateral source doctrine by creating an exception for evidence of collateral source payments in medical malpractice actions:

> In an action for injury or death against a provider of health care based upon professional negligence, if the defendant so elects, the defendant may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the injury or death pursuant to . . . any contract or agreement of any group, organization, partnership or corporation to provide, pay for or reimburse the cost of medical, hospital, dental or other health care services.

NRS 42.021(1); *see also McCrosky v. Carson Tahoe Reg'l Med. Ctr.*, 133 Nev. 930, 936, 408 P.3d 149, 154-55 (2017) (discussing the change from common law). However, if evidence is introduced pursuant to subsection (1), the source of the collateral benefits cannot "[r]ecover any amount against the plaintiff . . . or . . . [b]e subrogated to the rights of the plaintiff against a defendant." NRS 42.021(2). This statute was thus intended to prevent a situation where a jury would reduce a plaintiff's award based on collateral source evidence, but the collateral source would still seek reimbursement from the award. *Harper v. Copperpoint Mut. Ins. Holding Co.*, 138 Nev., Adv. Op. 33, 509 P.3d 55, 60 (2022) (citing *McCrosky*, 133 Nev. at 936, 408 P.3d at 155).

Construing this statute narrowly, we conclude that the district court erred in finding that the statute permitted the admission of insurance write-downs. *See Branch Banking & Tr. Co. v. Windhaven & Tollway, LLC*, 131 Nev. 155, 158-59, 347 P.3d 1038, 1040 (2015) ("Statutes that operate in derogation of the common law should be strictly construed . . . ."). NRS 42.021(1) contemplates evidence only of actual benefits paid to the plaintiff by collateral sources, and insurance write-downs do not create any payable

benefit to the plaintiff. Insurance write-downs are therefore inadmissible under NRS 42.021(1).

*Closing arguments*

Lastly, Taylor asserts that the district court improperly limited her closing arguments. We review de novo whether an attorney's comments would constitute misconduct. *Grosjean v. Imperial Palace, Inc.*, 125 Nev. 349, 364, 212 P.3d 1068, 1078 (2009); *see also Lioce v. Cohen*, 124 Nev. 1, 20, 174 P.3d 970, 982 (2008).

Taylor sought to make a closing argument "that the jury with its verdict should 'send a message' to Defendants that safety is important, that [Dr. Brill] must answer for the injury he caused to his patient, and that he cannot be careless toward his patient, etc." In denying this request, the district court stated that Taylor "shall not be permitted to use the phrase 'send a message[ ]' . . . in closing argument." But Taylor's argument was not inappropriate because it was based on the evidence in the case, rather than "implor[ing] the jury to disregard the evidence." *Capanna*, 134 Nev. at 890-91, 432 P.3d at 731. Asking the jury to send a message is not prohibited "so long as the attorney is not asking the jury to ignore the evidence." *Id.* (quoting *Pizarro-Ortega*, 133 Nev. at 269, 396 P.3d at 790). The district court therefore erred in limiting Taylor's closing argument in this manner.

## *CONCLUSION*

Informed consent evidence is inadmissible, and an assumption-of-the-risk defense is improper, in professional negligence suits when the plaintiff does not challenge consent, as it serves only to confuse and mislead the jury. Additionally, expert or physician testimony is not required to demonstrate the reasonableness of the billing amount of special damages. And evidence of insurance write-downs does not fall within the type of evidence NRS 42.021(1) makes admissible. The errors made below

regarding these issues, along with the improper limiting of Taylor's closing argument, warrant reversing the judgment in Docket No. 83847 and remanding for further proceedings in line with this opinion, including a new trial.[3]

Because we reverse the underlying judgment, we necessarily reverse the order granting in part and denying in part Taylor's motion to retax and settle costs in Docket No. 84492 and the order denying Dr. Brill's request for attorney fees in Docket No. 84881. *See Frederic & Barbara Rosenberg Living Tr. v. MacDonald Highlands Realty, LLC*, 134 Nev. 570, 579-80, 427 P.3d 104, 112 (2018) (recognizing the necessity of reversing a fees and costs order when the substantive judgment was being reversed).

_____, J.
Herndon

We concur:

_____, C.J.
Stiglich

_____ J.
Parraguirre

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[3]We have considered Taylor's remaining arguments, including her assertions that the district court erred in limiting her voir dire, in not admitting into evidence a demonstrative medical device, in not allowing proposed impeachment of a defense expert, in the settling of jury instructions, and in allowing misconduct by defense counsel in closing argument, and we find no errors.

2021 WL 858436
United States District Court, D. Massachusetts.

Kate WEISSMAN, Plaintiff,
v.
UNITEDHEALTHCARE INSURANCE COMPANY, UnitedHealthcare Services, LLC, and Interpublic Group of Companies, Inc. Choice Plus Plan, Defendants.
Richard Cole, Plaintiff,
v.
UnitedHealthcare Insurance Company, Defendant.
Zachary Rizzuto, Plaintiff,
v.
UnitedHealthcare Insurance Company, UnitedHealthcare Services, Inc., and the Hertz Custom Benefit Program, Defendants.

Civil Action Nos. 19-cv-10580-ADB, 19-cv-12224-ADB, 19-cv-12239-ADB
|
Signed 03/08/2021

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## MEMORANDUM AND ORDER ON DEFENDANTS' MOTION TO DISMISS

BURROUGHS, D.J.

***1** Plaintiffs Kate Weissman, Richard Cole, and Zachary Rizzuto (together, "Plaintiffs") bring this putative class action suit, alleging that Defendants UnitedHealthcare Insurance Company ("UnitedHealthcare Insurance"), UnitedHealthcare Services, LLC ("UnitedHealthcare Services," and, with UnitedHealthcare Insurance, "UnitedHealthcare"), Interpublic Group of Companies, Inc. Choice Plus Plan (the "Interpublic Plan"), and The Hertz Custom Benefit Program (the "Hertz Plan," with the Interpublic Plan, the "Plans," and with UnitedHealthcare and the Interpublic Plan, "Defendants") violated the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* ("ERISA"). See [ECF No. 41 ("Am. Compl.")]. More specifically, Plaintiffs assert that UnitedHealthcare deceptively and unfairly administered their ERISA plans by refusing to cover Proton Beam Radiation Therapy ("PBRT"), a form of radiation used to destroy cancerous tumors, because it is more expensive than more traditional cancer treatments such as Intensity Modulated Radiotherapy ("IMRT"). [Id. ¶¶ 1–3]. Currently before the Court is Defendants' motion to dismiss. [ECF No. 46]. For the reasons set forth below, the motion is DENIED.

  

## I. BACKGROUND

### A. Factual Background

For purposes of the instant motion to dismiss, the Court, as it must, "accept[s] as true all well-pleaded facts alleged in the complaint and draw[s] all reasonable inferences therefrom in the pleader's favor." A.G. ex rel. Maddox v. Elsevier, Inc., 732 F.3d 77, 80 (1st Cir. 2013).

#### 1. The Parties

Ms. Weissman is a Massachusetts citizen who resides in Suffolk County. [Am. Compl. ¶ 4]. Mr. Cole is a Florida citizen who lives in Miami-Dade County. [Id. ¶ 5]. Mr. Rizzuto is a Florida citizen who resides in Lee County. [Id. ¶ 6]. All three are participants in group health plans governed by ERISA and administered by UnitedHealthcare. [Id. ¶¶ 4–6]. UnitedHealthcare is a healthcare plan provider and insurer that provides, administers, and insures health plans. [Id. ¶¶ 7–8]. It acts as a fiduciary with respect to its administration of ERISA plans, and, in so doing, interprets and applies ERISA plan terms, makes coverage and benefit decisions in its sole discretion, and provides payment to plan participants and beneficiaries and/or their providers. [Id. ¶ 20]. Regardless of whether a given health insurance plan is fully insured (i.e., UnitedHealthcare pays the benefits out of its own assets) or self-funded (i.e., the employer or plan sponsor is ultimately responsible for paying benefits), UnitedHealthcare administers the plan and makes all benefits determinations. [Id. ¶ 21]. The Plans are self-funded group health plans organized and regulated under ERISA. [Id. ¶¶ 9–10].

#### 2. PBRT

PBRT is a medical procedure that uses protons to deliver a curative dose of radiation to a cancerous tumor, while reducing radiation doses to healthy tissues and organs. [Am. Compl. ¶ 40]. It has fewer complications and side effects than IMRT because proton beams are so targeted that patients can tolerate greater doses of radiotherapy than with the photon beams that are used in IMRT. [Id.]. The beam used in PBRT can be adjusted to match the size and shape of the cancerous tissue being targeted, which limits the degree to which healthy tissue is harmed. [Id.]. PBRT, which was invented in 1946, has been used to treat cancer since the 1950s, was approved as a cancer treatment by the Food and Drug Administration ("FDA") in 1988, and, today, is recognized by numerous medical organizations across the United States as a safe and effective method for treating cancer. [Id. ¶ 41].

***2** As set forth in its PBRT Medical Policy No. T0132 (the "PBRT Policy"), UnitedHealthcare generally takes the position that PBRT is experimental or investigational, and therefore not a covered treatment under most of the group health plans it administers. [Am. Compl. ¶ 42]. According to Plaintiffs, the PBRT Policy ignores conclusions from the medical community regarding the efficacy of PBRT and relies on outdated and unreliable scientific studies. [Id. ¶ 44]. On January 1, 2019, UnitedHealthcare issued a revised policy (the "New PBRT Policy") to reflect the fact that it no longer considered PBRT to be experimental insofar as it is used to treat prostate cancer. [Id. ¶ 45].

#### 3. Ms. Weissman's Allegations

Ms. Weissman is a beneficiary under the Interpublic Plan, which is administered by UnitedHealthcare. [Am. Compl. ¶ 24]. The Interpublic Plan "pays Benefits for therapeutic treatments ..., including ... intravenous chemotherapy or other intravenous infusion therapy and radiation oncology." [Id. ¶ 26]. That said, the Interpublic Plan limits coverage to healthcare services that are "Medically Necessary," defined as follows:

> **Medically Necessary** - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:
>
> - In accordance with Generally Accepted Standards of Medical Practice.

- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.

- Not mainly for your convenience or that of your doctor or other health care provider.

- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

[Id. ¶¶ 26–27]. Additionally, the Interpublic Plan contains a number of exclusions from coverage, including an exclusion for experimental or investigational services (the "Experimental Exclusion"), which are defined as follows:

> **Experimental or Investigational Services** - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator and the Plan Administrator make a determination regarding coverage in a particular case, are determined to be any of the following:
>
> - Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
>
> - Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)
>
> - The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

[Id. ¶ 28].

In October 2015, Ms. Weissman was diagnosed with Stage IIB squamous cell carcinoma of the cervix. [Am. Compl. ¶ 61]. She completed successful traditional treatments in December 2015. [Id.]. A few months later, however, a PET/CT scan revealed two small lymph nodes in her para-aortic region, which were confirmed to be squamous cell carcinoma. [Id. ¶ 62]. She underwent laparoscopic resection of the nodes in April 2016. [Id.]. Subsequently, Ms. Weissman was referred to Dr. Andrea L. Russo, a professor at Harvard Medical School and a member of Massachusetts General Hospital's Department of Radiation Oncology, for consideration of PBRT. [Id. ¶ 63]. Dr. Russo, along with other members of Ms. Weissman's care team, determined that PBRT was essential for multiple medical reasons. [Id.]. Pursuant to the Interpublic Plan's protocols, Ms. Weissman's providers contacted UnitedHealthcare to seek prior authorization for her treatment plan, which included PBRT. [Id. ¶ 64]. In an April 6, 2016 letter, UnitedHealthcare denied coverage based on the PBRT Policy and the Experimental Exclusion. [Id. ¶¶ 64–65]. Ms. Weissman and Dr. Russo appealed the adverse decision, both within UnitedHealthcare and with an external review organization, but were unsuccessful in obtaining coverage for Ms. Weissman's PBRT treatment. [Id. ¶¶ 66–76]. Despite the lack of coverage, Ms. Weissman underwent successful PBRT treatment and is now cancer-free. [Id.¶¶ 77–78]. Her treatment cost $95,000. [Id. ¶ 77].

### 4. Mr. Cole's Allegations

***3** Mr. Cole is covered by a health insurance plan issued on behalf of his employer, Cole, Scott & Kissane, P.A. (the "CSK Plan") and administered by UnitedHealthcare. [Am. Compl. ¶ 29]. Under the CSK Plan, Mr. Cole is covered for healthcare services that are "medically necessary" (i.e., "health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms"). [Id. ¶¶ 30–31]. The CSK Plan includes the same Experimental Exclusion as Ms. Weissman's plan. [Id. ¶ 32].

In April 2018, Mr. Cole was diagnosed with high-risk prostate cancer. [Am. Compl. ¶ 81]. In May 2018, his radiation oncologist, Dr. Marcio Fagundes of the Miami Cancer Institute at Baptist Health South Florida, recommended that Mr. Cole undergo PBRT because, among other reasons, it would have a higher likelihood of achieving a better outcome than IMRT. [Id.]. UnitedHealthcare denied Mr. Cole's request for pre-authorization, citing the Experimental Exclusion and the PBRT Policy. [Id. ¶ 82]. Mr. Cole and Dr. Fagundes appealed the coverage denial, both within UnitedHealthcare's internal appeal channels and externally, but were unsuccessful in obtaining coverage for Mr. Cole's PBRT treatment. [Id. ¶¶ 83–94]. Nonetheless, Mr. Cole underwent PBRT treatment, with positive results. [Id. ¶ 95]. His out-of-pocket expenses were $85,000. [Id.].

5. Mr. Rizzuto's Allegations

Mr. Rizzuto is a beneficiary under the Hertz Plan, which is administered by UnitedHealthcare. [Am. Compl. ¶ 33]. The Hertz Plan provides coverage that is nearly identical to the coverage provided under Ms. Weissman's plan. Compare [id. ¶¶ 26–28], with [id. ¶¶ 34–36].

Mr. Rizzuto was diagnosed with brain cancer in August 2017. [Am. Compl. ¶ 98]. In December 2017 and again in January 2018, Mr. Rizzuto underwent craniotomy procedures, which led to adverse side effects including cognitive deficits, fatigue, and loss of peripheral vision. [Id. ¶¶ 100–01]. Subsequently, Mr. Rizzuto's radiation oncologist, Dr. Robert Lustig, the Chief of Clinical Operations for Radiation Oncology and a professor of Clinical Radiation Oncology at the University of Pennsylvania, recommended PBRT. [Id. ¶ 101]. Mr. Rizzuto's doctors believed that PBRT was safer than traditional radiation and would spare healthy brain tissue. [Id. ¶ 102]. Accordingly, Mr. Rizzuto sought prior authorization from UnitedHealthcare for his PBRT treatment. [Id.]. Shortly thereafter, UnitedHealthcare denied coverage based on the PBRT Policy and the Experimental Exclusion. [Id. ¶ 104]. Mr. Rizzuto, his wife, and his doctors appealed the decision, both internally and externally, but could not convince UnitedHealthcare to change its position. [Id. ¶¶ 105–115]. Mr. and Mrs. Rizzuto raised the $126,000 needed for Mr. Rizzuto's PBRT treatment through a Go Fund Me page. [Id. ¶ 116]. Mr. Rizzuto's tumor is now stable. [Id. ¶ 117].

**B. Procedural Background**

Ms. Weissman filed her original complaint in this action on March 26, 2019. [ECF No. 1]. On March 25, 2020, the Court granted Defendants' motion to dismiss, but gave Ms. Weissman leave to amend. [ECF No. 36]. On April 8, 2020, the Court consolidated Ms. Weissman's case with Mr. Cole's, which was transferred to this district from the United States District Court for the Southern District of Florida, [ECF No. 39], and on April 13, 2020, the Court further consolidated the cases with Mr. Rizzuto's, which was transferred to this district from the United States District Court for the Middle District of Florida, [ECF No. 40].

***4** On May 15, 2020, Plaintiffs filed their two-count consolidated, amended class-action complaint. [Am. Compl.]. Their proposed class consists of:

> All persons covered under ERISA-governed plans, administered or insured by UnitedHealthcare, whose requests for PBRT were denied at any time within the applicable statute of limitations, or whose requests for PBRT will be denied in the future, based upon a determination by UnitedHealthcare that PBRT is not medically necessary or is experimental, investigational or unproven.

[Id. ¶ 126].[1] In Count I, asserted against UnitedHealthcare, they allege that UnitedHealthcare breached its fiduciary duties "by adopting, implementing, and applying a policy to deny coverage for PBRT based on the Experimental Exclusion under its Plans, when such a finding was contrary to generally accepted practices and to the terms of the Plans." [Id. ¶ 146]; see [id. ¶ 153]. Pursuant to 29 U.S.C. § 1132(a)(3), ERISA's "catch-all" provision, they seek an injunction requiring United Healthcare to: (1) "[r]etract its categorical denials of PBRT prior authorization requests and/or claims"; (2) "[p]rovide notice to all PBRT Class Members who have had prior authorization requests or claims for PBRT denied"; (3) "[r]e-evaluate all prior authorization requests or claims for PBRT

by Plaintiffs and the PBRT Class Members under an ERISA-compliant procedure and, where warranted, reimburse Plaintiffs and the PBRT Class Members for amounts incurred for PBRT as a result of coverage denials in violation of ERISA"; and (4) "[a]ccount for and disgorge any profits UnitedHealthcare may have realized by virtue of its improperly denied claims and violations of ERISA." [Id. at 43].

In Count II, asserted against all defendants, Plaintiffs allege that UnitedHealthcare improperly denied their benefits. [Am. Compl. ¶¶ 154–61]. Under 29 U.S.C. § 1132(a)(1)(B), they seek: (1) an award of the amounts owed to them; or (2) the injunctive relief described above. [Id. at 43–44].[2]

On June 29, 2020, Defendants moved to dismiss. [ECF No. 46]. Plaintiffs opposed on August 10, 2020, [ECF No. 50], and Defendants replied on September 2, 2020, [ECF No. 54].

## II. LEGAL STANDARD

In reviewing a motion to dismiss under Rule 12(b)(6), the Court must accept as true all well-pleaded facts, analyze those facts in the light most favorable to the plaintiff, and draw all reasonable factual inferences in favor of the plaintiff. See Gilbert v. City of Chicopee, 915 F.3d 74, 76, 80 (1st Cir. 2019). "[D]etailed factual allegations" are not required, but the complaint must set forth "more than labels and conclusions." Bell Atl. Corp. v. Twombly, 550 U.S. 544, 555 (2007). The alleged facts must be sufficient to "state a claim to relief that is plausible on its face." Id. at 570.

***5** "To cross the plausibility threshold a claim does not need to be probable, but it must give rise to more than a mere possibility of liability." Grajales v. P.R. Ports Auth., 682 F.3d 40, 44–45 (1st Cir. 2012) (citing Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009)). "A determination of plausibility is 'a context-specific task that requires the reviewing court to draw on its judicial experience and common sense.' " Id. at 44 (quoting Iqbal, 556 U.S. at 679). "[T]he complaint should be read as a whole, not parsed piece by piece to determine whether each allegation, in isolation, is plausible." Hernandez-Cuevas v. Taylor, 723 F.3d 91, 103 (1st Cir. 2013) (quoting Ocasio-Hernández v. Fortuño-Burset, 640 F.3d 1, 14 (1st Cir. 2011)). "The plausibility standard invites a two-step pavane." Elsevier, 732 F.3d at 80 (citing Grajales, 682 F.3d at 45). First, the Court "must separate the complaint's factual allegations (which must be accepted as true) from its conclusory legal allegations (which need not be credited)." Id. (quoting Morales-Cruz v. Univ. of P.R., 676 F.3d 220, 224 (1st Cir. 2012)). Second, the Court "must determine whether the remaining factual content allows a 'reasonable inference that the defendant is liable for the misconduct alleged.' " Id. (quoting Morales-Cruz, 676 F.3d at 224).

## III. DISCUSSION

### A. Breach of Fiduciary Duty

As noted above, Plaintiffs allege that UnitedHealthcare breached its fiduciary duties by "adopting, implementing, and applying a policy to deny coverage for PBRT based on the Experimental Exclusion under its Plans, when such a finding was contrary to generally accepted practices and to the terms of the Plans" and seek relief under 29 U.S.C. § 1132(a)(3). [Am. Compl. ¶ 146]. Defendants make two arguments as to why Plaintiffs' breach of fiduciary duty claim should be dismissed. For the reasons discussed below, the Court finds each unconvincing, and Defendants' motion to dismiss Plaintiffs' breach of fiduciary duty claim, [ECF No. 46], is therefore DENIED.

#### 1. The Court's Prior Ruling Does Not Bar Plaintiffs' Claim

Defendants argue that the Court already determined, in its March 25, 2020 Memorandum and Order granting Defendants' motion to dismiss Ms. Weissman's complaint (the "March 2020 Order"), [ECF No. 36], that Plaintiffs' breach of fiduciary duty claim fails as a matter of law, and that the claim should therefore be dismissed, [ECF No. 47 at 10–12]. Plaintiffs respond that Defendants misread the March 2020 Order and that even if their denial of benefits and breach of fiduciary duty claims are ultimately found to be duplicative, the Court should not dismiss either at the motion to dismiss stage. [ECF No. 50 at 9–11]. In the March 2020 Order, the Court found the following:

ERISA provides various civil enforcement mechanisms in 29 U.S.C. § 1132(a). Each subsection provides a separate cause of action, requiring different elements and providing different relief. Section 1132(a)(1)(B) allows a participant in an ERISA-governed plan to bring a civil action to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan. Section 1132(a)(3), meanwhile, provides that a participant may bring a civil action (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

The Supreme Court has explained that § 1132(a)(1)(B) allows a plaintiff to recover benefits due under the plan, to enforce rights under the terms of the plan, and to obtain a declaratory judgment of future entitlement to benefits under the provisions of the plan contract. The Supreme Court has also said that § 1132(a)(3) is a catch-all provision that act[s] as a safety net, offering appropriate equitable relief for injuries ... not elsewhere adequately remed[ied] under § 1132(a). [F]ederal courts have uniformly concluded that, if a plaintiff can pursue benefits under the plan pursuant to Section [(a)](1), there is an adequate remedy under the plan which bars a further remedy under Section [(a)](3).

***6** In response, Weissman argues that it is premature to determine whether she can bring claims under both § 1132(a)(1)(B) and § 1132(a)(3). Other circuits that have considered the issue have found that a plaintiff may plead claims under both § 1132(a)(1)(B) and § 1132(a)(3) at the motion to dismiss stage, so long as the plaintiff does not actually recover under both theories. This Court recently found that it is inappropriate to dismiss a complaint that brings claims under both § 1132(a)(1)(B) and § 1132(a)(3) as duplicative because plaintiffs can bring claims under both sections even though plaintiffs cannot recover under both provisions. In this case, however, where the complaint only seeks relief under § 1132(a)(3) and makes no mention of § 1132(a)(1)(B), Weissman's argument that she may seek relief under both statutes is inapposite.

> Here, Weissman seeks a disgorgement of any profits that the Defendants made by wrongfully denying coverage, and she also seeks an injunction compelling UnitedHealthcare to (1) provide coverage for proton beam therapy, (2) provide notice to plan members of that coverage, and (3) re-evaluate all prior authorization requests for coverage for proton beam therapy. Because the complaint seeks relief that is generally available under § 1132(a)(1)(B), it must be dismissed because it has inappropriately repackaged a request for relief under § 1132(a)(1)(B) as an action under § 1132(a)(3).

[ECF No. 36 at 11–13 (alterations in original) (citations and internal quotation marks omitted)]. Additionally, the Court noted that Ms. Weissman's "complaint inappropriately seeks *only* relief under 29 U.S.C. § 1132(a)(3)." [Id. at 16 (emphasis added)].

Contrary to Defendants' assertion, the problem with Ms. Weissman's initial complaint was not that her § 1132(a)(3) claim was deficient as a matter of law but rather that bringing a standalone § 1132(a)(3) claim, where § 1132(a)(1)(B) might provide an adequate remedy, is inappropriate. In other words, an ERISA plaintiff cannot eschew the statute's preferred enforcement mechanism, § 1132(a)(1)(B), for its catch-all provision, § 1132(a)(3), by electing to forgo a § 1132(a)(1)(B) claim. The amended complaint remedies that problem by asserting claims under both § 1132(a)(3) and § 1132(a)(1)(B). Although Defendants are correct that Plaintiffs will not be permitted to ultimately recover under § 1132(a)(3) if § 1132(a)(1)(B) provides an adequate remedy, for the reasons noted in the March 2020 Order, the Court need not dismiss the § 1132(a)(3) claim at this stage merely because it may turn out to be duplicative. Accordingly, the March 2020 Order does not foreclose Plaintiffs' breach of fiduciary duty claim.[3]

### 2. Plaintiffs Have Not Alleged a Breach of Fiduciary Duty Based Solely on the Adoption of the PBRT Policy

Defendants next argue that Plaintiffs cannot challenge UnitedHealthcare's PBRT Policy because the establishment of a clinical coverage policy used for interpreting plan terms is not a fiduciary act under ERISA. [ECF No. 47 at 13–14; ECF

No. 54 at 10–11]. Plaintiffs maintain that they are not challenging UnitedHealthcare's mere establishment of the PBRT Policy but rather its application of the policy to their claims. [ECF No. 50 at 11–14].

***7** As the Court noted in the March 2020 Order, Defendants are correct that Plaintiffs cannot assert that UnitedHealthcare's establishment of the PBRT Policy is, itself, a breach of fiduciary duty under ERISA. See [ECF No. 36 at 9–11]. The Court, however, does not understand the amended complaint to be advancing a theory based only on the creation of the PBRT Policy. Plaintiffs allege that UnitedHealthcare breached its fiduciary duties by denying their requests for pre-authorization for PBRT treatment based on the PBRT Policy and the Experimental Exclusion. [Am. Compl. ¶ 146 ("UnitedHealthcare violated these duties by adopting, implementing, and *applying* a policy to deny coverage for PBRT based on the Experimental Exclusion under its Plans ..." (emphasis added)); id. ¶ 124 ("By drafting, implementing, and *applying* its PBRT Policy, UnitedHealthcare sacrificed the interests of insureds like Plaintiffs ..." (emphasis added))]. Plaintiffs do not object to the PBRT Policy's mere existence but rather to UnitedHealthcare's reliance on it in denying coverage for PBRT treatment.

**B. Denial of Benefits**

As noted above, Plaintiffs allege that UnitedHealthcare improperly denied them benefits to which they were entitled and seek an award reimbursing them for the cost of their PBRT treatment under § 1132(a)(1)(B). [Am. Compl. ¶¶ 154–61; id. at 43–44]. Defendants make two arguments as to why Plaintiffs' denial of benefits claim should be dismissed. For the reasons discussed below, each is unpersuasive, and Defendants' motion to dismiss Plaintiffs' denial of benefits claim, [ECF No. 46], is therefore DENIED.

1. Plaintiffs Have Adequately Alleged that the Exclusions Do Not Apply

Defendants argue that Plaintiffs have failed to plausibly allege that both potentially applicable coverage exclusions are inapplicable. [ECF No. 47 at 14–19; ECF No. 54 at 12–16]. Plaintiffs maintain that their allegations on this issue are sufficient to withstand a motion to dismiss. [ECF No. 50 at 14–18].

As an initial matter, by focusing on exclusions, Defendants seem to concede that PBRT was "medically necessary" for each plaintiff. See [ECF No. 47 at 14–19 (focusing exclusively on exclusions); ECF No. 54 at 12–16]. Additionally, Plaintiffs appear to accept that it is their burden to plead facts suggesting that the exclusions are inapplicable. See [ECF No. 50 at 14–18 (focusing on sufficiency of allegations and not challenging Defendants' statement concerning burden)]. Accordingly, the question before the Court is whether Plaintiffs' denial of benefits claim is viable in light of the potentially applicable exclusions and Plaintiffs' factual allegations regarding those exclusions.

The first potentially applicable exclusion is the Experimental Exclusion, which excludes coverage if the healthcare service in question is determined to be: (1) not approved by the FDA; (2) subject to review and approval by any institutional review board; or (3) the subject of an ongoing clinical trial. [Am. Compl. ¶¶ 28, 32, 36]. Defendants admit that Plaintiffs have adequately alleged that the FDA approved PBRT in 1988, [ECF No. 47 at 16], but argue that Plaintiffs have failed to plead facts suggesting that PBRT does not fall into the exclusion's other two categories, [id. at 16–19].

The second potentially applicable exclusion is the unproven services exclusion, which exempts from coverage "services ... that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature." [Am. Compl. ¶ 53]. Defendants assert that Plaintiffs have pointed to no specific clinical evidence from controlled trials or cohort studies in peer-reviewed medical literature evidencing that PBRT is medically effective. [ECF No. 47 at 17–18].

Given Plaintiffs' burden at the motion to dismiss stage, see supra, Section II, their allegations are sufficient to survive a

motion to dismiss. Specifically, Plaintiffs allege that, among other things:

***8** • Medicare and Medicaid cover PBRT, [Am. Compl. ¶ 39];

• PBRT has been used to treat cancer since the 1950s, [id. ¶ 41];

• The National Association for Proton Therapy, the Alliance for Proton Therapy Access, and other medical organizations and studies have validated the safety and effectiveness of PBRT, [id.];

• Multiple cancer facilities and providers, including Baptist Hospital's Miami Cancer Institute, the MD Anderson Cancer Center, Loma Linda University, the University of Florida, the University of Maryland, Northwestern University, the Mayo Clinic, Emory University, Case Western Reserve University, Washington University in St. Louis, the University of Washington, the New York Proton Center, and the Texas Center for Proton Therapy regularly recommend and use PBRT, [id.];

• UnitedHealthcare covers PBRT for individuals younger than nineteen, [id. ¶ 43];

• One of UnitedHealthcare's affiliates recently pledged over $15 million to construct and operate a proton center in New York City, [id. ¶ 57];

• Ms. Weissman's medical team considered PBRT to be her best option and did not consider it to be experimental or investigational, [id. ¶¶ 63, 67, 73];

• Mr. Cole's doctor believed PBRT would be more effective than IMRT and did not consider it to be experimental, [id. ¶¶ 81, 92]; and

• Mr. Rizzuto's doctors considered PBRT to be his best option and did not consider it to be experimental, [id. ¶¶ 101–02, 105–06].

Taking these factual allegations together, see Hernandez-Cuevas, 723 F.3d at 103, drawing on its experience and common sense, see Grajales, 682 F.3d at 44, and making all reasonable factual inferences in Plaintiffs' favor, see Gilbert, 915 F.3d at 80, the Court concludes that Plaintiffs have plausibly alleged that PBRT is not subject to either of the two asserted exclusions.

As to the Experimental Exclusion, based on the factual allegations, the Court can reasonably infer that PBRT, at least insofar as it is used to treat Plaintiffs' specific conditions, was not being reviewed by an institutional review board or the subject of an ongoing clinical trial because if either were pending, Plaintiffs' doctors specifically, and the medical community more generally, would not have characterized PBRT as safe.

As to the unproven services exclusion, the Court can reasonably infer that PBRT, at least to the extent it is used to treat Plaintiffs' conditions, is effective because otherwise Plaintiffs' doctors would not have recommended it to their patients and renowned medical organizations and cancer treatment centers would not trumpet its effectiveness and recommend its use. Whether the exclusions are, in fact, applicable is a question for a later day but because Plaintiffs' factual allegations allow a reasonable inference that the PBRT is not barred by either exception, they have put forth enough to survive a motion to dismiss.[4] See Twombly, 550 U.S. at 570.

2. Plaintiffs Have Adequately Alleged that the Denial Was Arbitrary and Capricious

***9** Defendants argue that Plaintiffs have failed to plausibly allege that the benefit determinations at issue were arbitrary and capricious. [ECF No. 47 at 19–22; ECF No. 54 at 16–17]. Plaintiffs maintain that their allegations are sufficient at this stage. [ECF No. 50 at 18–20].

Plaintiffs specifically allege that UnitedHealthcare had discretion to interpret plans and make benefit determinations, see [Am. Compl. ¶¶ 22, 24, 29, 33], and seem to concede that the arbitrary and capricious standard is appropriate, see [ECF No. 50 at 18–20 (focusing on sufficiency of factual allegations and not challenging Defendants' statement of the proper standard)]. Accordingly, the question before the Court is whether Plaintiffs have plausibly alleged that

UnitedHealthcare's denial of their benefits was arbitrary and capricious.

Given Plaintiffs' burden at the motion to dismiss stage, see supra, Section II, they have alleged enough to withstand a motion to dismiss. Specifically, Plaintiffs allege the following facts, among others:

- UnitedHealthcare covers PBRT for those younger than nineteen but not those older than nineteen despite a lack of medical studies supporting such an age-based distinction, [Am. Compl. ¶ 43];
- The PBRT Policy is based on out-of-date scientific literature and is infrequently updated, [id. ¶ 44];
- UnitedHealthcare issued the New PBRT Policy but did not cite any significant clinical developments indicating why the policy was changed, [id. ¶ 46];
- UnitedHealthcare failed to address the information that Mr. Cole's doctor provided concerning PBRT's safety and efficacy, [id. ¶ 93];
- UnitedHealthcare's denial of Mr. Rizzuto's request for pre-authorization was ambiguous and unspecific, [id. ¶ 104];
- The medical directors who reviewed Mr. Rizzuto's appeals were specialists in family medicine and internal medicine, not oncology, [id. ¶¶ 107, 109]; and
- The individual handling Mr. Rizzuto's appeal failed to discuss the evidence and literature that Mrs. Rizzuto cited in her letter, [id. ¶ 115].

Taking these factual allegations together, see Hernandez-Cuevas, 723 F.3d at 103, drawing on its experience and common sense, see Grajales, 682 F.3d at 44, and making all reasonable factual inferences in Plaintiffs' favor, see Gilbert, 915 F.3d at 80, the Court concludes that Plaintiffs have plausibly alleged that Defendants acted arbitrarily and capriciously. Defendants emphasize that Plaintiffs themselves allege that both UnitedHealthcare's physicians and external review organizations reviewed Plaintiffs' requests, see [ECF No. 47 at 19–21], and note the fact that portions of the PBRT Policy support UnitedHealthcare's coverage determinations, see [id. at 21–22]. These allegations and facts, however, do not render Plaintiffs' claim implausible as a matter of law. Although the facts advanced by Defendants may carry the day at summary judgment, the question before the Court now is not whether UnitedHealthcare's coverage determinations were, in fact, arbitrary and capricious, but rather whether Plaintiffs have alleged facts sufficient to make out a plausible claim for relief. See Twombly, 550 U.S. at 570. They have met that burden.

**C. Available Relief**

Defendants make two additional arguments regarding the relief that Plaintiffs seek. First, they argue that the Court should dismiss Plaintiffs' request for an accounting and disgorgement of profits because Plaintiffs have failed to allege facts showing they are entitled to such relief. [ECF No. 47 at 22–23; ECF No. 54 at 17–19]. Second, they argue that the Court should reject Plaintiffs' request for prospective injunctive relief because Plaintiffs have not alleged facts showing that they have standing to seek prospective injunctive relief. [ECF No. 47 at 23–24; ECF No. 54 at 19–21]. Plaintiffs maintain that the Court should not limit their potential relief at this stage of the litigation and that ERISA explicitly gives plaintiffs a right to seek a court order ensuring that a policy is applied correctly prospectively. [ECF No. 50 at 21–25].

***10** With respect to accounting and disgorgement, as noted supra, Section III.A.1, on the record before it, the Court cannot determine whether Plaintiffs' remedy under § 1132(a)(1)(B) would be adequate and, at this point in the proceedings, the Court is not prepared to foreclose the availability of an accounting and/or disgorgement. See N.Y. State Psychiatric Ass'n, Inc., 798 F.3d 125, 134 (2d Cir. 2015) (reversing district court's dismissal of § 1132(a)(3) claim and noting that if plaintiff prevailed on remand, the district court should then determine whether equitable relief is appropriate). Notwithstanding Defendants' arguments to the contrary, Plaintiffs have alleged more than just that their requests for pre-authorization for PBRT were arbitrarily and capriciously denied. Rather, they have alleged that UnitedHealthcare has developed and applied the PBRT Policy to broadly deny coverage for PBRT, even though it is safe and effective, because it is more expensive than IMRT. [Am. Compl. ¶¶ 118–

24]. If these allegations are borne out, § 1132(a)(1)(B)'s remedy of repayment of benefits may turn out to be inadequate, and it would therefore be premature to foreclose the possibility of equitable relief, including an accounting and disgorgement, at this time. See Ehrman v. Standard Ins. Co., No. 06-cv-05454, 2007 WL 1288465, at *4–5 (N.D. Cal. May 2, 2007) (declining, at the motion to dismiss stage, to foreclose the plaintiff from obtaining equitable relief, in addition to relief under § 1132(a)(1)(B), where he alleged that the defendant adopted a "biased claim practice" "designed to increase [its] financial profitability").

Further, even if Plaintiffs can ultimately prove only that UnitedHealthcare breached its fiduciary duty by impermissibly denying their benefits, it is possible that relief under § 1132(a)(1)(B) would still be insufficient. In other words, it is conceivable that even past due benefits, prejudgment interest, and attorneys' fees may not put Plaintiffs in the position they would have been in but for UnitedHealthcare's alleged misconduct. See Mullin v. Scottsdale Healthcare Corp. Long Term Disability Plan, No. 15-cv-01547, 2016 WL 107838, at *4 (D. Ariz. Jan. 11, 2016) (noting that "retroactive reinstatement of benefits does not account for [all] financial harms," that it was "conceivable that past due benefits, prejudgment interest, and attorneys' fees w[ould] be inadequate to put [plaintiff] in the position she would have been in but for [defendant]'s alleged fiduciary misconduct," and that "at the pleading stage ... without factual development, the [c]ourt c[ould not] determine whether [plaintiff]'s financial harm exceeds the relief available to her under § 1132(a)(1)(B)"). Accordingly, at this juncture, the Court will not foreclose the possibility of an accounting and/or disgorgement under § 1132(a)(3).

With respect to prospective injunctive relief, the Court is similarly unprepared to restrict Plaintiffs' potential relief at the motion to dismiss stage. If Plaintiffs prevail, the parties can dispute the availability of prospective injunctive relief. At this point, however, the Court declines to speculate as to whether a given plaintiff's cancer will recur and/or whether he or she will be a plan participant in the future. Further, given that this is a putative class action and the proposed class includes "[a]ll persons ... whose requests for PBRT will be denied in the future," [Am. Compl. ¶ 126], the availability of prospective injunctive relief may not depend solely on Ms. Weissman, Mr. Cole, and Mr. Rizzuto. Finally, the recent Supreme Court case upon which Defendants rely, Thole v. U.S. Bank N.A., does not compel a different result. That case stands for the proposition that plaintiffs lack standing where they "have no concrete stake in t[he] lawsuit." 140 S. Ct. 1615, 1619 (2020). Here, Plaintiffs have a concrete stake in this lawsuit, and if they prevail, the Court can then decide whether the prospective injunction that Plaintiffs seek is an available and appropriate remedy to redress their injury.

## IV. CONCLUSION

Accordingly, for the reasons set forth above, Defendants' motion to dismiss, [ECF No. 46], is DENIED.

**SO ORDERED.**

### All Citations

Not Reported in Fed. Supp., 2021 WL 858436, 2021 Employee Benefits Cas. 83,259

  

## Footnotes

[1] Excluded from the putative class are:

> (a) Defendant, including any entity or division in which Defendant has a controlling interest, as well as its agents, representatives, officers, directors, employees, trustees, and other entities related to, or affiliated with Defendant, (b) Class Counsel, and (c) the Judge to whom this case is assigned and any members of the Judge's staff or immediate family.

[Am. Compl. ¶ 127].

[2] In connection with both counts, Plaintiffs seek pre- and post-judgment interest as well as attorneys' fees. [Am. Compl. at 44].

[3] The parties dispute the applicability of the law-of-the-case doctrine as to the March 2020 Order, noting, among other things, that Messrs. Cole and Rizzuto were not parties to the litigation when the Court made its ruling. See [ECF No. 47 at 11–12; ECF No. 50 at 9, 9 n.1; ECF No. 54 at 8, 8 n.1]. The Court need not decide whether any exceptions apply or whether the law-of-the-case doctrine binds non-parties whose claims have since been consolidated because the Court did not, in fact, find that Plaintiffs' § 1132(a)(3) claim was legally deficient.

[4] Defendants argue that, at a minimum, the Court should "dismiss the Amended Complaint to the extent Plaintiffs assert claims for coverage of PBRT for conditions other than cervical, prostate, and brain cancer." [ECF No. 47 at 18–19]. In essence, Defendants are seeking to limit the putative class to those individuals with the particular types of cancer that Plaintiffs had. The First Circuit has directed district courts to "exercise caution when striking class action allegations based solely on the pleadings." Manning v. Bos. Med. Ctr. Corp., 725 F.3d 34, 59 (1st Cir. 2013). Accordingly, Defendants' arguments are better addressed during the class certification process should Plaintiffs move for class certification in the future. See O'Leary v. N.H. Boring, Inc., 176 F. Supp. 3d 4, 13 (D. Mass. 2016).