Case Nos. 85525 & 85656

In the Supreme Court of Nevada

UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTH CARE SERVICES, INC.; UMR, INC.; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; and HEALTH PLAN OF NEVADA, INC., Appellants, *vs.* FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; and CRUM STEFANKO AND JONES, LTD., Respondents.	Case No. 85525
UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTH CARE SERVICES, INC.; UMR, INC.; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; and HEALTH PLAN OF NEVADA, INC., Petitioners, *vs.* THE EIGHTH JUDICIAL DISTRICT COURT of the State of Nevada, in and for the County of Clark; and the Honorable NANCY L. ALLF, District Judge, Respondents, *vs.* FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; and CRUM STEFANKO AND JONES, LTD., Real Parties in Interest.	Case No. 85656

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148	Second Amended Complaint	10/07/21	21 22	5246–5250 5251–5264
458	Second Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits (Filed Under Seal)	01/05/22	126 127	31,309–31,393 31,394–31,500
231	Special Verdict Form	11/16/21	41	10,169–10,197
257	Special Verdict Form	11/29/21	49	12,035–12,046
265	Special Verdict Form	12/07/21	49	12,150–12,152
6	Summons – Health Plan of Nevada, Inc.	04/30/19	1	29–31
9	Summons – Oxford Health Plans, Inc.	05/06/19	1	38–41
8	Summons – Sierra Health and Life Insurance Company, Inc.	04/30/19	1	35–37
7	Summons – Sierra Health-Care Options, Inc.	04/30/19	1	32–34
3	Summons - UMR, Inc. dba United Medical Resources	04/25/19	1	20–22
4	Summons – United Health Care Services Inc. dba UnitedHealthcare	04/25/19	1	23–25
5	Summons – United Healthcare Insurance Company	04/25/19	1	26–28
433	Supplement to Defendants' Motion to Seal Certain Confidential Trial Exhibits (Filed	12/08/21	110 111	27,383–27,393 27,394–27,400

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170	Supplement to Defendants' Objection to Media Requests	10/31/21	29	7019–7039
439	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 1 of 18 (Filed Under Seal)	12/24/21	114	28,189–28,290
440	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 2 of 18 (Filed Under Seal)	12/24/21	114 115	28,291–28,393 28,394–28,484
441	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 3 of 18 (Filed Under Seal)	12/24/21	115 116	28,485–28,643 28,644–28,742
442	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 4 of 18 (Filed Under Seal)	12/24/21	116 117	28,743–28,893 28,894–28,938
443	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 5 of 18 (Filed Under Seal)	12/24/21	117	28,939–29,084
444	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 6 of 18 (Filed Under Seal)	12/24/21	117 118	29,085–29,143 29,144–29,219
445	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 7 of 18 (Filed Under Seal)	12/24/21	118	29,220–29,384
446	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 8 of 18 (Filed Under Seal)	12/24/21	118 119	29,385–29,393 29,394–29,527
447	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 9 of 18 (Filed Under Seal)	12/24/21	119 120	29,528–29,643 29,644–29,727
448	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial	12/24/21	120 121	29,728–29,893 29,894–29,907

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	Exhibits – Volume 10 of 18 (Filed Under Seal)			
449	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 11 of 18 (Filed Under Seal)	12/24/21	121	29,908–30,051
450	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 12 of 18 (Filed Under Seal)	12/24/21	121 122	30,052–30,143 30,144–30,297
451	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 13 of 18 (Filed Under Seal)	12/24/21	122 123	30,298–30,393 30,394–30,516
452	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 14 of 18 (Filed Under Seal)	12/24/21	123 124	30,517–30,643 30,644–30,677
453	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 15 of 18 (Filed Under Seal)	12/24/21	124	30,678–30,835
454	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 16 of 18 (Filed Under Seal)	12/24/21	124 125	30,836–30,893 30,894–30,952
455	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 17 of 18 (Filed Under Seal)	12/24/21	125	30,953–31,122
456	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 18 of 18 (Filed Under	12/24/21	125 126	30,123–31,143 31,144–31,258

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466	Transcript of Proceedings re Hearing Regarding Unsealing Record (Filed Under Seal)	10/05/22	129	31,923–31,943
350	Transcript of Proceedings re Status Check	10/10/22	72 73	17,994–18,000 18,001–18,004
467	Transcript of Proceedings re Status Check (Filed Under Seal)	10/06/22	129	31,944–31,953
157	Transcript of Proceedings Re: Motions	10/19/21	22 23	5339–5500 5501–5561
160	Transcript of Proceedings Re: Motions	10/22/21	24 25	5908–6000 6001–6115
459	Transcript of Proceedings Re: Motions (Filed Under Seal)	01/12/22	127	31,501–31,596
460	Transcript of Proceedings Re: Motions (Filed Under Seal)	01/20/22	127 128	31,597–31,643 31,644–31,650
461	Transcript of Proceedings Re: Motions (Filed Under Seal)	01/27/22	128	31,651–31,661
146	Transcript of Proceedings Re: Motions (Via Blue Jeans)	10/06/21	21	5202–5234
290	Transcript of Proceedings Re: Motions Hearing	02/17/22	53	13,098–13,160
319	Transcript of Proceedings Re: Motions Hearing	04/07/22	68	16,837–16,855
323	Transcript of Proceedings Re: Motions Hearing	04/21/22	69	17,102–17,113
336	Transcript of Proceedings Re: Motions Hearing	06/29/22	71	17,610–17,681
463	Transcript of Proceedings Re: Motions Hearing (Filed Under Seal)	02/10/22	128	31,673–31,793

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464	Transcript of Proceedings Re: Motions Hearing (Filed Under Seal)	02/16/22	128	31,794–31,887
38	Transcript of Proceedings, All Pending Motions	06/05/20	6	1350–1384
39	Transcript of Proceedings, All Pending Motions	06/09/20	6	1385–1471
46	Transcript of Proceedings, Plaintiff's Motion to Compel Defendants' Production of Unredacted MultiPlan, Inc. Agreement	07/29/20	7	1644–1663
482	Transcript of Status Check (Filed Under Seal)	10/10/22	142	35,248–35,258
492	Transcript Re: Proposed Jury Instructions	11/21/21	146	36,086–36,250
425	Trial Brief Regarding Evidence and Argument Relating to Out-of-State Harms to Non-Parties (Filed Under Seal)	10/31/21	109	26,953–26,964
232	Trial Brief Regarding Jury Instructions on Formation of an Implied-In-Fact Contract	11/16/21	41	10,198–10,231
233	Trial Brief Regarding Jury Instructions on Unjust Enrichment	11/16/21	41	10,232–10,248
484	Trial Exhibit D5499 (Filed Under Seal)		142 143	35,264–35,393 35,394–35,445
362	Trial Exhibit D5502		76 77	18,856–19,000 19,001–19,143
485	Trial Exhibit D5506 (Filed Under Seal)		143	35,446
372	United's Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time (Filed Under Seal)	06/24/21	82	20,266–20,290
112	United's Reply in Support of Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified	07/12/21	18	4326–4340

Tab	Document	Date	Vol.	Pages
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258	Verdict(s) Submitted to Jury but Returned Unsigned	11/29/21	49	12,047–12,048

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I certify that on April 18, 2023, I submitted the foregoing appendix for filing *via* the Court's eFlex electronic filing system.

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Unjust Enrichment Instructions

Instruction No. ___

Plaintiffs may recover the reasonable value of a direct or indirect benefit conferred on defendants if defendants knew of the benefit conferred and accepted the benefit, and retention of the benefit is unjust without paying its reasonable value. This is called "unjust enrichment."

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NEV. J.I. 13.12 (2018) (modified); *Topaz Mut. Co. v. Marsh*, 108 Nev. 845, 856, 839 P.2d 606, 613 (1992); *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 283 P.3d 250, 256 (2012) (a claim for relief relating to unjust enrichment where a contract is implied in law is based on a benefit conferred which is unjustly retained without payment of the reasonable value); *Nevada Industrial Dev. v. Benedetti*, 103 Nev. 360, 363 n. 2, 741 P.2d 802, 804 n. 2 (1987); *Unionamerica Mortg. & Equity Tr. v. McDonald*, 97 Nev. 210, 212, 626 P.2d 1272, 1273 (1981) ("'The essential elements of quasi contract are a benefit conferred on the defendant by the plaintiff, appreciation by the defendant of such benefit, and acceptance and retention by the defendant of such benefit under circumstances such that it would be inequitable for him to retain the benefit without payment of the value thereof.' *Dass v. Epplen*, 162 Colo. 60, 424 P.2d 779, 780 (1967).").

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Instruction No. ___

In determining the measure of damages in a claim of unjust enrichment, the focus is on the reasonable value of the services by which the defendant would be unjustly enriched.

Certified Fire Prot. Inc. v. Precision Constr., 128 Nev. 371, 381, 283 P.3d 250, 257 (2012); *Fairbanks N. Star Borough v. Tundra Tours, Inc.*, 719 P.2d 1020, 1029 n. 15 (Ala. 1986).

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Contracts Instructions

Instruction No. ___

A contract may be implied as well as expressed. For an implied contract, the existence and terms of the contract are inferred from the conduct of the parties, but both an express and implied contract require a manifestation by the parties of an intent to contract and an ascertainable agreement.

Even if the parties did not agree on a price term, you may find the parties formed an implied contract if the parties' general obligations are otherwise sufficiently clear. In that case, you may find that the contract includes an agreement to pay a reasonable price.

In Nevada, implied-in-fact contracts and express contracts stand on equal footing.

NEV. J.I. 13.11 (2018); *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 380, 283 P.3d 250, 256 (2012); *Smith v. Recrion Corp.*, 91 Nev. 666, 668, 541 P.2d 663, 665 (1975); *Magnum Opes Const. v. Sanpete Steel Corp.*, 2013 WL 7158997 (Nev. Nov. 1, 2013) (quoting 1 Williston on Contracts § 1:5 (4th ed. 2007) (noting that the legal effects of express and implied-in-fact contracts are identical); *Cashill v. Second Judicial Dist. Court of State ex rel. Cty. of Washoe*, 128 Nev. 887, 381 P.3d 600 (2012) (unpublished) ("The distinction between express and implied in fact contracts relates only to the manifestation of assent; both types are based upon the expressed or apparent intention of the parties.").

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Instruction No. ___

Parties to a contract may modify the contract, but all parties to the contract must agree to the new terms. In order for a modification to be valid, both parties must receive additional consideration. Consideration may include performance, an act, a promise not to act, or a return promise.

To prove modification, there must be clear and convincing evidence of:

1. A written or oral agreement of the parties to modify the contract; or

2. Conduct of the parties that recognizes the modification, such as a course of performance that reflects the modification; or

3. Other evidence sufficient to show the parties' agreement to modify their contract, such as acquiescence in conduct that is consistent with the modification and a failure to demand adherence to the original contract terms.

NEV. J. I. 13.15 (2018) (modified to omit sentence addressing modification of written contracts and to add discussion of consideration); *Ins. Co. of the West v. Gibson Tile Co.*, 122 Nev. 455, 464, 134 P.3d 698, 703 (2006) (contract modification requires additional consideration); *Jones v. SunTrust Mortgage, Inc.*, 274 P.3d 762, 764, 128 Nev. 188, 191 (2012) ("Consideration is the exchange of a promise or performance, bargained for by the parties."); RESTATEMENT (SECOND) OF CONTRACTS § 71 (1973) (consideration includes a performance or return promise; performance may consist of an act other than a promise, a forbearance, or the creation, modification, or destruction of a legal relation).

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Instruction No. ___

The measure of damages for a breach of contract is the amount that will reasonably compensate an injured party for all the detriment, harm or loss flowing from the breach and which was reasonably foreseeable (that is, which might have been reasonably contemplated by the parties) as the probable result of the breach when the contract was made.

NEV. J.I. 13.45 (2018) (revised to exclude consequential damages).

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Instruction No. ___

A party seeking damages has the burden of proving both that it did, in fact, suffer injury and the amount of damages that resulted from that injury. The amount of damages need not be proved with mathematical exactitude, but the party seeking damages must provide an evidentiary basis for determining a reasonably accurate amount of damages. There is no requirement that absolute certainty be achieved; once evidence establishes that the party seeking damages did, in fact, suffer injury, some uncertainty as to the amount of damages is permissible. However, even if it is provided by an expert, testimony that constitutes speculation not supported by evidence is not sufficient to provide the required evidentiary basis for determining a reasonably accurate award of damage.

NEV. J.I. 13.47 (2018) (modified to replace "they did" with "it did").

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Unfair Insurance Practices Instructions

Instruction No. ___

Nevada's Unfair Insurance Practices Act prohibits any person in the insurance business from engaging in activities which constitute an unfair or deceptive act or practice. In order to establish a claim for breach of the Nevada Unfair Insurance Practices Act, plaintiff must prove:

1. That defendant violated a provision of the Nevada Unfair Insurance Practices Act; and
2. The violation was a substantial factor in causing plaintiff's damages.

NEV. J.I. 11.20 (2018).

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Instruction No. ___

The following activity is considered to be an unfair insurance practice: Failing to effectuate prompt, fair, and equitable settlements of claims in which liability of the defendant has become reasonably clear.

Nev. J.I. 11.21 (2018) (modified).

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Instruction No. ___

The measure of damages for unfair insurance practices is the difference between the amount defendant would have paid plaintiff if it had not engaged in the unfair insurance practice(s) and the amount, if any, defendant has already paid plaintiff.

See N.R.S. § 686A.310(2).

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Prompt Pay Instruction

Instruction No. ___

To succeed in a claim under the Prompt Pay statutes, plaintiff must show that defendant failed to fully pay, within 30 days of submission of the claim, a claim that was approved and fully payable.

See N.R.S. 683A.0879(4) (third party administrator); N.R.S. 689A.410 (individual health insurance); N.R.S. 689B.255 (group and blanket health insurance); N.R.S. 689C.485 (Health Insurance for Small Employers); and N.R.S. 695C.185 (HMOs).

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Punitive Damages (Part I) Instruction

Instruction No. ___

If you find that plaintiffs suffered damages as a result of the defendants' unjust enrichment, if any, or because of the defendants' unfair insurance practices, if any, and you have found defendants liable for such claim(s), you may then consider whether you should award punitive or exemplary damages against those defendants. Punitive or exemplary damages are to make an example of or punish wrongful conduct. You have discretion to award such damages, only if you find by clear and convincing evidence that defendant was guilty of fraud, oppression, malice, or bad faith in the conduct providing your basis for liability.

"Malice" means conduct which is intended to injure a person or despicable conduct which is engaged in with a conscious disregard of the rights or safety of others.

"Oppression" means despicable conduct that subjects a person to cruel and unjust hardship with conscious disregard of the rights of that person.

"Fraud" means an intentional misrepresentation, deception or concealment of a material fact known to a defendant with the intention to injure or deprive a person of rights or property.

"Bad faith" means that the defendant had no reasonable basis for disputing the claim; and the defendant knew or recklessly disregarded the fact that there was no reasonable basis for disputing the claim.

"Conscious disregard" means knowledge of the probable harmful consequences of a wrongful act and a willful and deliberate failure to avoid these consequences.

NEV. J.I. 12.1 (2018) (first part; modified to include bad faith); NRS 42.005; *Powers v. United Services Auto. Ass'n*, 114 Nev. 690, 702–03, 962 P.2d 596 (1998).

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Punitive Damages (Part II) Instruction

Instruction No. ___

The law provides no fixed standards as to the amount of punitive damages, but leaves the amount to the jury's sound discretion, exercised without passion or prejudice. In arriving at any award of punitive damages, you are to consider the following:

1. The reprehensibility of the conduct of defendant;
2. The amount of punitive damages which will serve the purposes of punishment and deterrence, taking into account the defendants' financial condition.

NEV. J.I. 12.1 (2018) (second part).

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of Ahmad, Zavitsanos, Anaipakos, Alavi and Mensing, P.C. and on this 15th day of November, 2021, I caused a true and correct copy of the foregoing **PLAINTIFFS' PROPOSED JURY INSTRUCTIONS (CONTESTED)** Filing system in the above-captioned case, upon the following:

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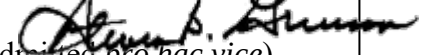

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DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,

Plaintiffs,

vs.

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

Defendants.

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

PLAINTIFFS' TRIAL BRIEF REGARDING PUNITIVE DAMAGES FOR UNJUST ENRICHMENT CLAIM

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Fremont Emergency Services (Mandavia), Ltd.; Team Physicians of Nevada-Mandavia, P.C.; Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine (collectively the "Health Care Providers") submit this Trial Brief Regarding Punitive Damages for Unjust Enrichment Claim (the "Trial Brief"). This Trial Brief is based upon the record in this matter, the points and authorities that follow, the pleadings and papers on file in this action, and any argument of counsel entertained by the Court.

POINTS AND AUTHORITIES

I. RELEVANT FACTS

In its Jury Instructions, United attempts to limit any award of punitive damages to the Health Care Providers' claim under Nevada's Unfair Insurance Practices Act. Specifically, United contends that:

> Each Plaintiff seeks punitive damages against each Defendant only with respect to their claim under Nevada's Unfair Insurance Practices Act. Therefore, if you find that Fremont, Ruby Crest, or Team Physicians suffered damages as a proximate result of a violation of Nevada's Unfair Insurance Practices Act for which UHIC, UnitedHealthcare, UMR, Sierra, or the Health Plan of Nevada is liable you may then consider whether you should award punitive or exemplary damages against only the Defendant or Defendants you have found liable under Nevada's Unfair Insurance Practices Act.

The only limitation to asserting the remedy of punitive damages, is the inapplicable restriction on breach of contract claims. However, United has repeatedly and consistently asserted to this Court that no contract existed between United and the Health Care Providers during the subject time period. *See* Defendants' Motion to Dismiss Plaintiffs' First Amended Complaint at 24:3-4 ("Plaintiffs…[have] no contractual relationship with Defendants"); Defendants' Motion for Partial Summary Judgment at 14:24-15:1 ("Where the third-party payor (here, the six Defendants that adjudicated and allowed payment of benefit claims) and the out-of-network provider (here, TeamHealth Plaintiffs), had no network contract in the 12 months before the date of service, subsection (2) applies."). In all, because punitive damages are sought under the Health Care Providers' claim for unjust enrichment and because such punitive damages are available under an unjust enrichment claim, any instruction to the jury concerning punitive damages should make

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clear that punitive damages can be awarded under the Health Care Providers' claim for unjust enrichment, in addition to their claim for violation of Nevada Unfair Insurance Practices Act in the event the jury finds that United is liable under the unjust enrichment claim.

II. LEGAL ARGUMENT

A. Legal Standard

The Health Care Providers' trial brief is brought pursuant to EDCR 7.27 which provides:

> Unless otherwise ordered by the court, an attorney may elect to submit to the court in any civil case, a trial memoranda of points and authorities at any time prior to the close of trial. The original trial memoranda of points and authorities must be filed and a copy of the memoranda must be served upon opposing counsel at the time of or before submission of the memoranda to the court.

B. Punitive Damages Can Be Awarded for a Claim of Unjust Enrichment.

1. Unjust Enrichment Is Not a Breach of an Obligation Arising from a Contract.

Under NRS 42.005(1), "[e]xcept as otherwise provided in NRS 42.007, in an action for the breach of an obligation not arising from contract, where it is proven by clear and convincing evidence that the defendant has been guilty of oppression, fraud or malice, express or implied, the plaintiff, in addition to the compensatory damages, may recover damages for the sake of example and by way of punishing the defendant." Although the Nevada Supreme Court has held that punitive damages are not available for *breach of contract* claims, no such restriction exists for a claim of unjust enrichment, which, by its terms and United's own arguments throughout the course of this litigation, is not based on a contract. *See Ins. Co. of the West v. Gibson Title Co., Inc.*, 122 Nev. 455, 464, 134 P.3d 698, 703 (2006) ("[T]he award of punitive damages cannot be based upon a cause of action sounding **solely** in contract.") (emphasis added); *see also Peri & Sons Farms, Inc. v. Jain Irr., Inc.*, 933 F. Supp. 2d 1279, 1294 (D. Nev. 2013) ("Punitive damages are not available under Nevada law for contract-based causes of action); *Leasepartners Corp. v. Robert L. Brooks Tr. Dated Nov. 12, 1975*, 113 Nev. 747, 755–56, 942 P.2d 182, 187 (1997) ("[a]n action based on a theory of unjust enrichment is not available when there is an express, written contract, because no agreement can be implied when

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there is an express agreement."). Federal court decisions are in accord. *See e.g. Hester v. Vision Airlines, Inc.*, 687 F.3d 1162 (9th Cir. 2012); *Bavelis v. Doukas*, No. 2:17-CV-00327, 2021 WL 1979078, at *3 (S.D. Ohio May 18, 2021) (affirming punitive damages award based on a theory of unjust enrichment).

In *Hester*, the Ninth Circuit, considering Nevada law, addressed whether a federal district court improperly dismissed a claim for punitive damages where claims of conversion, money had and received and unjust enrichment had been asserted. *Hester v. Vision Airlines, Inc*., 687 F.3d 1162, 1166 (9th Cir. 2012). The Ninth Circuit concluded that the "claims are not based on an action for breach of contract. Thus, the statute allows punitive damages." *Id*. at 1172. It went on to conclude that the federal district court's decision concerning punitive damages should be reversed because the conduct alleged could give rise to punitive damages:

> Likewise, in this case, the Complaint alleges facts that could allow a jury to conclude that Vision engaged in oppression, fraud, or malice when it refused to pay its employees the hazard pay they were due, when it fired those employees to whom it had already paid hazard pay, or when it continued to accept hazard pay monies from upstream contractors for years with no intention of distributing that money.

Id. at 1173. Thus, after determining that unjust enrichment is not a contract claim which would be excluded under NRS 42.005(1), the Court focused on the conduct alleged and whether it could demonstrate the existence of oppression, fraud and malice.

Here, unjust enrichment has been asserted among evidence which will demonstrate United's wrongful conduct. Just as was the case in *Hester*, unjust enrichment is not within the breach of contract exclusion under NRS 42.005 – rather, the focus must be on whether the conduct at issue demonstrates oppression, fraud or malice. United would like this Court to disregard the conduct and simply reach a conclusory decision that unjust enrichment cannot give rise to punitive damages. No such exclusion exists. In the event the jury determines that United is liable for unjust enrichment, this Court should instruct the jury to consider whether the conduct at issue gives rise to punitive damages.

2. <u>The Policy Underlying Unjust Enrichment Claims and NRS 42.005 Supports the Allowance of Punitive Damages.</u>

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Unjust enrichment "is grounded in the theory of restitution, not in contract theory." *Schirmer v. Souza*, 126 Conn. App. 759, 765, 12 A.3d 1048 (2011). "Before 1938, when the United States Supreme Court adopted the Federal Rules of Civil Procedure abolishing the division between law and equity, unjust-enrichment claims, though ascribed different labels, proceeded in both courts of law and equity." *Wright v. Genesee Cty.,* 504 Mich. 410, 420, 934 N.W.2d 805, 811 (2019). "Unjust enrichment has evolved from a category of restitutionary claims with components in law and equity into a unified independent doctrine that serves a unique legal purpose: it corrects for a benefit received by the defendant rather than compensating for the defendant's wrongful behavior. Both the nature of an unjust-enrichment action and its remedy—whether restitution at law or in equity—separate it from tort and contract." *Id*. at 422.

Thus, while some unjust enrichment claims involve an innocent defendant who – through no fault of his own received a benefit from the plaintiff – other unjust enrichment claims involve wrongful, oppressive and intentional conduct from the defendant. *See e.g.* Restatement (Third) of Restitution and Unjust Enrichment § 40 (2011) ("A person who obtains a benefit by an act of trespass or conversion, by comparable interference with other protected interests in tangible property, or in consequence of such an act by another, is liable in restitution to the victim of the wrong."). It is under these latter circumstances that an award of punitive damages is appropriate – and consistent with the policies underlying NRS 42.005(1) which focuses on deterring similar behavior and punishing the defendant for its wrongful conduct. Indeed, the restriction on breach of contract claims under NRS 42.005(1) is because contracting parties can already accomplish these two goals through appropriate drafting. *See Gibson Title*, 122 Nev. at 464, 134 P.3d at 703. Of course, under an unjust enrichment theory, there is no contract and, thus, the underlying policy goals of NRS 42.005(1) would not be served if punitive damages were prohibited for an unjust enrichment claim. *See e.g. Bergerud v. Progressive Cas. Ins.*, 453 F. Supp. 2d 1241, 1251 (D. Nev. 2006) (noting that claims for breach of implied covenant of good faith and fair dealing may also give rise to punitive damages notwithstanding the fact that the existence of a contract is a precondition to such a claim). In all, given these policy goals and the absence of any caselaw prohibiting punitive damages for unjust enrichment in Nevada, an instruction

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allowing for the jury to award punitive damages upon a finding of liability for unjust enrichment is appropriate.

III. CONCLUSION

For the foregoing reasons, the Health Care Providers respectfully request that the Court instruct the jury that, upon a finding of liability for unjust enrichment, they may consider awarding punitive damages to the Health Care Providers.

DATED this 15th day of November, 2021.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and on this 15th day of November, 2021, I caused a true and correct copy of the foregoing **PLAINTIFFS' TRIAL BRIEF REGARDING PUNITIVE DAMAGES FOR UNJUST ENRICHMENT CLAIM** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

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DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIS) LTD., ET AL., Plaintiffs, vs. UNITED HEALTHCARE INSURANCE COMPANY, ET AL., Defendants.	CASE#: A-19-792978-B DEPT. XXVII

BEFORE THE HONORABLE NANCY ALLF
DISTRICT COURT JUDGE
MONDAY, NOVEMBER 15, 2021

RECORDER'S TRANSCRIPT OF JURY TRIAL - DAY 12

APPEARANCES:

For the Plaintiffs: PATRICIA K. LUNDVALL, ESQ.
JOHN ZAVITSANOS, ESQ.
JASON S. MCMANIS, ESQ.
JOSEPH Y. AHMAD, ESQ.
KEVIN LEYENDECKER, ESQ.

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RECORDED BY: BRYNN WHITE, COURT RECORDER

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FOR THE DEFENDANTS	MARKED	RECEIVED
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Las Vegas, Nevada, Monday, November 15, 2021

[Case called at 8:33 a.m.]

[Outside the presence of the jury]

THE MARSHAL: -- in session. The Honorable Judge Allf presiding.

THE COURT: Thanks everyone. Please be seated.

MR. ZAVITSANOS: Good morning, Your Honor.

THE COURT: Good morning.

MR. BLALACK: Good morning, Your Honor.

THE COURT: So I'm calling the case of Fremont v. United. Let's do appearances real quick.

MR. AHMAD: Yes, Your Honor. Joe Ahmad for the Plaintiff healthcare providers.

MS. LUNDVALL: Good morning, Your Honor. Pat Lundvall from McDonald Carano here on behalf of the healthcare providers.

MR. ZAVITSANOS: John Zavitsanos on behalf of the healthcare providers.

MR. LEYENDECKER: Good morning, Your Honor. Kevin Leyendecker.

THE COURT: Thanks everyone. For the Defense, please?

MR. BLALACK: Good morning, Your Honor. Lee Blalack on behalf of the Defendants.

MR. ROBERTS: Good morning, Your Honor. Lee Roberts also on behalf of the Defendants.

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MS. FARJOOD: Good morning, Your Honor. Nadia Farjood on behalf of the Defendants.

MR. GORDON: Morning, Your Honor. Jeff Gordon on behalf of the Defendants.

THE COURT: Okay. Thank you.

MR. ZAVITSANOS: And, Your Honor, we missed one. Mr. McManis also on behalf of the healthcare providers.

THE COURT: Very good. All right, so Juror Number 4, Dereck -- I'm sorry, Zerrick Walker, called in this morning. He's tested positive for COVID. He will not be here. So another one bites the dust.

What do we need to take up before we bring in the jury?

MR. BLALACK: Your Honor, we -- in response to your request at the end of the day Friday, the parties did confer on how are we going to get this trial done before the deadline issue. We've exchanged lists of what we think are the most likely witnesses and time allocations. There are areas of agreement. There are areas of disagreement. We've submitted a -- we exchanged a chart, which we attached to a filing we just made this morning that's responsive to request for our view on this issue. I think there will be a need to argue how this gets resolved to avoid a mistrial.

My preference would be, just on behalf of the Defense, that we do it at a break so -- because every second from here until 4:45 on the 22nd is going to be precious. So that would be in our request, but I think if the Court wants to entertain that now we will.

THE COURT: Not now. I want to do it later because I need to

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read your brief. And also, we have an hour of overtime after 4:45 today. So let's do it at break, and we'll bring in the jury as soon as I see the marshal's face.

MR. BLALACK: Thank you. Should I put Ms. Paradise on the stand, Your Honor?

THE COURT: Please.

MR. ZAVITSANOS: And, Judge, we agree. We don't want to take up jury time, so.

THE COURT: Thank you.

MR. MCMANIS: And, Your Honor, just to preview one thing while we're getting it ready right now. There are some deposition objections for a video that we may play today, so we'll try to handle that at a break this morning.

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THE COURT: Very good. Thank you.

[Pause]

THE MARSHAL: All rise for the jury.

[Jury in at 8:36 a.m.]

THE COURT: Thank you. Please be seated. Good morning, everyone. Happy Monday. Unfortunately, we have lost Juror Number 4, Mr. Walker, due to a health test that he took over the weekend. So we'll be going forward with you guys. And everybody stay safe and healthy please.

Ms. Paradise, you are under the same oath you previously took. There's no reason to re-swear you.

THE WITNESS: Okay.

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REBECCA PARADISE, PLAINTIFFS' WITNESS, PREVIOUSLY SWORN

THE COURT: Thank you. Go ahead, please.

DIRECT EXAMINATION CONTINUED

BY MR. AHMAD:

Q Thank you, Your Honor. Good morning, Ms. Paradise. How are you?

A Good morning. I'm great.

Q Earlier we were talking -- I think Friday we were talking about MultiPlan, and I think we saw a little bit about how they might pay less than the plan requires. My question for you is, have you ever seen a situation where MultiPlan bragged about paying more than the plan required?

A Well I believe when we were talking Friday, there was a bullet that suggested paying something different than the benefit plan. I believe I stated that United would not pay something different than the benefit plan required. I don't know if I would characterize that as bragging.

Q o my question is, does MultiPlan ever brag or indicate that they're going to pay more than the plan required?

A No. MultiPlan does not brag about their payments period.

Q Well did they ever indicate that they will pay more than the plan required?

A There are certain circumstances where you may pay more to comply with either the benefit plan or client direction on a specific claim.

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Q Well that's my question. I'm saying do they ever indicate that they will pay more than the plan requires as opposed to less?

A MultiPlan may pay more given a certain situation either per the benefit plan direction or direction from the client to do so.

Q Okay. Let me just ask you. Have you ever seen any presentations by them where they say they'll pay more?

A The point of the presentations typically are explaining their offerings, what the methodologies are. The presentations typically aren't about, or I haven't seen a presentation where they're bragging about paying more or less than the benefit plan.

Q Okay. Well we saw something Friday indicating that they would pay less.

A I understand that document. There was a bullet on a presentation. Simply because MultiPlan put something in writing on a presentation, does not mean that that was executed. I can say confidently, United would not implement something that did not align with our client's instructions on the benefit plan.

Q How does that work, right? Because MultiPlan would pride something through Data iSight, right? And they would come up with that as the allowed amount, right?

A When we use MultiPlan for services, they provide recommendation. That price or that recommendation is sent back to United. The claim goes on for further claim adjudication. So to be clear, MultiPlan isn't specifically pricing or adjudicating our clients.

Q Well, but does MultiPlan tell the member what they're going

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to pay?

A No. That's a function of United Healthcare and the benefit plan.

Q Okay. So -- and by the way, if a member had an issue, whether it comes from MultiPlan or whoever, if they have an issue with how much is being paid on a claim, is that something you get involved in?

A I don't personally get involved in, but the member would call their benefit plan and speak to somebody within United Healthcare to understand their benefit coverage and how that claim was adjudicated.

Q And -- but typically, you don't get involved in that?

A I very rarely will get involved in a particular dispute. What I will be clear about is my team does not engage directly with members or providers. We are administering programs. Our frontline provider or member services would be speaking directly to external constituents.

Q Okay. Can you look at Exhibit 218?

A Do you mind if get up and --

Q And we can take it down for that.

A Do you mind if I get up?

Q Yes, of course.

THE COURT: What was the number?

MR. AHMAD: I beg your pardon, Your Honor?

THE COURT: What was the number?

MR. AHMAD: 218, Your Honor.

THE COURT: Thank you.

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MR. AHMAD: Plaintiff's Exhibit 218. Is there any objection?

MR. BLALACK: No objection.

MR. AHMAD: Your Honor, I'll move for the admission.

THE COURT: Exhibit 218 will be admitted.

[Plaintiffs' Exhibit 218 admitted into evidence]

BY MR. AHMAD:

Q Now if -- I guess we can put it up now. Now at the top, and I know this is the last email in the bunch, I see an email from Jolene Bradley. She's part of your team, right?

A Jolene is part of my team.

Q And she's sending an email to you, "Important. Hi. Giving you the status of what appears to be a claimed specific experience of an internal employee." Is that right?

A That's accurate.

Q And if we look back at the first email, it's on page 3, actually the second to the last email, if we look under -- towards the bottom of that, middle to the bottom, it looks like this member -- first of all, a member was actually calling in, right?

A Yes. I remember this situation. One of our internal employees, a family member, did call into member services to get some information about an EOB and a balance bill that they had received.

Q Yes. They had been balance billed because Data iSight had priced something and sent to the member an explanation of benefits that was lower than the billed charged, correct?

A That's inaccurate. MultiPlan does not send out EOB's. That's

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a function of the benefit plan. So United Healthcare would have sent the explanation of benefits. It's the provider who chose to balance bill the member and send the bill to the member.

Q Well, but that's because you all, using Data iSight, paid less than the bill charge, right?

A We do not believe bill charges are -- I can affirm. Bill charges aren't what's owed.

Q Ms. Paradise, I'm just asking because you paid less than the bill charged?

A We are playing -- sorry. We are paying per the plan benefits period. So we're administering the benefit plan as it's written. It's the provider who's choosing to balance bill for the difference.

Q Did I just hear you say you're paying for the plan benefits period? Is that what you said?

A We administer the plan benefits, so the initial payment would have reflected the Data iSight rate.

Q Well didn't you have to remove the Data iSight rates because you were paying less than what the plan benefits allowed?

A That's not why that was removed. We had a member who was continuing to be harassed and balance billed by a provider. Our organization had MultiPlan outreach to that provider in an attempt to negotiate something different. So we have instructions from the client to try to resolve the issue by potentially paying slightly more than the benefit plan. That provider refused to negotiate to help resolve that issue, continued to harass our member, and ultimately the client made

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the decision to remove that discount.

Q Now this just -- and I'll get to that, but this wasn't just any member, right? Because you got a call.

A It -- well, it is a member. This one happened to come to me based on the fact that it was an internal employee.

Q Well can we look at the top of page 2? And if we look at the email from again, one of your team members Jolene Bradley to a Tammy Klinger, asking Tammy to check on where they're at with these employee claims because it's a senior executive, from Optum's, husband. Do you see that?

A Yes, I do. That's right.

Q And Optum is a United company, correct?

A It is.

Q And it says you're following very closely, right?

A Yes.

Q Not something you typically do?

A I believe my testimony earlier was it's not something I typically do, but from time to time I may get involved in an escalated dispute.

Q Now is it fair to say that the plan benefits allowed billed charges in this instance?

A No. I would not characterize it that way.

Q Okay. Well let's look at the first page. And it's the bottom, mid to bottom email, from Tammy Klinger to Jolene Bradley. And it says, "Hi Jolene. Here are the details." And if we look below, we can just

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highlight kind of the mid-section there. And blow that up because I can't even see it. Okay. And it says on this one, and we can look at the next one. It's the same thing. But claim was adjusted to remove Data iSight rates. Do you see that?

A I see that.

Q And processed at plan benefits. Does it say that?

A I see where it says that.

Q Following -- allowing rather, bill charges. Do you see that?

A I see that sentence.

Q It says that plan benefits allow bill charges.

A I think it's a mischaracterization by our operational people. It -- technically, we're paying at the client's direction. The client gave us direction because our member was being consistently harassed by a provider choosing to balance bill them aggressively, that they were willing to pay bill charge in that instance to resolve the issue for the matter.

Q Well the client was you essentially, United.

A Well I understand the client was us. We're probably our toughest client. So we treat UnitedHealth Group as the client as any other ASO client. And if they give us direction to deviate from what's in the actual SPD, that is their discretion. And it's our duty as the plan administrator to execute what our client is telling us to do.

Q Okay. Well this seems to suggest -- and by the way, you call it a mischaracterization. Is it a mischaracterization in this email?

A I believe it is.

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Q Okay. And then my next question I guess is, when you say at client direction and you treat everybody else the same, have you ever personally gotten involved to make sure that somebody got paid the full bill charges?

A You're mischaracterizing my involvement. Typically, when I get involved, it's just ensuring that the appropriate action is being executed in a timely fashion. I -- not every instance have I been directed to pay bill charges in those situations. I think the key element in this scenario was the provider was not operating in good faith and was demanding bill charges. This is one of the biggest challenges we're facing in healthcare today. This, I believe, was an ambulance situation. But hospital-based providers, ambulance providers, have been aggressively balance billing.

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MR. AHMAD: Your Honor, I'm going to object to the nonresponsive part. It's nothing about this.

THE COURT: Move on.

MR. AHMAD: I'm sorry.

THE COURT: You can move on. The answer was not responsive.

BY MR. AHMAD:

Q Ms. Paradise, you've never gotten involved and directed for any other member for them to be paid at the full bill charge?

A That's not true, and it wasn't my direction to pay bill charge. The direction came from the client. It was not at my direction.

Q Okay. And who was it specifically at the client that directed

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you to do this, because I don't see this here?

A That conversation happened offline. It's not contained in that email. I did not specifically speak to someone at the client. There were a number of other folks talking to our account management team that manages that relationship.

Q Okay. Now when we talk about OCM, and OCM uses Data iSight, correct?

A Yes.

Q You were the champion, and we can go to -- don't put it up. If you can go to page 288. Excuse me, Exhibit 288.

A Okay, I'm there.

Q Okay. And do you have that presentation in front of you?

A I do.

Q It's entitled value creation?

A Yes.

MR. AHMAD: Do you all have an objection to 288?

MR. BLALACK: No objection to admission. We know this an AEO document pursuant to our procedures, so just be aware of that.

MR. AHMAD: Sure. Your Honor, we move for admission of 288.

THE COURT: Exhibit 288 will be admitted.

[Plaintiffs' Exhibit 288 admitted into evidence]

BY MR. AHMAD:

Q Now if we go to page 70 of 288 --

MR. AHMAD: and we can put that up now.

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BY MR. AHMAD:

Q Under problem --

MR. AHMAD: Yeah. If you scroll down you'll see problem, I believe. Or actually -- yeah. Scroll up on page 70. Okay.

BY MR. AHMAD:

Q And this talks about OCM rate reduction. And I believe this is for an ER facility, correct?

A Oh. The document states ER facility, and I believe bullet two is professional ER facility.

Q And you're the champion of that? You're listed as the champion of that?

A Yes.

Q And reduction is from 350 to 250 percent for fully insured and ASO business. Is that correct?

A That's correct.

Q Okay. And if we go to page 176, also look under problem. This one pertains to emergency room, right?

A Yes, that's right.

Q Okay. And you're also -- it looks like you're lowering OCM ER professional from 350 to 250, correct?

A That's correct.

Q CMS is Medicare?

A Correct.

Q And that is something that you actually did in March of 2019?

A Well, on this document, I -- there were some staggered

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implementations, but March was one of the dates.

Q March of 2019?

A Correct.

Q Okay. And you reduced it from 350 -- the reimbursement rate from 350 percent Medicare to 250 percent Medicare, correct?

A That's correct.

Q All right. If we look at Exhibit 444, which I believe has been admitted -- and first of all, tell us what something like 444 is.

A Do you mind if I get the actual document?

Q Oh, of course.

A This document is a member explanation of benefits or otherwise known as an EOB.

Q Okay. And the member or patient gets one of these explaining how United arrives at the allowed amount for a provider charge?

A That's accurate.

Q And does something like this go to the provider as well?

A The EOB doesn't go directly to the provider. There's a documented called a PRA or a provider remittance advice that would be sent to the provider.

Q Yeah. And it has a similar explanation, does it not?

A It will have similar information.

Q And if we look at page 2 of this exhibit, Exhibit 444, and at the top, under -- I can barely see it, but I'm going to approach, just so that I can. Under IS member at the top. Okay. See a little bit better.

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And it indicates that this member is -- excuse me -- this member charges were reimbursed and you're saying you paid the provider according to your benefits and data provided by Data iSight. Is that right?

A That's what it says.

Q Okay. Is that accurate?

A Yes, it's accurate.

Q Well, if we look at the actual reimbursement rate for this charge, if you go to the bottom of page 1, now we can see that this plan was paid -- the allowed amount was 435.20. Do you see that?

A I see that dollar amount.

Q Okay. And if I represent to you that the Medicare rate for this, which is a Code 99285, is $174.08, you would see that it comes out to exactly 250 percent of the Medicare rate. Is that a coincidence?

A Well, it's not a coincidence, if the ER rate was set at 250 percent of CMS. Then this benefit -- or this EOB is demonstrating that the allowed amount was based on 200 percent -- 250 percent of CMS.

Q And they're all like that after March of 2019, right? Because you all have reduced the rate from 350 to 250, correct?

A When we reduced the rate, yes. The EOB should represent then how the claim was paid given the ER rate at the time.

Q Now, you all chose that rate for override. You chose 350 and you chose 250, correct?

A United does instruct MultiPlan on the level of the override, yes.

Q And so that's a United choice, not a Data iSight selection?

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A Well, when we implemented -- well, it is the client's choice. The rate is determined by various analytics we're doing internally and the key piece that we have set up with our Data iSight rates is the logic within Data iSight. We'll still calculate a Data iSight rate for that particular service and it will compare it to our override, so we'll always pay the greater of those two amounts. So if the Data iSight rate is greater, we would pay that. If not, the override, which at the time was 250 percent would be paid.

Q Well in fact, if we look at all of these, it's always paid according to the override that United, not Data iSight has selected, correct?

A I'm not -- well, I haven't seen all the data in this case. If that -- you know, I'll assume that that's an accurate statement. And that would just show that our greater of methodology to ensure that we've got a floor on how we're paying to comply with the Affordable Care Act.

Q Well, let me just ask you this. You don't mention anything in there about 350 or 250. This would be 250. In the explanation to the member on how you got to the allowed amounts, you don't tell them it's just multiplied by 250, do you?

A Well no, we don't state the specific amount being calculated in the EOB.

Q I mean, in fact, the allowed amount has nothing to do with Data iSight, because it's 250, the number you chose.

A Well, I disagree, because we have the compare logic built in Data iSight to ensure we've got a floor to comply with the Affordable

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Care Act.

Q Well, let me just ask you this. I mean, if all of these charges that are allegedly using Data iSight is just 250 percent Medicare, I mean, I could do that, right?

A I'm not going to answer if you could do the calculation yourself or not.

Q Could you do it?

A I could, but it would be untenable to manually price millions of claims.

Q Well, a computer could do it, right?

A A computer could do it, but clients have purchased that program and that's the tool that's -- is the underlying support for the program.

Q Well, but I mean, the whole process is automated, right? Data iSight is an automated process, correct?

A The process to adjudicate claims typically is automated and our transferring data back and forth to MultiPlan is automated and how they price the claim is automated. It has to be. We're passing millions of claims back and forth between our organization and Multiplan.

Q But instead of saying it was processed using data from Data iSight, you could tell them it's actually based on 250 percent. You could say that, right?

A The do -- well, the EOB is disclosing we're using Data iSight. We are using Data iSight. The override is loaded in Data iSight and is always compared to the actual Data iSight rate.

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Q Okay. You agree with me that unless I notice that it just happens to be two and a half or 250 percent, the member has no idea how you got to that number.

A Well, the member is going to understand that the plan paid per their benefit plan. Obviously, if they have questions, they can call our vendor or they can call United Healthcare, if they need to understand the specific reimbursement level.

Q Well, the plan doesn't say anything about 250 percent, does it?

MR. BLALACK: Objection. Foundation.

THE COURT: Objection sustained.

BY MR. AHMAD:

Q Well, are you aware of whether the plan says anything about 250?

MR. AHMAD: And Your Honor, I'm asking, because she claimed that it was pursuant to plan.

THE COURT: All right..

BY MR. AHMAD:

Q And so I'll ask you. Do you know whether 250 percent is anywhere in the plan?

A Benefit plan language isn't always going to give a specific rate. Because we're using the Data iSight tool and/or override, that rate can vary, based on the data in the Data iSight tool and so it would be -- you wouldn't be able to list the precise rate for each and every code in each and every EOB or in the benefit plan.

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Q You could say, though, that there's override rate of 250 percent.

A Putting -- well, our benefit plan language is written to describe the program that the client has chosen. If a member needs or wants additional detail, that's what our member services team is for, that they can look at that specific claim and give them the specific information about that specific claim.

Q Okay. I'm just asking since you put down the 250 percent override.

A Given the fact we administer, you know, thousands of benefit plans, our benefit plan language, it gets challenging to be super prescriptive, because you would literally have to be writing down rate that can change, due to data updates. Or if we change the override, we could be changing those rates and you would have to fix those benefit plans the code and the rate change. That would be untenable.

Q Well, but it's been at 250 percent since March of 2019, right?

A Right. That's five CPT codes out of thousands that could be billed and paid under the benefit plan.

Q Well, except that it's always 250 percent of the Medicare rate for that CPT code. You could say that.

A Well, specifically for the plans and the clients who have purchased this program, for those five codes, typically there are going to be multiple other CPT codes that are billed, so you would have to then list in the benefit plan every code and the rates associated with what you're requesting.

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Q You can't just say generally you apply a 250 percent override? You can't say that?

A Well, if we said that, we'd have to be prescriptive about what codes are with that. Again, as I stated, those E&M codes that are specific to ER. There's five codes. Typically there are going to be additional CPT codes that are going to bill -- be billed along with that code. So what you're asking is put a specific rate in related to five codes. There's thousands of other codes that could also be billed. You then would have to put all of those details into benefit plan language, which would just be really impossible to make sure that you're keeping that up to date.

Q Well, I'm just asking about, for example, ER, right? The plan has specific language about emergency room benefits, correct?

A It does have language around emergency room benefits.

Q And you all are applying a 250 percent override on ER benefits.

A Well, the 250 percent override, again, is for five E&M codes. When you're in the emergency room, you're likely having multiple other things potentially done in that visit that would not be one of those or would be in addition to those five ER-specific E&M codes.

Q Well. I understand, but you can't say 250 as applied to each of these codes individually --

MR. BLALACK: Object to --

THE WITNESS: We would have to --

MR. BLALACK: -- one second.

THE WITNESS: -- say 250 --

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MR. BLALACK: We object --
THE WITNESS: -- 250 percent.
MR. BLALACK: -- to form. A question's been asked.
THE COURT: Over --
MR. BLALACK: That question's been asked and answered --
THE COURT: It has been --
MR. BLALACK: -- and asked and answered.
THE COURT: -- asked and answered, but overruled. But you need to move on, Mr. Ahmad.
MR. AHMAD: Okay.
BY MR. AHMAD:

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Q Did you finish your answer?

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A Well, my answer is, as I've stated, to be prescriptive about those five codes, you then have to be prescriptive about the various other codes that could be billed. A benefit plan document already can be in the hundreds of pages, and it would really be impossible to administer for thou -- you know, thousands of clients that may have this program, what the specific rate is for five codes along with the other thousands of codes, could be there could be multiple combinations that would go along with those five E&M codes.

Q Does United, in fact, in order to incentivize its options of its lower discount programs or high discount programs, rather, does it suggest plan language, so that you can move people to the higher discount rates?

A For all of our programs, our clients are given proposed

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language. Ultimately, the clients make the decision on what language ends up in their SPD. So some clients will take the language we've provided them. They expect us to propose language for them that is, you know, complies with any state or federal regulations and represents those programs, since we are the experts in how those programs work. Ultimately, though, the client makes the decision on what specific language ends up in their SPD.

Q Do you try to sell them on that language?

A We don't sell them the language. We would present the language. If they chose to adopt a program, we would provide the suggestion on what updates to their benefit plan would need to occur and they would be making the decision to tell us to go ahead and insert that language or they potentially with their benefits representatives, if they're using a consultant, their legal team might review that language and provide suggested adjustments.

Q Well, would you agree with me that the plan language was preventing United from moving to higher discount programs?

A I don't agree with that statement. Each of our programs has specific language. So when we're introducing or developing a new program, there typically is new or different benefit language that has to be developed to support that program. So it isn't a forced migration. We're providing solutions for our clients. They make a choice and then as a result, when we're reviewing the program that they've chosen, we will provide to them suggested language that helps support that program. Ultimately, it's their decision to have us put that in their SPD

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or not on their behalf.

Q Okay. Let's go to Exhibit 268.

MR. BLALACK: Joe, I think this is already in.

MR. AHMAD: It is, Your Honor.

MR. BLALACK: It is -- it's AEO though.

THE COURT: I show it is admitted.

MR. BLALACK: Okay.

BY MR. AHMAD:

Q Go to page 7. And if we go at the top of -- where it says the opportunity -- it talks about how you're going to move ASO non-par. That's out-of-network, right?

A Non-par is out-of-network.

Q Reimbursement from low discount to high discount programs using a four-year phased approach. Do you see that?

A I see that language.

Q And then it says 70 percent of non-par plan dollars are not eligible for high discount programs, due to plain -- benefit plan language. Is that right?

A That statistic's accurate and that was in reference to both the in-network benefit level and the out-of-network benefit level.

Q Well, non-par is out-of-network, right? That's nonparticipating.

A It's nonparticipating spent across in-network benefit level, which are ER services, as an example, and the out-of-network benefit level, which are situations where a member is making a choice to go out-

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of-network. So it was the whole universe of non-par claims.

Q Well, but nonparticipating is out-of-network. I think we just established that, right?

A It is out-of-network.

Q Okay. So given the plan language won't let you move to these high discount programs, you then try to come up with plan language that would, right?

A We develop plan language to support our programs. And I believe my testimony just a few minutes ago -- we present solutions to our clients to help them provide affordable benefits for their members. When they choose one of those programs, we're going to provide the suggested language. Ultimately, it's their choice to make that change.

Q Well --

A To apply a program, the benefit plan, the language needs to exist, so it's not a forced migration, it's a conversation with the client.

Q Well, let's talk about that conversation. Can you look at Exhibit 144?

A Okay. I'm there.

Q Okay. And this is shared savings program enhanced talking points, an FAQ, correct?

A That's what the document says.

Q Yes. And this is the conversations you're having with the clients, your talking points with the clients about your SSPE Program, correct?

A Well, these are the talking points and FAQ's that we provide

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to our sales organizations to support them when they're providing an -- providing a solution option to their clients.

Q Okay. And for example, on page 6, if you go to the bottom? Or actually, we can go to page 7, and then we could just go directly to page 7. And then to number 10. And it says at the top, "SSPE requires update, updated SPD language." Says, "Fully support implementation of program to strengthen UHC's ability to negotiate on accessibility." Do you see that?

A I see that.

Q And you all are providing that SSPD language, or excuse me, SPD language?

A Yes, as I stated before, we had language drafted and would propose clients use that.

Q Okay. And you even have talking points, if we go to page 11? Or excuse me, point number 11 on page 8? Number 11 is, "What if a client is not going to use the new SPD language." You see that?

A I see that.

Q And then on the next one, point 12, just down below, "How should I have conversations with my clients about SSPE," talked about in the first bullet point, "by having conversations, comply, use the internal SSPE talking points, client, hand out elevator pitch to highlight program benefits and importance of updated SPD language." Do you see that?

A Yes, I see those two bullets, and it reaffirms that we're not going to administer a program if the client isn't going to appropriately update their benefit plan language to support the program.

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Q And it seems like your sales organization is trying to talk the client into the updated SPD language?

A I disagree with that characterization. Our sales people are always bringing a variety of solutions to our clients. This document is to help them explain our particular out-of-network programs as our sales folks are talking to our clients about multiple offerings for United, so it is helpful for our sales folks to understand particular programs that we're wanting to propose to our clients.

Q Okay. So when it says elevator pitch, that's not a sales pitch?

A It's not a sales pitch. I -- it's basically helping them understand how the program works and being able to talk about it in simple terms and explain the value of the program.

Q Okay. And let me talk to you about the next phase. If we go to Exhibit 329

A Okay.

Q If we go to page 44 of Exhibit 329? You see at the top where it says, "For the unit platform non-participating dollars are heavily weighted to low discount plans."

A I'm sorry. Page 24, did you say?

Q 44.

A Oh, sorry. Yes, I see that.

Q And it says, "With the four plan shift," or excuse me, "four-year plan to shift majority of dollars to at least OCM." Do you see that?

A I see that.

Q Okay. And that would be under your domain, correct?

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A Well --

MR. BLALACK: Objection. Vague.

THE WITNESS: -- we --

THE COURT: Overruled.

THE WITNESS: We developed the programs. Our sales folks are actually having the conversations with the client.

BY MR. AHMAD:

Q Okay. For example, if we look on this and it talks about an R&C program; do you see that?

A I see that.

Q And then it -- the next phase looks like OCM; correct?

A Yes, that's accurate.

Q And then the next phase after that is MNRP and ENRP. Do you see that?

A Correct.

Q And those are all out-of-network programs, correct?

A Those are all out-of-network programs.

Q And those are ones that you oversee?

A Yes, that's accurate.

Q Okay.

MR. AHMAD: Your Honor, I don't know if there's an objection to 329. I'd move the admission of Exhibit 329.

MR. BLALACK: Object to the foundation of the document, Your Honor. She didn't write it or receive it.

MR. AHMAD: Well, you -- if I may ask one more question?

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BY MR. AHMAD:

Q You have certainly seen this document, page 44 as it pertains to the out-of-network programs; have you not?

A Page 44, yes.

Q Okay.

MR. AHMAD: And if I have to, Your Honor, I'm happy to admit just page 44.

MR. BLALACK: No objection to that, Your Honor.

THE COURT: All right. We can admit page 44 of 329.

[Plaintiffs' Exhibit 329, page 44 admitted into evidence]

BY MR. AHMAD:

Q Okay. And if I'm -- if we could pull up page 44? Is it fair to say that there is a plan to shift the out-of-network programs from lower discount to higher discount?

A There was a plan to work with our sales organization to have conversations with their clients about our out-of-network spend, and, you know, billing practices we were seeing out there, and helping them be aware of other solutions that we had available.

Q Okay. And on the far left, which is the latest in time, 2021 to 2022, we see MNRP and ENRP? You see that?

A Yes, I see that.

Q And the one that would pertain to emergency room is actually ENRP, correct?

A That's accurate.

Q And those are the biggest discounts if we go back and look at

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44. Those are the biggest discounts. Those have 70 to 79 percent discounts, correct?

A Yes, those are discounts, and they're discounts off billed charge.

Q Correct. And that's greater than R&C and OCM discounts, correct?

A Those discounts are greater than R&C which is based on billed charge, and they are slightly higher than OCM.

Q Okay. And if we look -- we looked at Exhibit 450?

A Okay.

Q This document is entitled, "Out-of-Debt Work or OO double down"?

A That's what the document says.

Q Okay. And I noticed that where it says, "levels for discussion consideration, 1B, for people on point it," says, "you/John Haben." Is that right?

A That's accurate.

Q Okay. And you -- I take it you've seen this document before?

A I do recall I've seen this document.

Q Okay.

MR. AHMAD: Your Honor, I -- doesn't appear there's an objection, I move for the admission of Plaintiffs' Exhibit 450.

MR. BLALACK: No objection to the document, Your Honor, to its admission. It is a -- yeah.

THE COURT: Exhibit 450 will be admitted.

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[Plaintiffs' Exhibit 450 admitted into evidence]

BY MR. AHMAD:

Q Okay. And if we just pull up now under Levers for discussion consideration, number 1? And it says, "move remaining FI," that's fully insured; is that correct?

A Yes, that's accurate.

Q "Off OCM to MNRP or ENRP, meaning from 65 percent discount to 80 percent discount." And then it says, " maybe about 50 million." Do you see that?

A I see that bullet.

Q And actually, if we just scroll up just a tad, I think we can see, put a little bit more context on it. Where above that point it says -- right above levers for discussion, consideration, it says, "total addressable opportunity". Is that the potential revenue that United can make by doing this?

A Well, that's the additional medical cost savings.

Q Okay. And it says, "may be about 50 million"?

A That was a slag, but yes, it says about 50 million.

Q And so when we say medical cost, let's be very clear, that's the cost to United because it's fully insured, correct?

A Medical cost for a fully insured plan are the pairs, cost.

Q Yes, and you are the payer in a fully insured situation?

A That's accurate.

Q And so again, the less you pay, the higher the discount, right? The higher the discount, the less you pay?

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A Well, the higher the discount, the function of the discount is the bill charge, so as bill charges are escalating, when you do the math to calculate the discount, as bill charges are higher, it's going to make the percent off the billed increase.

Q Well, but here it says you guys are going to make 50 million, right?

A Well, it doesn't say we're going to make 50 million, it's stating the potential additional medical expense savings is 50 million. What actually ends up being United's profit is a little more complicated than that on a fully insured plan.

Q Okay. Well, let me just ask you overall, has anybody calculated what this -- what these programs cost the providers?

A I'm not sure I understand the question.

Q Well, let me just back up for a second. When we are talking about the SPD language, right? This is a conversation that United is having with the client, correct?

A Yes.

Q And you are saying you have to follow the plan language?

A That's accurate.

Q Okay. And so -- but that discussion is only between you and the employer group, correct?

A That's not accurate. All of our fully insured plans have to be filed and approved in the state.

Q Okay. But that's when you're negotiating the SPD language, that is a conversation between you and the client?

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A An SPD is an ASO document, and yes, that conversation would be between United and the client.

Q And we, the provider, we're not at the table during that discussion, are we?

A No, the provider doesn't have a role in developing benefit plan language, and providers are choosing to stay out-of-network and subject to those network program -- out-of-network programs.

Q Well, we're not part of this discussion, correct?

MR. BLALACK: Objection. Asked and answered.

MR. AHMAD: I'll move on, Your Honor.

BY MR. AHMAD:

Q You agree with me that the provider never necessarily agrees with the SPD language, correct?

A The SPD language is a client choice on the benefits they're trying to offer their members. And out-of-network provider, no, it does not have a say in the benefits that a client is choosing to provide their members. They're making a choice to be out-of-network, and that they're there for subject to the provisions of the various benefit plans that offer out-of-network programs.

Q Well, you say we're making a choice to be out-of-network, but it obviously takes two to tango, you have to get both sides to agree, right?

A Both parties need to agree to enter into a network agreement.

Q Okay. But I'm really focused on the SPD because I have

heard you all say, I think I heard you say that we can't do anything other than what's in the SPD. Right?

A The SPD outlines all of the provisions for the benefit plan and is what we administer and follow.

Q But we're not bound, you understand the providers are not bound by the SPD?

MR. BLALACK: Object to form. Asked and answered previously.

MR. AHMAD: I didn't ask that.

THE COURT: Overruled.

THE WITNESS: I -- the benefit plan is providing the provisions for the benefit plan.

BY MR. AHMAD:

Q But we, the provider, is not bound by that?

A A provider does not get involved in drafting benefit plan language that outlines what a plan is covering no.

Q Can we agree that we, the providers, should be paid a reasonable value for our services?

A I agree providers should be paid a reasonable value.

Q And who is responsible in this discussion between you and the client on the SPD language? Who is responsible for making sure that we get paid the reasonable value of our services?

A Well, ultimately, the client is going to make a choice, first of all, if they're going to offer an out-of-network benefit, and second, what reimbursement methodology they're going to choose to reimburse both

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claims.

Q Are you saying it's the client's responsibility to make sure we're paid a reasonable value?

A I am saying the client will evaluate the programs, and they will determine what they feel is the right reimbursement level or reasonable value for that service, but it's a client choice. We are developing programs, a variety of programs and solutions based on those client needs and desires.

Q Well, but let's be very clear, the client in the ASO context is the one paying the bills, right?

A That's an accurate statement.

Q And I think you have said that the client sometimes has an interest in paying less, fair?

A Yes, the client has an interest in paying out-of-network claims, yes.

Q Okay. And you all in the ASO context, at least with respect to OCM, you all can receive a percentage of any savings that you save for your client?

A That's accurate, if we derive savings, we may take a fee on that.

Q Okay. And you know, for example, with respect to some of the providers, such as a TeamHealth, it can cause millions of dollars, its OCM program can cause millions of dollars in reductions in reimbursement, right?

MR. BLALACK: Objection. Foundation.

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THE COURT: Overruled.

BY MR. AHMAD:

Q Well, let's look at Exhibit 289.

MR. BLALACK: Your Honor, can we approach?

THE COURT: You may.

[Sidebar at 9:36 a.m., ending at 9:37 a.m., not transcribed]

THE COURT: Okay. This is a good time for our first break of the day. During this recess do not talk with each other or anyone else on any subject connected with the trial. Don't read, watch, or listen to any report of or commentary on the trial. Don't discuss this case with anyone connected to by any medium of information, including with that limitation newspapers, television, radio, internet, cellphones, or texting.

Don't conduct any research on your own relating to the case. Don't consult dictionaries, use the internet, or use reference materials. During the recess don't post any -- or during the trial. Don't post any social media about the trial. Don't talk, text, Tweet, Google issues, or conduct any other type of book or computer research with regard to any issue, party, witness, or attorney involved in the case.

Most importantly, do not form or express any opinion on any subject connected with the trial until the matter is submitted to you.

It's 9:38. Let's be back sharp at 9:50. I realize that's a shorter break than usual.

THE MARSHAL: All rise for the jury.

THE COURT: And Ms. Paradise, you may step down during the recess.

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[Jury out at 9:39 a.m.]

[Outside the presence of the jury]

THE COURT: You guys want to take this up at 9:45?

MR. AHMAD: That would be fine with us, Your Honor.

THE COURT: So be back at 9:45. Have a good recess.

IN UNISON: Thank you, Your Honor.

[Recess taken from 9:39 a.m. to 9:46 a.m.]

[Outside the presence of the Jury]

THE COURT: -- session now?

MR. AHMAD: Yes, Your Honor. I --

THE COURT: But let me ask Mr. Blalack to bring the issue --

MR. BLALACK: Thank you, Your Honor. This is --

THE COURT: -- and then I'll ask for your response.

MR. BLALACK: If I could just look at this just real quick. The email in question is a -- this is Plaintiff's Exhibit 289. It's dated January 29, 2019, and from a man named Greg Dosedel, who was a deponent in this litigation, and Ms. Paradise, subject line, TeamHealth, and then he proceeds to refer to analysis of impact to decline in various out-of-network programs through TeamHealth, non-par providers. And then it goes through an analysis, financial analysis, and then it says, "Based on these assumptions, with the existing TeamHealth our providers will experience," and then it talks about effects on reimbursement.

We think Mr. Dosedel was one person. He's not involved in the out-of-network programs at all. He's not involved in this. He never worked as part of Mr. Haben's crew, Ms. Paradise. He's a contract

negotiator. He was on point for the network -- national network negotiations between TeamHealth and UnitedHealthcare that was transferred basically from early 2018 through the middle of 2019, that resulted also in this lawsuit and other lawsuits and other terminations.

This analysis is discussing -- is in the context of a back and forth regarding the application of the various programs both with respect to this statement of the jurisdictions that ultimately led to contract terminations when the negotiations were not successful. And so these are basically two parts from the organization sharing information with each other in connection with Mr. Dosedel's negotiation strategy.

So my view on this, Your Honor, is if they're going to get in to be able to talk about -- and just to be clear, the reason he said nonteam health, non-par providers is because at that point there were still lots and lots of participating TeamHealth providers at that point, right? And so the question was are they going to remain, you know, TeamHealth participating providers or they going to be become non-par, and that's this setup and financial analysis was in service with that.

Again, I don't have any problem with the document being used. It's fine with me. But once it's used, then I need to go in and explain who Mr. Dosedel was, what the context of this was, the fact that there's these negotiations, and everything that goes with it. You know, that they had -- what the prior rates were and all that goes with that and where it ultimately ended up. So that's the issue for me.

MR. AHMAD: Your Honor, if I may hand Your Honor the document because I think, you know, that is a long explanation for what

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is a fairly short document? And the only relevant part, which I'm happy to -- the top part I don't think has anything to do with negotiations. But the bottom part --

THE COURT: You already have in evidence that there was a $50 million savings.

MR. AHMAD: Yes.

THE COURT: So why does is needed?

MR. AHMAD: Just the impact to us. That's all, Your Honor.

THE COURT: I'm afraid it would open the door. I -- so I'm going to caution you that I won't admit.

MR. AHMAD: Thank you, Your Honor.

THE COURT: All right. You've all -- did you guys get a break?

MR. BLALACK: We're ready. I'm -- I want to hit the target, Your Honor. So I think --

THE COURT: Right.

MR. BLALACK: -- we're ready to go when you are.

THE COURT: Well, as soon as the --

MR. BLALACK: So can we bring Ms. Paradise in?

THE COURT: Please.

[Pause]

THE COURT: Just waiting for the marshal to give me the high sign.

THE MARSHAL: All rise for the jury, please.

[Jury in at 9:51 a.m.]

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THE COURT: Thank you. Please be seated. And thanks, everyone, for being right on time. I appreciate it.

Mr. Ahmad, go ahead, please.

MR. AHMAD: Thank you, Your Honor.

BY MR. AHMAD:

Q Ms. Paradise, if we can have you look at Exhibit 423. It's not in -- it's not in yet, but if you can look at 423?

A 423.

[Pause]

THE WITNESS: Okay.

MR. AHMAD: Okay. Let me know when you're there.

THE WITNESS: Yep, I'm there.

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BY MR. AHMAD:

Q Okay. And that is a presentation that you did, correct?

A This was a presentation that Deborah Drinkwater, who is a VP in the market, and I consulted on. She actually drafted the document. I provided some input.

Q Okay. It has your name and her name as the presenters, correct?

A Correct. We were both present for the presentation.

Q And it concerns out-of-network issues?

A Yes. It's specific about the out-of-network issues in the West region.

Q Okay.

MR. AHMAD: Your Honor, I'd move for the admission of

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Exhibit 423.

MR. BLALACK: No objection to admissibility, Your Honor, though this isn't a --

THE COURT: Good enough. 423 will be admitted.

[Plaintiffs' Exhibit 423 admitted into evidence]

MR. AHMAD: Okay. And if we could put up page 2. And I think midway down, key areas of opportunities.

MR. AHMAD: Oh, I'm sorry. It's the next section up. There we go.

BY MR. AHMAD:

Q And I assume this is something that you're aware of in terms of the key areas of opportunities; is that right?

A Yes.

Q All right. And I notice the third bullet point says, "Optimize out-of-network programs." Do you see that?

A Yes, I see that --

Q What is --

A -- bullet.

Q -- meant by the term optimize?

A So optimize out-of-network programs is just a terminology we're using to talk about management of the existing programs. So it could be -- a simple example is a new CPT code is published and we're ensuring that our program's appropriately priced per that program's methodology for any new codes, would be an example.

Q Okay. Does it have anything with the adoption of high

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discount programs?

A That bullet does not. I believe there's a bullet above that talks about adoption.

Q Yes. Because the key area of opportunity, at least the first bullet point, is advancing client adoption, correct, of high discount programs?

A Correct.

Q And then if we go down a little bit, we see those programs again. ENRP [sic] and ENRP, correct?

A I see MNRP and ENRP listed, yes.

Q Okay.

MR. AHMAD: If we can go down below and go to top five strategies.

BY MR. AHMAD:

Q And, again, we see client adoption of high discount programs, correct?

A That is the bullet, yes.

Q And then it says, "Reduce OON networks to less than par levels," correct?

A The bullet is less than or equal to par levels.

Q Okay. So you're trying -- in this one it says you're trying to reduce those that are out-of-network to that that is below in-network or equal to it, right?

A We were evaluating opportunities to pay at or below par levels. I'm unaware of a rule that states we should be paying out-of-

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network providers more than our in-network providers.

Q Well, you'd agree with me that the rule is you should pay reasonable value for services --

A We should be --

Q -- correct?

A -- paying a reasonable value that does not equate to billed charge.

Q All right. Well, you agree though that this issue is all about reasonable value?

MR. BLALACK: Objection. Vague.

THE COURT: Overruled.

BY MR. AHMAD:

Q Correct?

A Reasonable value is how we should be paying our claims. We define that as Medicare plus a small margin.

Q Now, if we go to Exhibit 239, specifically page 2, and you see the bottom right, I believe, where it talks about action with urgency and acceleration?

A Yes, I see that section.

Q And the second bullet point, which talks about improve OON network reimbursement levels to 80 percent of par rates, do you see that?

A I see that bullet.

Q And that would actually be less, obviously, only 80 percent of the in-network prices, correct?

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A That would be 80 percent of the par rates, and it was a suggestion.

Q Okay. Now, earlier I think you said you define reasonable value as a percentage of Medicare plus? Did you say that?

A I did say that.

Q Now, have you seen any of the services that we have provided in the ER room?

A Are you asking me if I've seen specific claims when you say services? What --

Q No. The actual services. Have you been to any of our facilities?

A No. Fortunately I haven't had to visit an ER.

Q Okay. Do you understand that emergency room doctors have some unique characteristics?

A I understand ER docs, yes, have unique characteristics.

Q I mean you understand that unlike other doctors, we have to treat everybody? We have to give the same high quality emergency room care to every single person, correct?

A I understand that, yes.

Q We don't get to pick them?

A The doctors do not get to pick the patients.

Q You understand that that's going to bring a fair amount of uninsured patients, correct?

A I understand that, yes.

Q Have you done any analysis on how many uninsured or even

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Medicare insured, Medicaid insured that any of our facilities treat?

A I don't have those statistics. It's not something I would commonly look at.

Q Can you imagine that it can vary from place to place, even state to state, city to city?

A I would imagine there could be a wide variability.

Q When you -- when you think about reasonable value, did you factor in any of these unique characteristics for emergency room doctors?

A There are characteristics that are evaluated or considered in development of those reimbursement levels, depending on the methodology that's used.

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Q Okay. But you have no idea how many of our patients are uninsured, or Medicare insured, or Medicaid insured as opposed to have commercial insurance?

A I personally do not know those statistics, no.

Q Do you think that matters when evaluating reasonable value?

A If that matters, then you're making the assumption that the commercial business needs to fund Medicare and Medicaid.

Q But you understand we have to treat everybody regardless?

A I understand you have to treat everybody.

MR. AHMAD: I'll pass the witness, Your Honor.

THE COURT: All right. Cross-examination, please, Mr. Blalack.

MR. BLALACK: You're way ahead of us. My apologize,

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Ms. Paradise, it's taking me so long to get all suited up here.

THE WITNESS: No worries.

MR. BLALACK: By the way, Counsel, the exhibits that I provided to you all, do you all have any objection to the admission of any of them?

MR. AHMAD: I think we do to some, yeah?

UNIDENTIFIED SPEAKER: No. No objection.

MR. AHMAD: No. No objection, Your Honor.

MR. BLALACK: Your Honor, real quick before the examination, I'm going to move for admission of Defendants' Exhibit 4048, Defendants' Exhibit 4478, Defendants' Exhibit 4529, Defendant's Exhibit 4531, Defendants' Exhibit 4573, Defendants' Exhibit 5505, Defendants' Exhibit 5506, and lastly, Defendants' Exhibit 5507.

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MR. AHMAD: And no objection, Your Honor.

THE COURT: All right. Exhibits 4048, 4478, 4529, 4531, 4573, 5505, 5506, and 5507 will be admitted.

[Defendants' Exhibit 4048, 4478, 4529, 4531, 4573, 5505, 5506, and 5507 admitted into evidence]

MR. BLALACK: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. BLALACK:

Q Good morning, Ms. Paradise.

A Good morning.

Q I'd like to cover a few points about your background before we talk about some of the questions that Mr. Ahmad had asked you here

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in just a little bit -- not long ago. And let's introduce you a little bit to the jury. Where do you live, ma'am?

A I live in Victoria, Minnesota.

Q And are you married?

A I am.

Q How long have you been married?

A 22 years.

Q Do you have any children?

A I have two daughters.

Q How old are your daughters?

A 18 and 17.

Q Are they in college now?

A One just started her freshman year.

Q Okay. And the other, is she in high school?

A The other is a senior this year.

Q What about you, did you attend college?

A I did attend college.

Q Did you receive a degree?

A I received my bachelor of science degree.

Q And from where?

A Ball State University in Muncie, Indiana.

Q What academic discipline did you earn a degree in?

A My degree was a double major in business administration and finance.

Q Did you later attend any further formal education like

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graduate school or something like that?

A I did. I attended graduate school.

Q And where did you attend graduate school?

A At St. Thomas University, which is in Minneapolis, Minnesota.

Q Did you earn a degree?

A I did. I earned my MBA.

Q And after completing graduate school, did you go into the workforce immediately?

A I was working at United while I was obtaining my master's.

Q Okay. That was what I was getting at. Did you start working at UnitedHealthcare after completing your undergraduate degree?

A I started shortly after I completed my undergrad.

Q Okay. What year did you start working for UnitedHealthcare?

A I started in 1996.

Q And have you worked for UnitedHealthcare continuously since then to today?

A I've worked for UnitedHealth Group. I had -- I spent some of my time in our Optum entity, but primarily have been in the UnitedHealthcare organization.

Q So within one United company or another, how long have you been with the company roughly?

A 25 years.

Q And what was your first position at UnitedHealthcare?

A My very first role was an associate accountant in our

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UnitedHealthcare health plan accounting organization.

Q And when did you first join UnitedHealthcare's out-of-network programs team?

A That was in 2015.

Q What was your position when you joined the out-of-network team?

A When I joined that team, I was Senior Director for out-of-network.

Q Did your job title change between 2015 and now?

A It did.

Q How did it change?

A I was promoted twice during that time period, and ultimately have my title now, Vice President of Payment -- Out-of-Network Payment Strategy.

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Q And when did you assume the current role that you have?

A That would have been in early 2019.

Q And have your job duties within the out-of-network program changed over the course of time since you joined in 2015 up until the present?

A They have.

Q How?

A When I first joined the organization, I had oversight primarily for just the operations of the out-of-network programs. That meant care and feeding of our existing programs. We have a operational team that handles member [sic] and helps the organization respond to provider and member disputes and also manages the work back and forth with our vendor. And then, upon my promotion, I took on additional

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accountabilities, which included development and management of our out-of-network strategies.

Q Now, for the period from 2015 when you joined the out-of-network program team up until this year, to whom did you report?

A I reported to John Haben.

Q And did you report to John Haben continuously from 2015 until the present?

A I did, up until August of this year.

Q And what happened in August of this year?

A Mr. Haben retired.

Q And who do you report to now?

A I report to a Victoria Bogatyrenko.

Q Did your job responsibilities change once you stopped reporting to Mr. Haben?

A They did.

Q In what way?

A John and I would divvy up some of the strategic components of our job. And in his departure, I have full oversight now of our programs.

Q Okay. So how would you describe your current job responsibilities within the out-of-network program team, just at a high level?

A So there's a couple chief components. So I have oversight of our vendor relationships with MultiPlan and CareHealth, and that includes oversight of the contract, relations, engaging with them, other

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program implementations. I also have oversight to ensure that all of our programs are operating effectively. We have -- my team has oversight of helping the organization respond to provider and member disputes. We have oversight to work within the organization to ensure we're retaining any legal and regulatory evaluation input to our programs. And then ultimately, I have oversight for development of any new out-of-network programs or new initiatives in response to client needs or market plans.

Q Great. I wanted to explain a little bit more to the jury about how you -- your job does or does not relate to the final Defendants that are in this case, okay? That's what I'm going to do now.

A Okay.

Q So I'm just -- what company do you currently work for in your role?

A So I am a part of our UnitedHealth Networks organization.

Q And ma'am, I'll represent to you that the five Defendants in this case UnitedHealthcare Insurance Company, UnitedHealthcare Services, UMR, which is an acronym for United Medical Resources, Sierra Health and Life, and Health Plan of Nevada. Okay? Those are the five Defendants.

A Okay.

Q Are you an employee at any of these five Defendants?

A I'm an employee of UnitedHealthcare Services.

Q Through your role at UnitedHealth Network?

A Through my role at UnitedHealth Networks.

Q Have you ever worked for Sierra Health and Life Insurance

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Company?

A I have not.

Q Have you ever worked for Health Plan of Nevada?

A I have not.

Q Have you ever worked for UMR?

A I have not.

Q Have you ever had responsibility for the out-of-network program for Sierra Health?

A I have not.

Q Have you ever had responsibility for the out-of-network programs for Health Plan of Nevada?

A I have not.

Q Have you ever had responsibility for out-of-network programs for UMR?

A No.

Q Now, during -- in your role on the out-of-network team for UnitedHealthcare, do you ever engage with people at those companies about their out-of-network programs and communicate with them at all?

A From time to time, we'll engage primarily with UMR.

Q Okay. Do you know if UMR, Sierra, and Health Plan of Nevada used out-of-network programs that were different from the programs that you manage for UnitedHealthcare?

A I believe they do use different programs.

Q Now, I want to talk about some of those subjects that have come up in the course of the trial before the jury, some of the topics

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about which you were questioned. And the first issue I would like to discuss relates to whether billed charges for out-of-network providers have increased during the period in dispute in this case that's the subject of it. Okay?

A Okay.

Q Now, I will represent to you, ma'am, that the period of dispute in this case is July 1, 2017, to January 31, 2020. Okay?

A Okay.

Q Ma'am, have you ever heard of something called a chargemaster?

A I have.

Q What is a chargemaster?

A A chargemaster is the provider's fee schedule, for lack of a better word.

Q Is it fair to call a chargemaster a price list for a healthcare service?

A It is their price list.

Q Okay. Now, during the period in dispute, do you have an understanding of whether the billed charges of out-of-network providers as reported on those providers' chargemasters have gone up, have gone down, have basically stayed the same?

A We did see the chargemasters and those billed charges increasing.

Q Okay. Now, do you know whether any particular types of out-of-network providers during this period, 2016 to 2019, reported

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significant increases in the billed charges as noted on their chargemasters?

A We were seeing significant increases in -- by hospital-based providers.

Q When you refer to a hospital-based provider, can you give the jury an example of what are hospital-based providers?

A Sure. They're the RAPL providers, so that would be anesthesiology, ER physicians, lab, pathologists.

Q Now, during your time managing UnitedHealthcare's out-of-network programs, have you observed any trends that contributed to this outcome of increases in the chargemasters of those hospital-based providers?

A We did review metrics that were demonstrating that there was an increase in those provider types, billed charges increasing.

Q And how did that trend impact your work within out-of-network programs?

A So that impacted our work with programs that historically were based on billed charge. The costs associated with those programs were arbitrarily increasing as the result of those provider billing tactics of increasing their billed charges.

Q And did you, in your role on the out-of-network programs team, play personally a role in responding to that trend?

A Our team did play a role in responding to that as we were identifying those trends.

Q Let me ask Shane to bring up Defendant's Exhibit 4048,

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which I believe is in evidence, so I can show that to you, Ms. Paradise, and also show it to the jury.

A Okay. Is that in this?

Q You can find that. There should be a binder --

A Four zero eight?

Q -- of documents right there, 4048.

MR. BLALACK: May I approach, Your Honor?

THE COURT: You may.

THE WITNESS: Four zero -- sorry.

MR. BLALACK: I'll help you find this binder.

THE WITNESS: Oh, is it in this one?

MR. BLALACK: I think that might actually be it.

THE WITNESS: Okay. Sorry. Okay.

BY MR. BLALACK:

Q Would you find 4048 --

A Yes.

Q -- 4048, and just take a look at it and tell me if you've ever seen this document -- whether you've seen it before.

A Yes, I believe I've seen this or a version of it.

Q Now, is it fair, ma'am, to say that this Exhibit 4048 provides background information on UnitedHealthcare's out-of-network program?

A Yes. This document appears to be a member flyer that provides information for members about our out-of-network programs.

Q Now, let's turn to page 11 of the document. Ma'am, I'm referring to the -- you'll see an EX number at the bottom, and then it'll

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have a point, and then it'll have 000 on the page. That's what I'm talking about, that page 11. And ma'am, I'm showing the jury and you that page of the document now that is entitled "Professional, Reasonable, and Customary: Rising Cost Trends." Do you see that?

MR. AHMAD: If I may, I'm sorry, what exhibit is this?

MR. BLALACK: This is 4048, I believe. Is that what you've got?

MR. ZAVITSANOS: Is this the cover of the one you just showed, or is this --

MR. BLALACK: This is part of that exhibit.

MR. AHMAD: Is this -- my question, I guess, from the first page is, is this about pain management?

MR. BLALACK: No.

MR. AHMAD: With that representation.

MR. BLALACK: It says that the -- can you go back to the front -- first page?

MR. ZAVITSANOS: Up at the top.

MR. BLALACK: Yeah. See, it says, "Know your -- know more before choosing out-of-network provider plan management."

MR. AHMAD: Okay.

MR. BLALACK: Not pain management, plan management.

MR. AHMAD: Got it.

MR. BLALACK: If you go to page 11, please?

MR. ZAVITSANOS: Believe that's why we have these.

MR. BLALACK: It may involve pain management as well, but

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it's mostly focused on plan management.

BY MR. BLALACK:

Q All right. So let's look back at the title of this. It says "Professional, Reasonable, and Customary: Rising Cost Trends." Do you see that, ma'am?

A I do.

Q And I think you've discussed with Mr. Ahmad the term reasonable and customary. Do you recall that?

A I do.

Q When the out-of-network program team refers to reasonable and customary charges, to what are you typically referring?

A Reasonable and customary charges were usually referring to our facility and physician reasonable and customary programs. And our physician reasonable and customary program will use a fair health bill benchmark as a reimbursement component of that program.

Q Okay. And have you had a chance to look at page 11?

MR. AHMAD: Excuse me. Your Honor, I probably need to approach on this.

THE COURT: Come on up. Come on up, guys.

[Sidebar at 10:16 a.m., ending at 10:19 a.m., not transcribed]

THE COURT: Okay. We got some direction on how the examination will go. Go ahead, please.

MR. BLALACK: So Shane, bring that up and move up the page. See underneath the chart thing? I don't need the chart. It's underneath the chart. Down there below, yeah, where it says -- there

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you go.
BY MR. BLALACK:
Q Now, ma'am, the information that's reflected on this page of the document, Exhibit 4048, where is it coming from and what's it based on?
A The information that was used to put together this chart was taken from the FAIR Health Bill Benchmarks at the 80th percentile.
Q And explain to the jury, what is the FAIR Health Bill Charge Benchmarks? Let's start there first.
A So FAIR Health is an independent third-party organization that compiles healthcare data. And they publish benchmarks that array that data into what are called percentiles. So this particular graph is portraying --
Q Ma'am, I'm just going to ask you to focus on the three- to five-year period that's reflected here on this -- on the portion of the slide being shown to the jury.
A Okay. So that three- to five-year period, it's arraying the rate at which billed charges were escalating over that period of time for out-of-network providers.
Q And when you say the rate at which they were escalating based on the 80th percentile of those benchmarks?
A Correct. So the 80th, this chart is tracking the 80th percentile over time. So that period is demonstrating that that 80th percentile was increasing as a result of bill charges increasing.
Q Now, just to remind the jury, Ms. Paradise -- I think you may

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have said this even earlier in response to my question -- does UnitedHealthcare rely on FAIR Health for any out-of-network programs?

A We do rely on FAIR Health Billed Benchmarks to support our physician reasonable and customary program, which does not apply to ER services but applies to the out-of-network benefit level for physician services.

Q Okay. I want to discuss that more in a moment, but let's focus on the information on this page first. Now, based on the data that was reflected from the FAIR Health database here, can you explain to the jury what UnitedHealthcare was seeing in the FAIR Health data at the 80th percentile during the three- to five-year period reflected in this slide?

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A So United was seeing the billed charge by out-of-network providers escalate. In this chart, to demonstrate that escalation, was translating those charges into a CMS equivalent, which is a benchmark that more easily portrays what the true cost of those services are. And so this is demonstrating over that time period the percent of CMS was increasing at a rapid rate with respect to physician bill charges. So that 80th percentile was arbitrarily increasing as a result of those billing practices.

Q Yeah. Now, this bullet point says, "The last three-five years. It looks like steep growth in usual, customary, and reasonable levels in the 80th percentile reasonable and customary (R&C) for comparison." So again, to orient the jury, this document was dated what time period?

A I believe this is 2018.

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Q So that three- to five-year period would have been somewhere between 2013 and 2015?

A That's accurate.

Q Now, the second bullet says, "This trend contributes to increasing the number of employer claim costs." Do you see that?

A I do see that bullet.

Q What does that mean?

A So as billed charges are increasing, any program that uses billed charges as a basis, by virtue, that reimbursement is going to increase arbitrarily. And typically, member cost share is going to be a percent of what we pay. So if you've got a program that's paying a percent of billed charge or is paying billed charge, that member percent is going to increase along with the increase in the billed charge, as well as for the client or for the plan. If they're using a methodology that's based on billed, as that arbitrarily increases, the cost of the plan as well is going to increase arbitrarily as a result.

MR. BLALACK: I want to see if we can illustrate that dynamic for the jury's benefit, so they really understand what you mean. And I'm going to ask Mr. White if I could turn on the ELMO real quick.

BY MR. BLALACK:

Q Okay. So I've written down four years, 2017, 2018, 2019, and 2020, Ms. Paradise. So I just want to use a hypothetical. So a claim -- an out-of-network claim is adjudicated using the physician reasonable and customary program. That's the hypothetical I'm using, okay?

A Okay.

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Q And you've been through this already, but which benefit level is the physician reasonable and customary program associated with?

A So that program only applies to the out-of-network benefit level.

Q So -- and are emergency room claims adjudicated on the out-of-network benefit level?

A No, they are not.

Q So it would the physician reasonable and customary program be used to adjudicate out-of-network emergency room professional claims?

A That program would not apply to ER services.

Q All right. Now, I want to -- let's assume for the sake of this hypothetical that an out-of-network ER service could apply to be adjudicated using a physician R&C, just for the illustration of this exercise, okay?

A Okay.

Q So in a world where the plan contemplated the claim would be adjudicated and priced at the 80th percentile of FAIR Health, okay? I'm going to use that as an assumption; you follow me?

A Okay. Yep.

Q All right. Now, I'm just going to assume for the sake of argument that the 80th percentile of FAIR Health is $1,000. Okay?

A Okay.

Q So if you have, in 2017, a plan document that contemplated

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reimbursement using the physician reasonable and customary program tied to the 80th percentile of FAIR Health and a claim came in with a $1200 charge on it. Would the allowed amount for that claim be $1,000?

A If that was the rate, for the 80 percentile for that service, yes, the $1,000 would apply.

Q Okay. Now let's say we're in the next year, same scenario plays out. But in the next year, the 80th percentile of the FAIR Health benchmark has gone up 10 percent. Do you understand the scenario I'm assuming?

A Yes, I do.

Q So now you get bill charge. And we'll keep it simple. We'll keep the bill charge the same for this one provider. But the claim comes in and is now being reimbursed at the 80th percentile, which we said was gone up 10 percent, and that would be $1,100 at the 80th percent; is that right?

A Yes.

Q So the same program, same size, same bill charge. But because the charges in the FAIR Health benchmark data have increased at the 80th percentile by 10 percent, the allowed amount has gone up for the plan from 1,000 to $1100; is that right?

A That's accurate.

Q All right. Now let's go to 2019. We'll keep the same $1200 bill charge. Let's assume that the FAIR Health benchmark in 2019 goes up another -- let's say it goes up 5 percent this time. So it goes up a little bit, but not as much as before. What would that generate for the new

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allowed amount at the 80th percentile of FAIR Health? Do you want me to get my calculator?

A Yeah, probably.

Q So according to my math, and probably people on the jury already know the answer to this question. So 5 percent, it would be another $55 according to my math, which would mean now the allowed amount is $155. So is that -- assuming my math is right, is that how it would change between 2018 and 2019, if the 80th percentile FAIR Health benchmark increased between 2018 and 2019 of 5 percent?

A That's an accurate representation.

Q All right. Same thing. $1200 bill charge. The last year for the same service. Reimbursing at the same program at the FAIR Health benchmark at 80th percentile. And this time let's assume it goes up 10 percent. Now we've got 1155 x .1 that adds another, let me do my math on it. That takes us to $1270.50. Would that be the allowed amount using the 80th percentile for FAIR Health database?

A That would be the result of the FAIR Health calculation.

Q But in this case, would that be paid, or would a different number be paid?

A A different number would be paid. Our claim system will never pay more than bill charge, so it will cap it at least at bill charge if the reasonable and customary rate comes back at a higher level.

Q So for a provider to have kept their charge the same all four years, the allowed amount reimbursement would increase every year to the point that it ultimately exceeded the charge, simply because the

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providers in that region reporting their charges to FAIR Health, had their charges increased over that time?

MR. AHMAD: Your Honor, I would object to the leading nature of the question.

MR. BLALACK: I'll withdraw it.

THE COURT: It is leading.

BY MR. BLALACK:

Q Explain how you could get to a point , ma'am, where the allowed amount could increase in this fashion over four years, when the charge has never changed?

A So this is the challenge with basing reimbursement methodologies on bill charges. FAIR Health collects data and arrays those bill charges into what they call percentiles. So as those bill charges are escalating, those percentiles are simply arraying and presenting what's happening with those bill charges. So the 80th percentile, basically means, at that level, 80 percent of the providers are billing something less, the other 20 percent are billing something more. As those bill charges increase, that 80th percentile, if you're using that as a reimbursement, your reimbursement level is increasing, just by virtue of the practices of those providers in the data.

Q So in this case, the only variable that changed over that four year period is the rates being reported to FAIR Health at the 80th percentile by providers in the region, correct?

A That's accurate.

Q Now if you go back to Exhibit 4048. Let's go to page 9.

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Ma'am, the title of this slide is, "A Strong United Healthcare Network." And it says the breadth of UnitedHealthcare's provider network insures today up to 95 percent of member medical claims with contracted providers. That means means that healthcare costs should really take members by surprise. The number of healthcare providers in the network, and it has it in the right hand column with the figure 90-95 percent of the claims captured in the network." Do you see that?

A I do.

Q What does that refer to?

A So that's a statistic to demonstrate that United does offer a wide network, and that most of our -- most of our charges are running through our network. And there's a small portion that is an actual out-of-network provider.

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Q So when you're talking about out-of-network claims, which is what's in dispute in this case, that would fall in the portion that's not captured there, which is the five or ten percent of claims that are not reimbursed within the network?

A That's accurate.

Q Now --

MR. BLALACK: Thank you. You can pull that down, Shane. And I want to go to another document, which is -- oh, I'm sorry no, actually -- keep that up, Shane. My apologies. And go to page 42.

BY MR. BLALACK:

Q And you'll see a summary page that says out-of-network programs overview. Do you see that?

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A Yes, I do.

Q Down at the second paragraph it says out-of-network programs utilize several different reimbursement methodologies that may apply based upon the benefit level. And then it says, (in-network benefit level vs. out-of-network benefit level). Do you see that?

A I do see that.

Q I think there's been some confusion, and I understand why, by the terminology. Benefit level. You've heard of the out-of-network providers, out-of-network claims, in-network providers, in-network claims. But I'm asking about the benefit level. Do you understand those are different?

A I do understand those are different.

Q Okay. What is a -- could you explain to the jury the difference between a network or in-network benefit level and an out-of-network benefit level?

A Yes, so an in-network benefit level claim, and there are some examples listed here in the document, are things like an emergency room visit, a hospital based provider that's non-par or out-of-network but is practicing at an in-network facility. For those situations, the benefit plans will cover those services -- will cover those services. And the member cost share will be the same as if they saw an in-network provider.

So an example would be if you go to an in-network provider, your cost share is 20 percent of what the plan pays. Even when you're out-of-network, that same cost share will apply when that claim is subject to the

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in-network benefit level. So we're not punishing the member for unknowingly seeing an out-of-network provider, as example in an emergency situation.

On the contrary, an out-of-network benefit level, those are scenarios and there's a couple of examples here, seeing a specialist. Members are making a choice to see that out-of-network provider. And as a result their cost share may be different. In those scenarios, you know maybe there's a 60 percent cost share for the member by choosing to go to an out-of-network provider.

Q And you use the term choice. Does the notion of member choice play a role in what's in the in-network benefit level or the out-of-network benefit level?

A Member choice comes in to play at the out-of-network benefit level. The member is choosing to see an out-of-network provider.

Q And in this example, you've listed, as you noted, services that are associated with the in-network benefit level and services that are associated with the out-of-network benefit level. And I see a reference to emergency under the in-network benefit level, and I see a reference to non-emergent under the out-of-network benefit level. Could you explain to the jury those two terms and how they're relate to the benefit level?

A Sure. So emergency services, you know, a visit to an ER room, those services are going to be covered at the in-network benefit level. Again, same member cost share as if they were at an in-network doctor. Non-emergent below on the out-of-network is basically -- it's not

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an emergency situation, so you're seeing a specialist, maybe a dermatologist, and you're choosing to see someone that's out-of-network.

Q Does -- with the benefit level that's been utilized, impact which out-of-network program UnitedHealthcare will use to reimburse a claim?

A Yes, the benefit level can determine which program will apply.

Q All right. So let's turn to page 43 through -- start at 43. And you'll see a summary of programs. I'm just going to scan them. First we see NRP; is that right?

A Yes, that's the first program listed.

MR. BLALACK: Go down a little bit farther, Shane.

BY MR. BLALACK:

Q And you'll see MNRP; is that right?

A Yes.

Q Keep going down. Then you see shared savings program enhanced.

A Correct.

Q All right. You see shared savings program, the old legacy program; is that right?

A Yes.

Q Then you see facility reasonable and customary; Facility R and C. Do you see that?

A Yes.

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Q Then you see physician reasonable and customary, Physician R and C?

A Yes.

Q And finally outlier cost management. Do you see that?

A Yes.

Q Okay. Does that listing that's in this Exhibit 4048 summarize the range of out-of-network programs your team manage and offered for clients during this period at issue we have in this case?

A Yes, it does.

Q Now I want to focus -- turn to page 45 of that list. And if you go down to the bottom, physician reasonable and customary. We were just discussing this. If you look at the program description, it says Physician R and C provides savings on non-contracted claims, when the member had a choice and knowingly received care from an out-of-network provider. Do you see that?

A I see that section.

Q When you're referring there to member had a choice, what are you talking about?

A So that's a member is choosing to seek care from a provider. Again I'll use a dermatologist as an example. The member understands that they're out-of-network and they still choose to use that provider to -- for their services.

Q Is that associated with emergency non-care or a non-emergent service?

A That's going to be a non-emergent situation, not an

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emergency situation.

Q And then on the reimbursement methodology, it says claims are repriced using FAIR Health bill benchmark; do you see that?

A Yes.

Q Is that referring to the FAIR Health data we referred to earlier?

A Yes. That's referring to the FAIR Health bill benchmark data.

Q And then under benefit level, what does it explain about the benefit level for that program?

A That section describes that the benefit level of this program only applies in non-emergent situations and only applies in that out-of-network benefit level when a member is making a choice to see an out-of-network provider, and it would not apply in emergency services.

Q All right. Finally the facility, because I think this came up last Friday, and I want to make sure the record is clear. For the facility reasonable and customary program, does that ever apply to professional out-of-network emergency services?

A No, it does not.

Q That would not apply to professional ER claims?

A It would not apply to professional ER claims.

Q Okay. Now I would like to show you Plaintiffs' Exhibit 370, which I believe is already marked. If you turn to page 2.

MR. BLALACK: Blow up that email from Ms. Paradise dated June 24th, 2019.

BY MR. BLALACK:

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Q And if you look at the bottom, ma'am, it's discussing -- the subject line is SSP. Do you see that?

A I see that.

Q And at the bottom there's a paragraph that says, "As we've discussed, even though we're seeing increasing savings, we're experiencing continued reduction in non-par bill charges that I believe that has been the case since 2016." Do you see that?

A I do see that.

Q Okay. And the -- I'll represent to you that the TeamHealth Plaintiffs have suggested in this trial that your statement in this document means that the bill charges for out-of-network services were going down, not up, as stated in the prior exhibit we saw, Exhibit 4048. Do you agree with the Plaintiffs characterization of your statement in this email?

A No, I do not.

Q How is it possible that you observed a reduction in non-par bill charges from 2016 through 2019 as reflected in this exhibit -- Plaintiffs exhibit, and at the same time you also observed bill charges for out-of-network providers increasing?

A So in the statement what I'm trying to describe is our overall aggregate pool of non-par charges. Non-par bill charges was going down in aggregate. We still, though, were seeing as we looked at that FAIR Health trend, the level of providers that were billing, though, was increasing. So this is simply referring to aggregate pool of dollars that were reducing coming into our programs.

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Q Remember when I showed you a moment ago the slide that referred to the volume of claims that are processed through your in-network system? They refer to 90-95 percent?

A Oh, yes.

Q So that would have meant that would have been 10 -- 5 to 10 percent of the claims that were being processed, as out-of-network claims?

A Correct.

Q Would the accrual of non-par bill charges go up or go down if the percentage of claims that were being processed within your network went up to 99 percent?

A So the pool of non-par out-of-network dollars is going to be lower or will reduce as more charges are running through our network.

Q Now so with regard to -- in looking back at that FAIR Health data we saw, for those providers who were still out-of-network, submitting claims that were not processing through your network program, for that group of providers who were in that pool were you observing that their chargemasters were going up, going down or staying the same during that period?

A So we were observing that their chargemasters were increasing over that period of time.

Q And is that what was reflected in the FAIR Health data we showed you a little while ago during the same period?

A Yes, that was the trend chart that we reviewed.

Q Is there anything inconsistent with your statement here in

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Plaintiffs' Exhibit 370, and the FAIR Health benchmark data that we showed the jury that's referenced in Defendant's Exhibit 4048?

A No.

Q Now I want to talk about the impact of those charges -- bill chargemasters increasing during this time. But to understand that I want to ask you a few questions about UnitedHealthcare's competitive position with out-of-network solutions, when you joined the team in 2015, okay? That's the topic I'm asking about.

A Okay.

Q Now when you joined that team, how would you describe your observation of the UnitedHealthcare's competitive position with respect to out-of-network programs in 2015?

A So when I joined the team in 2015, there was, you know, knowledge that we were behind the market in our program offerings.

Q And I want to show you a document -- well, we'll mark it as Plaintiffs' -- actually I think this is already in evidence. We just admitted it, Defense Exhibit 5506. And I think -- take a look at it and see if your name is referenced as a key team member associated with this document.

A It is.

Q Have you seen this document before, ma'am?

A I have seen this document.

Q I'd like to direct your attention to the box on the right hand side of the document with the header "problems". Do you see that?

A I see that section.

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MR. BLALACK: Can you pull that up, Shane?

BY MR. BLALACK:

Q And it says under problem, quote, "ASO clients have seen their out-of-network costs increase putting a financial strain on both Plaintiffs' sponsors and the insurers. Non-par providers are able to bill what they want for their services." Do you see that?

A I see that sentence.

Q Is that statement consistent with your understanding of the out-of-network market in January of 2018, when this document was written?

A Yes, it is.

Q Let's turn to the last sentence of that chart where it says, quote, "Our inability to reduce these claims payments threatens our competitiveness in the market." Do you see that?

A I see that sentence.

Q When it says that your inability to reduce these claims payments, quote, "threatens our competitiveness in the market," to what are you referring here?

A So United is responsible for providing cost-effective solutions for our clients. If we're unable to provide cost-effective solutions, obviously, that's put that -- puts us at risk for losing existing clients and puts us in a noncompetitive situation for obtaining new business.

Q Okay. If you look at the box on the left-hand side?

MR. BLALACK: Show the other side, Shane.

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BY MR. BLALACK:

Q And the last sentence in the first paragraph reads, quote, "Our client's costs have continued to rise at alarming rates, and one of the main concerns our clients raised to their account teams." Do you see that?

A I see that sentence.

Q What's being described there? What is that sentence describing, ma'am?

A So that's describing the feedback we were obtaining from parts of the organization, that we're hearing from our clients that they were concerned about the rising medical costs they were seeing, and their ability to provide affordable benefits for their employees.

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Q Now, Ms. Paradise, I want to shift to a --

MR. BLALACK: You can bring that down, Shane.

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BY MR. BLALACK:

Q I want to shift to a different topic which is the Data iSight tool. You were asked a number of questions by Mr. Ahmad about that tool; do you recall that?

A Yes.

Q In this case, the team of Plaintiff's have asserted that the Data iSight tool is a -- I believe a phrase that was used as, quote, "garbage", unquote, and like the Wizard of Oz. You think that's an accurate, fair statement?

A I don't agree with that statement.

Q Why not?

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A Well, the Data iSight tool does compile millions of -- millions and millions of claim data, and evaluates the cost, and develops a rate, so there's a sound amount of methodology behind it, it isn't an arbitrary methodology.

Q Now, ma'am, do you know whether any of your competitors also used the Data iSight tool?

A It's my understanding that that tool is broadly used by our major competitors.

Q Do you know whether UnitedHealthcare was the first of the major health insurers to adopt and started using the Data iSight tool?

A United was not the first.

Q When UnitedHealthcare decided to use that eyesight back in -- well, let me back up. When did -- when did you all first introduce that eyesight to your clients?

A Data iSight began to be used for our fully insured business in 2016, and then introduced to our ASO clients, I believe, in 2018.

Q Okay. When UnitedHealthcare decided to use that eyesight, did you have any understanding at the time of whether the payment rates recommended by that tool were broadly accepted by the providers in the market?

A So it was -- it was our understanding based on information provided by MultiPlan, that they were seeing a high acceptance rate of the -- of the rates out of the Data iSight tool.

Q Let's make sure before we get into the details of how this thing works, that the jury understands which of your out-of-network

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programs touch the Data iSight tool and which do not. Okay? And is it accurate to say, ma'am, that some of your out-of-network programs never are involved with Data iSight?

A That's accurate.

Q Okay. Now let's go through the list. Is Data iSight used for the Legacy, the original shared savings program?

A No, it is not.

Q Is Data iSight used for the physician reasonable and customary program?

A No, it is not.

Q Is Data iSight used for the ENRP Program?

A No, it is not.

Q So Data iSight never places a claim for ENRP?

A Never.

Q Is Data iSight used for the Outlier cost management program?

A It is used to support our outlier cost management program.

Q Is Data iSight every used as part of shared savings in any way?

A It is used when a client purchases a program called SSPE or shared savings program enhanced. That, in essence, layers our shared savings program which has access to wrap network agreements, a fee negotiation component, and then the outlier cost management program would be at the end of that hierarchy.

Q So other than shared savings program enhanced and outlier

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cost management, is that asset used for any other out-of-network programs at UnitedHealthcare?

A No, it is not.

Q Have you ever discussed with MultiPlan, ma'am -- strike that. Ma'am, have you ever discussed with MultiPlan how the Data iSight tool works?

A Yes, we've had conversations about the methodology.

Q Okay. And when did you have those discussions?

A Most discussions would have started in earnest prior to us implementing that tool for a fully-insured business in 2016.

Q Okay. And ma'am, do you consider yourself a technical expert on that iSight?

A I am not a technical expert, no.

Q But do you, based on the discussion you had, do you have -- consider yourself to have a general working knowledge of how it operates?

A I do.

Q Now -- and you said that that asset was initially adopted for a fully-insured business in 2016; is that right?

A That's a yes.

Q And then for a self-funded business in 2018?

A Yes.

Q Okay. Did your out-of-network team have a role in operationalizing that asset?

A Yes, we did.

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Q And I think you said you had discussed this; did you receive a briefing? How did you learn about the product?

A MultiPlan, as they do, would have proposed a new solution that they had. We would have reviewed that at a high level, and then we would be obtaining and asking for other information to do proper due diligence on the program before we would ever proceed implementing that.

Q Okay. Do you have an understanding -- I'm focusing on, ma'am, on physician claims, not facility claims; do you have a general understanding what payment data is utilized by MultiPlan's Data iSight tool to evaluate and recommend rates?

A Yes, I have a general understanding.

Q What is that general understanding?

A So MultiPlan is using published claim payments or claim information across the industry.

Q And in terms of the information on a claim that's in that data, are they using the billed charge or are they using the allowed amount, or are they using something different?

A Data iSight, the Data iSight methodology, it is a cost-plus tool, so they're going to be starting with the allowed amounts, so those are the amounts generally accepted by providers in the industry.

Q Now before UnitedHealthcare decided to use the Data iSight tool to reimburse out-of-network claims for some of the programs, did it do any vetting of the tool with MultiPlan to understand how the service operate?

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A So we would have been provided information about how that underlying methodology works. I do believe we were provided a document that outlined that methodology, and we would have had a variety of individuals with very expertise review that information to do our due diligence.

Q Let me show you a document that's been admitted into evidence, Defendant's Exhibit 4478. You'll see a reference to a UNET outlier cost management SSPE high-level overview. Do you see that?

A I see that.

Q And there's a woman's name underneath that, Jolene Bradley; do you see her?

A I do.

Q Do you know Jolene Bradley?

A I know a Jolene Bradley. She works for me.

Q So she reports up to you?

A Yes.

Q Okay. Now have you seen this document before, ma'am?

A I believe I have seen this.

Q Okay. Let's turn to page 2 of this document, and you'll see a header that reads, "Outlier Cost Management Methodology." Do you see that?

A Yes, I do.

Q And underneath that you'll see a reference in the, I guess, third bullet. It says -- it's talking about the Data iSight methodology, and using publicly made available data to evaluate claims, directly made

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reductions from a cost-up rather than a charge-down approach. Do you see that?

A I do.

Q Okay. And I'm focused on professional claims, ma'am, because -- well, let me back up. Does the Data iSight tool offer both a physician module and a facility module?

A Yes, it does.

Q And are those different?

A Yes.

Q Okay. So if we wanted to talk and learn about the product and how it worked, you'd need to focus on the physician module as opposed to the facility module?

A Yes.

Q Okay. Now underneath professional claims, it says, "Based upon stand relative value units, where applicable, the CPT picks a code, multiplied by a conversion factor, Data iSight is not Medicare-based. It does not use the CMS conversion factor. The conversion factors based on the median accepted reimbursement amounts by physicians, healthcare providers nationwide for each code. All reimbursements are adjusted based on the provided geographic location, and for daily labor cost therein." Do you see that?

A I do.

Q Is that description of how the method -- the physician methodology were consistent with the information that was shared to you by MultiPlan back when the program was being implemented?

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A Yes, it is.

Q And when it refers to the reimbursement being based on the median accepted reimbursement amounts by code, what do you understand that to mean?

A So we mentioned that MultiPlan obtains industry, and that basically is saying they're looking at the allowed amounts, and they're arraying them and choosing the median which is going to be in the middle of all the rates that are allowed and will calculate the factor based on that meeting.

Q So the recommended rate will -- the factor, conversion factor would be tied to the 50-yard line essentially, where they're half of the values are above and half or below?

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A That's accurate.

MR. AHMAD: Your Honor, I would object to the leading nature.

MR. BLALACK: Well, let's get this over.

THE COURT: You were leading.

MR. BLALACK: I'll withdraw it, Your Honor.

BY MR. BLALACK:

Q Do you understand what a median is?

A Yes.

Q What is a median?

A A median, you're going to array your values, and you're going to count down until you get to the middle value, so there's equal numbers above and equal numbers below.

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Q Now this document refers to the methodology having a proprietary -- being a proprietary methodology. What is your understanding of what it means from the MultiPlan characterizes this methodology as a proprietary methodology?

A That means to me that MultiPlan has developed that median methodology, and it also states they're levering geographic and prevailing labor information to ultimately develop a rate.

Q Okay. Now does United has access to the proprietary data and information that MultiPlan is relying on?

A No, we do not.

Q So how did you -- what did you do to become comfortable, that you could rely on this tool to give recommended prices for out-of-network claims if some of the information on which it was based was proprietary?

A So MultiPlan would have provided a number of pieces of information for us. One was, you know, the knowledge that most of our other competitors were already using this tool. We also understood that it was widely accepted, so they provided data and statistics related to the acceptance rate by providers of this tool, and also they provided information that our, you know, for example, healthcare economics people would have evaluated, reimbursement levels are the outcome of the tool, to validate that there was a sound methodology.

Q Okay. Let's go to Defense Exhibit --

MR. BLALACK: Thank you. You can bring that down, Shane. Let's look at Defendants' Exhibit 4529. It is in evidence.

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BY MR. BLALACK:

Q This is a presentation from MultiPlan referring to Data iSight. Can you take a look at that second, ma'am, and look at it and can you tell the jury if you've seen it before?

A Yes, I've seen this document.

Q And if you go to page 2, see at the top, it says, "Data iSight, patented highly defensible." Do you see that?

A I do.

Q So when it refers to defensible, what were you -- what was your understanding of what MultiPlan identified was representing this was defensible methodology?

MR. AHMAD: Judge, I'm going to object. I think it's calling for hearsay from MultiPlan.

MR. BLALACK: This is being offered for her state of mind, Your Honor, not to prove the truth of the matter.

THE COURT: Overruled. Overruled.

BY MR. BLALACK:

Q What was your understanding of what they were communicating to you about this defensibility of the methodology?

A Defensibility. That, to me, means that they're able to defend the rate and that providers are widely accepting this rate.

Q And underneath the -- there's an orange bullet, when it references physicians, and it references facilities. With respect to the physician, again, it says based on median reimbursement levels; do you see that?

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A I do.

Q What is that referring to?

A So as we discussed the calculation before, the conversion factor, they're contemplating the median values across the industry that providers are accepting as reimbursement.

Q If you go to page 3 of this document, you'll see it says this is what MultiPlan was representing to you all at UnitedHealthcare. It said methodologies reviewed and confirmed that R.R. Siskin, Ph.D. -- confirmed by Dr. Siskin and specifically found using proper statistical data collection, editing estimation methodology constitutes a reasonable methodology that is transparent to all parties. Do you see that?

A I do.

Q Do you recall MultiPlan advising you and the other network program team about this review by Dr. Siskin?

A Yes, I do.

Q Now let's go to page 6, and you'll see a reference to high acceptance rates with options for protecting member; do you see that?

A I do.

Q Okay. First green arrow there, it says provider acceptance rate, 93, 99 percent; do you see that?

A I do.

Q What did you understand MultiPlan to be telling you in this presentation?

A So that was telling me that across their clients that were currently leveraging the Data iSight tool, that providers were accepting

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those rates at very high levels.

Q And did that information play any role in the UnitedHealthcare's out-of-network program team's decision-making about whether this might be a useful methodology to adopt for some of your programs?

A Absolutely.

Q And why is that?

A The high provider acceptance rate means that, you know, the industry is accepting these rates and, therefore, they're widely accepted, and so it is a defensible good methodology.

Q And the second green arrow says Data iSight inquiry line receives and handles provider appeals and different inquiries, and then right underneath it --

MR. BLALACK: If you go back to that prior page, Shane, that we were just on? There you go. Pull up those first three bullets. There we go. First three. There you go. There. Perfect.

BY MR. BLALACK:

Q And it says we already talked about providers setting this rate, first, the Data iSight inquiry line receives and handles provider appeals, there were inquiries, and then it refers to an optional patient advocacy program, helps educate members and reduces or eliminates members financial obligations to providers. Do you see that?

A I do.

Q All right. What are -- what is MultiPlan describing there when it refers to the Data iSight inquiry line and the optional patient

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advocacy program?

A So MultiPlan is -- or describing that in addition to providing a pricing service to the Data ISight tool, they will support and handle any provider disputes about that reimbursement level, and they will also handle any situations, or they will intake a call from a member should they be getting balance-billed with respect to a claim that was paid with Data iSight. The optional patient advocacy program, again, is just an additional service that MultiPlan will provide, where they will take those provider disputes or member disputes, and they will then take that information and engage with the specific providers that's either downs-billing our member, or it's disputing the reimbursement level, and will attempt to work with them to educate, explain how the methodology works, and in some instances they may attempt to negotiate with that provider to resolve the balance billing issue for the member.

Q And were these services that MultiPlan was offering back when the program was being introduced, important to UnitedHealthcare's decision on whether to adopt the program?

A Absolutely.

Q Why?

A Obviously, we are trying to ensure that we're providing cost-effective solutions, but we do understand from time to time a provider's going to dispute the rate, and potentially might try to chase one of our members for additional charges, so it's important for us that we've got a service that will help our members, certainly work through those scenarios, and provide support for them, as well as working with the

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provider who has a dispute and helping explain our methodologies, and again, ultimately come to a resolution.

Q So ma'am, I want to show you another document. This is Defense Exhibit --

THE COURT: Is this a good time for a recess?

MR. BLALACK: Sure, take your time.

THE COURT: I think you're transitioning. All right. So let's take our second recess. It is 11:03. We'll go to 11:15, and work a little bit past noon, probably 'till 12:15.

During the recess, don't talk with each other, anyone else, on any subject connected with the trial. Don't read, watch, or listen to any report, offer commentary on the trial, don't discuss this case with anyone connected to it, by any medium of information, including without limitation newspapers, television, radio, internet, cellphones, or texting.

Don't conduct any research on your own. You can't consult dictionaries, use the internet, or use reference materials. During the recess, don't post on social media. Don't post on social media about the trial until it's over. But during the recess, don't talk, text, Tweet, Google, or conduct any other type of book or computer research with regard to any party, witness, or attorney involved in the case.

Most importantly, do not form or express any opinion on any subject connected with the trial until the matter is submitted to the jury. Have a good recess. We'll see you at 11:15.

THE MARSHAL: All rise for the jury.

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[Jury out at 11:05 a.m.]

[Outside the presence of the jury]

THE COURT: Okay. The room's clear. Plaintiff, do you have anything for the record?

MR. AHMAD: Nothing, Your Honor.

THE COURT: Did you want to put that issue about the graph?

MR. AHMAD: Yes, Your Honor. Yeah. That -- well, that issue, yes. Yeah, forgot we were supposed to put that on the record, Your Honor. I think we resolved it in terms of how he did it, but we did have -- what exhibit was that?

THE COURT: 44 --

THE CLERK: 4408.

THE COURT: -- 08, yeah.

MR. AHMAD: 4408.

THE COURT: 4048.

UNIDENTIFIED SPEAKER: 4040.

MR. AHMAD: 4048, Your Honor, has a chart with data going back to 2003. Obviously, that is the time of their -- the Ingenics case, which was resolved, finding, of course, that they had engaged in depressing those rates. We have been precluded from going into that lawsuit to explain the data going back to 2003. I do understand that they took the chart down after we raised the issue, but that would be -- that would be our objection, Your Honor.

THE COURT: Thank you.

MR. AHMAD: And we would, you know, we would still ask to

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be able to go into the Ingenics lawsuit to explain all of this data. It goes back into the early 2000's, the time period under with the Ingenics lawsuit.

MR. BLALACK: And my response, Your Honor, is I don't believe there's anything in that data, which is the FAIR Health data, not anything else that could conceivably open the door, but even if there was by virtue of how I conducted the examination, the issue is moot, and so that's our position, Your Honor.

THE COURT: All right. And the ruling was that I did not think that putting the prior data up starting in 2003, the FAIR Health 8 percentile opened the door for the Plaintiff to get into the Ingenics lawsuit.

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MR. AHMAD: And if I may respond, Your Honor?

THE COURT: Yes, of course.

MR. AHMAD: Their health data, of course, is it's based upon the data that was artificially deflated.

THE COURT: Got it.

MR. AHMAD: That's the problem.

MR. BLALACK: That's obviously a disputed fact --

THE COURT: Well, and you --

MR. BLALACK: -- that we don't believe did.

THE COURT: -- you pivoted, took down the graph, and then went down to the bullet points.

MR. BLALACK: I did because I don't need to, and I just removed the issue.

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THE COURT: Good enough. Have a good break, guys. See you at 11:15.

[Recess taken from 11:07 a.m. to 11:17 a.m.]

THE COURT: Let me know when everybody in your team is here.

MR. BLALACK: We're ready, Your Honor.

THE COURT: Thank you. Do you need Mr. Zavitsanos? Let's bring in the jury. Let's bring in the jury. So just to let you guys know --

THE MARSHAL: All rise for the jury.

THE COURT: I'll give you the update after, on the next break.

MR. AHMAD: Okay. Good.

[Jury in at 11:18 a.m.]

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THE COURT: Thank you. Please be seated. Mr. Blalack, go ahead, please.

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MR. BLALACK: Thank you, Your Honor.

BY MR. BLALACK:

Q More or less I just want to pick up where we left off. I believe we were about to move to a new document, and we were discussing the process -- we were discussing UnitedHealthcare's communication with MultiPlan back in 2015, 2016, 2017 time frame as the company was contemplating adopting Data iSight as a tool for one of its out-of-network programs. Do you recall that's where we were?

A Yes, I do.

Q Okay. I want to show you another document. This is Defendants' Exhibit 4531. This is in the -- you can see, ma'am, that the

cover page of this document is a Data iSight document reads Data iSight product and methodology [indiscernible] module. Do you see that?

A I do.

Q What's the date of this document?

A June 2016.

Q And were you part of the out-of-network programs team at that time?

A I was.

Q Have you seen this document before, ma'am?

A I've not seen this document.

Q And was this document provided to UnitedHealthcare by Data iSight?

A Yes, it was.

Q Do you know why MultiPlan gave this document to UnitedHealthcare?

A They provided this document for -- to help with our due diligence in evaluating the Data iSight tool and its methodology.

Q Now, let's turn to page 2. If you go to the top left-hand column, you'll see a paragraph that reads "Data iSight's physician module is available to address out-of-network physician and other medical healthcare professional claims for payments made utilizing a unique proprietary methodology that's applied consistently to all professional claims for a particular client." Do you see that?

A I do.

Q When it says methodology that is applied consistently, what

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did you understand that to be saying?

A So I understand that to mean that they -- the tool completes the calculation that we discussed earlier across the services and the calculation is applied to the appropriate services. So there isn't a unique or special calculation specific to one provider type or certain claim type.

Q Okay. Is it fair to say that you understood based on what Multiplan told you that Data iSight was aligned -- in terms of its recommended price, aligned as to the service that was being provided for the provider?

MR. AHMAD: Your Honor, I will object to leading. And again, all of this I assume is not for the truth of the matter but for state of mind.

MR. BLALACK: That's correct. The purpose of this question, Your Honor, is to explore what UnitedHealthcare understood about the product at the time it was assessing the --

THE COURT: Good enough. Just watch the leading.

MR. BLALACK: Thank you, Your Honor.

BY MR. BLALACK:

Q So ma'am, again, what was the relevance of applied consistently to all professional claims?

A Well that just to me and to our organization, that helped us understand that that calculation and methodology is consistent. They're going to be neutral as far as what the provider type is or the services. It's going to execute the calculation and there's no intervention in that calculation.

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Q And the next paragraph near the bottom, the last clause reads, "The physician module is based on the amounts generally accepted by the provider as payment in full for services." Do you see that?

A I do see that.

Q What did you understand Multiplan to be telling you there?

A So Multiplan is describing there that part of their methodology is looking at allowed amounts across the industry and in their experience as well as with that tool, that the outcome of their Data iSight tool is broadly accepted.

Q And if you go to the 4th page of this document, ma'am, you'll see a header that reads robust source data. Do you see that?

A I see that section.

Q And then it refers to the physician module utilizing the most recently available national, private, and professional claims data representing, and it says in excess of 80 pairs across the country, millions of covered lives, hundreds of millions of healthcare transactions; do you see that?

A I see that.

Q What did you understand Multiplan was representing about the source data that was being used for its methodology?

A So they're -- this is demonstrating that they're leveraging a wide variety and a wide swath of claim data as the source data for their methodologies.

Q Now, based on this description of the data on the Data iSight

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tool was to provide, was the UnitedHealthcare out-of-network team that you were a part of comfortable that the data was sufficiently robust for purposes of pricing out-of-network claims?

A We did feel the data was wide enough. Yeah.

Q Now, let's look at page 5 of this document. And you'll see in the right-hand column a text that starts with the word "finally"?

A Yes, I see that.

Q It says, "Finally, the client can specify a high or low override carve out codes they require for their contracts. For example, a Medicare override could be applied or applied only for specific codes." Do you see that?

A I see that section.

Q What do you understand an override to mean?

A So an override is a discretion the client of Multiplan would have to provide additional information on how they want to leverage the Data iSight reimbursement amount.

Q Okay. Has United Healthcare ever used an override in connection with Data iSight?

A We have used an override for ER services.

Q And I believe in response to questions from Mr. Ahmad, you discussed the ER override in answering his questions; is that right?

A That's right.

Q So when we're talking about the ER override, is that this sentence referring to something like that?

A Yes.

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Q Okay. Now, let's just make sure that the jury -- just remember [indiscernible] both of us, make sure we're clear on what the ER override is and how it works. So if you could just generally walk the jury through how the mechanics of the ER override works?

A Sure. The ER override is in place and is set up as a greater of comparison. So for the ER service codes, the Data iSight rate will be reviewed against our ER override, and we will pay the greater of those two rates. And the override really is put in place to help ensure that we are compliant with the Affordable Care Act requirements around ER services.

Q Is the -- you say the ER override, I mean, does that mean literally that this override that you're describing is only applicable to an ER service?

A That ER override is only applicable to ER. It is not across the various other services that the Data iSight tool would price.

Q And is that because of this Affordable Care Act requirement?

A Yes.

MR. AHMAD: Judge -- Your Honor, I'm going to object to -- I mean, it's come out a few times, but if she's going to be opining on the law, I'd have to object. She's not a legal expert.

MR. BLALACK: Your Honor, she's not opining on the law. She's simply explaining that that's why --

THE COURT: Just clarifying the questions.

BY MR. BLALACK:

Q Yeah. Ma'am, I'm not asking you whether the override -- you

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were successful with your override in complying with the Affordable Care Act. I'm asking was the reason for the override an attempt to comply with the Affordable Care Act?

A Yes, it was.

Q Now --

MR. AHMAD: Your Honor, can we approach for one moment?

THE COURT: You may.

[Sidebar at 11:26 a.m., ending at 11:30 a.m., not transcribed]

THE COURT: Thank you all for your professional courtesy.

MR. BLALACK: Should we proceed, Your Honor?

THE COURT: Please.

MR. BLALACK: Okay.

BY MR. BLALACK:

Q So Ms. Paradise, I just want to make sure the jury is clear, this override was put in place by the out-of-network program team as part of an effort to be compliant with rules, correct?

A That's correct.

Q Okay. You understand that in this case, the question is the reasonable value of the services under Nevada law, correct?

A Yes.

Q Okay. Now, let's talk about this override. I want to just make sure the jury is clear on the interplay here. If the Data iSight rate was higher than the override, which allowed amount would be used to [indiscernible] the final?

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A If the Data iSight rate is higher than the override, the Data iSight rate would be used.

Q Okay. If the Data iSight rate was lower than the override, which one would you use?

A If the Data iSight rate is lower, then the override would apply.

Q Okay. So this methodology, which was I think you said limited to these ER claims only, were just to ensure there was always the higher of those two rates was always paid?

A That's accurate.

Q Since it worked as a floor?

A Yes.

Q Now, in response to questions from Mr. Ahmad -- well, back up. I think you testified that at one point the ER override was set at 350 percent of Medicare; is that right?

A Yes, that's accurate.

Q And then it was dropped to what?

A 250 percent of CMS.

Q Of the Medicare fee schedule rate?

A Yes.

Q Okay. And I think Mr. Ahmad suggested to you that this override never really worked in such a way that the Data iSight rate would ever be paid, that it only paid the Medicare rate -- the override rate; do you know that to be true?

A I don't know that to be true.

Q Let's, for the sake of argument, let's say Mr. Ahmad is right

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and every single time the allowed amount was calculated using Data iSight for an ER service, it was paid at the override rate. That's my hypothetical, okay?

A Okay.

Q Consistent with what Mr. Ahmad was asking. What would that say about what the recommended rate was from Data iSight for those services?

A Well, that would mean the Data iSight rate was lower than that override threshold.

Q And UnitedHealthcare chose the higher rate?

A And UnitedHealthcare is choosing the higher rate.

Q Now, did Mr. Ahmad show you any evidence indicating that every single one of the claims reimbursed using the Data iSight tool for emergency services where the override applied always, and every time pay the override rather than Data iSight rate?

A I have not seen those statistics.

Q Now, I want to show you a document he showed you, which is Plaintiffs' Exhibit 444. Do you recall this as an explanation of benefits? Do you remember that?

A Yes. Can I get the document?

Q You absolutely can get it. I just want to focus on the remark codes that he showed you, ma'am, on the second page.

A Okay.

MR. BLALACK: Bring that up, Shane, and under the IS -- no, you're right. Keep going right there. See where it says IS [indiscernible]

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right there. Perfect.

BY MR. BLALACK:

Q Now, ma'am, in the circumstances where an out-of-network emergency room claim was priced using the ER override, does United Healthcare believe that Data iSight is still being used to adjudicate those kind of claims?

A The Data iSight tool is being used to administer the override and as part of paying the override, there is a compare function that happens within that tool.

Q So when a claim is run through Data iSight, is eligible for Data iSight, is the claim being reimbursed using Data iSight whether it's reimbursed using the Data iSight rate or reimbursed using the ER override?

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A Yes, that tool is being applied.

Q Okay. Now, I just want to make sure the jury is clear about disclosures in the summary plan description. You -- how many ER claims --

MR. BLALACK: Strike that.

BY MR. BLALACK:

Q -- how many CPT codes for ER services are, to your knowledge, subject to this override?

A There are five CPT codes.

Q How many ERs --

MR. BLALACK: I mean, strike that.

BY MR. BLALACK:

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Q How many codes, CPT codes, representing individual discreet services and procedures, are out there in the main role, that are being reported by doctors every day?

A Tens of thousands.

Q And does the ER override those other codes?

A No, it does not.

Q So you were talking about it being very -- it would be very descriptive to try and calculate the actual, and of course the actual reimbursement rate in the summary plan description for every single Data iSight rate under every circumstance. Do you remember that testimony?

A Yes, I do.

Q Why is that?

A Typically when you're visiting an ER, yes, there will be the ER code, that's the evaluation, but there likely are many other services that could be provided to you in that instance, and those services, you know, would be priced, using that data iSight rate.

Q And the ER override would be irrelevant?

A The ER override would be irrelevant to those none code services.

MR. BLALACK: So you can bring that down, Shane.

BY MR. BLALACK:

Q So just to tie this off, at the time that UnitedHealthcare was vetting that iSight tool for introduction into some of its out-of-network programs, is the information -- did the information that Multiplan

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provide make you comfortable with going forward with the product or not?

A It did make us comfortable.

Q What information that they provided you with, was most important to the company's decision to proceed?

A I think it was a combination of things. The fact that it was widely used by our competitors. The fact that it was widely accepted by providers, and they provided, also, information with respect to the methodology that we were able evaluate and do our due diligence.

Q Let's move to a different topic now, and I think Mr. Ahmad asked you about this, and I know the jury heard a lot about it from Mr. Haben, it's called total cost of care. Do you remember that phrase that you were questioned about?

A Yes, I do.

Q There's been a suggestion in this case, ma'am, that UnitedHealthcare was receiving complaints from clients about the shared savings fee for some of its the programs, and that it came up with a new out-of-network program called total cost for care, that would replace shared savings. In other words they have -- my colleagues on this side have suggested that total cost of care, you knew exactly what the shared savings program does, it just had a different name and a different keystroke. Is that -- is any of that statement consistent with your understanding of the term, total cost of care?

A No, it is not.

Q All right. First of all, explain to the jury what does total cost

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of care mean, as it was used within UnitedHealthcare?

A Total cost of care was terminology that the organization was developed to talk about all of the variety of programs and services we provide to our clients, to drive value for them. So it could be related all payment integrity, waste and abuse added. It could be our out-of-network programs, it could also -- or did also include such things as clinical programs and medical necessity type services we can provide.

Q And what was the objective of the total cost of care concept?

A The concept was trying coalesce the organization around all the things we do to bring our clients value, to ensure that we were, you know, managing and evaluating, and creating additional value for our clients, and then provided at least the idea of potentially we could develop a new way, or a new program for our clients, that would collectively bundle all of those services together, and charge a fee for all the services, versus a sort of list of different services that you'd pay one-off fees for.

Q So would it be fair to characterize total cost of care as bundling all of your service offerings into a single package, and charging a single fee, as opposed to an la carte pricing?

MR. AHMAD: Your Honor, I'll object to the leading.

MR. BLALACK: I'll withdraw.

BY MR. BLALACK:

Q How would the pricing suggest that it was partly undertaken at the time, the total cost of care, which was all types of care, for the proposed total cost of care, how did those compare?

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A The concept was to collectively pull together all of the value we were providing, and to develop a fee that would reflect all of that value.

Q Whereas, for example, for the shared savings program, when there's a savings fee charged, or administrative fee for that program was that programming charged separately from the PMPM administrative fee?

A Yes, that's accurate.

Q Would it be accurate to characterize the savings fee as an ala carte service?

MR. AHMAD: Your Honor, I'm going to object, again, it's leading.

MR. BLALACK: I'm asking, would it be accurate?

THE COURT: Just rephrase.

BY MR. BLALACK:

Q Ma'am, have you heard the term "a la carte"?

A Yes.

Q How would you describe "a la carte" in relationship to the administrative fee used for the shared savings program?

A A la carte would me there's additional services. A client could choose, in addition, that there would be a separate charge for, in addition to their base administration fee they pay the organization.

Q And was one of the goals of the total cost of care initiative to do away with that kind of [indiscernible]?

A That was the concept at the time, yes.

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Q Okay. Is it accurate to characterize the total cost of care concept as an out-of-network program to design and control out-of-network costs?

A No. It was not specific to out-of-network.

Q So if anyone suggested to this jury that total cost of care was simply synonymous with providing an out-of-network program solution, would that person be wrong?

A They would be inaccurate, yes.

Q As the total cost of care, single group concept, that UnitedHealthcare was discussing several years ago, ever been rolled out to clients?

A It has not at this time.

Q I want to talk about the shared savings fees which you were asked about and had come up again in this trial. There's been suggestion by the TeamHealth Plaintiffs that there isn't much involved in administering the shared savings program, and that therefore UnitedHealthcare is earning a windfall from that program. Do you believe that's an accurate characterization of the program?

A It is not accurate.

Q Why does UnitedHealthcare care charge the shared savings fee?

A The shared savings fee offsets a variety of expenses the organization incurs to develop, maintain, and support these out-of-network programs.

Q And what are the administrative expenses that you all incur

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that the fee is designed to cover?

A So there's a variety of things. One is a -- there's significant infrastructure built into our various claim adjudication systems, that have to have all of the various claim processing logic. There are some programs that United, itself, supports on its own, so there's a lot of technology involved in that.

It's also providing, you know, offsetting costs related to a routing to the vendor. There's a very complicated electronic data interchange. There's also fees associated with our various vendors. There is an infrastructure around managing the programs, helping support provider disputes, so my entire team is solely focused in this space, so there's costs for my team.

Our member and provider services teams also will field calls specific to these programs. There's also legal regulatory assessments and evaluations that have to be undertaken. There's operations around setting up these benefit plans, maintaining language in SPDs, et cetera. So it's quite of a large infrastructure.

Q Okay. Now the jury has heard a term in the trial called an FTE. Have you ever heard the term FTE?

A Yes.

Q What does an FTE mean to you?

A An FTE is a full-time equivalent. It's another term we use to describe employees of the company.

Q Was their plan for an employee -- one employee and one full-time equivalent?

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A One full-time equivalent is translating that FTE into the number of hours they work, so one FTE translates to a 40-hour work week.

Q So you could have an employee -- one employee that works 40 hours a week, or you might have ten FTEs that work 40 hours a week, four hours each, or some combination?

A Correct.

Q Now it's been suggested to the jury in this trial, that for the entire shared savings program, it was administered by 12 FTEs. Would that be inaccurate?

A That's not an accurate statement.

Q Can you give the jury a sense, based on your leadership of the program, possibly how many FTEs are involved in the support of the insurance industry?

A Sure. My team alone is roughly 70/80 FTEs, and there are hundreds of FTEs across the enterprise that support our programs.

Q Does United Healthcare earn a shared savings fee if its clients do not also save money on medical costs?

A Where United is charging a client on a percent of savings, we do not obtain a fee if we do not drive savings for them.

Q So if the allowed amount and the bill charges are the same, is there any saving?

A No.

Q Is there any fee?

A There's no fee.

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Q Now, based on your years of running this program for UnitedHealthcare, what is your understanding of what clients are willing to pay for a shared savings?

A Clients are willing to pay for these services. They want to provide robust medical benefit offerings for their clients, and oftentimes will provide for an out-of-network benefit. So these programs provide value to the clients, to provide cost effective solutions for their members. These programs help reduce their medical costs, so they can continue to provide those offerings.

Q And what about the extent to which the clients are seeking advocacy and protection for their employees, who are subject to [indiscernible]?

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A And that's another important component of our program is that our ASO clients demand, that we are engaging and protecting their members with our program. So it's a key component.

Q It's my understanding that the shared savings fee can be different based on the client; is that correct?

A That fee can vary, yes.

Q Is there a typical number, in your experience, that a fee usually hovers around?

A When it's a percent of saving, it's typically in the 30 to 35 percent range.

Q And have you ever heard of a fee cap?

A I have heard of fee cap.

Q What is a fee cap?

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A So a fee cap is a dollar amount that is put in place. So if a particular claim drives savings greater than that dollar amount, the fee for that claim will only be calculated on that dollar amount.

Q Is that part of the fee structure for some ASO clients?

A That is part of the structure for some, yes.

Q So just to get a sense of the relationship between savings and your fees that you earned, there's been evidence in the case that they were years, in which UnitedHealthcare earned across the whole United States, all clients, all members, something along the order of a million dollars in shared savings fees. Is that consistent with your memory

A Yes. That's my understanding, yes.

Q So using just this general 30 percent as a typical fee, if that's what was the average fee, can you give the jury a sense of what the savings, the value to clients and the members were to earn that fee?

A So the total savings that would have been driven to drive that fee would have been in the neighborhood of four to $5 billion of medical cost savings.

Q Ma'am, are you proud about you've done, leading out-of-network program team in the last four or five years?

A Yeah. I'm very proud.

Q Why is that?

A We are helping solve problems for our clients. We are addressing egregious billing behavior in the market, and we're providing a very valuable product for our clients, and I think most importantly

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we're helping protect our members from balance billing tactics.

Q Thank you, for time, ma'am.

MR. BLALACK: I'll pass her back to Mr. Ahmad.

THE COURT: Redirect.

MR. AHMAD: Thank you.

REDIRECT EXAMINATION

BY MR. AHMAD:

Q Ms. Paradise, I just want to make sure I'm clear, you are familiar with the revenue numbers of shared savings; is that right?

A Yes, I am.

Q And you know that the whole shared savings program added, is it 12 employees?

A I'm not sure where the 12 FTEs is coming from.

Q Well, if we look at Exhibit 76 -- and I'm talking about added.

MR. AHMAD: You can put up Exhibit 76, at page 21.

BY MR. AHMAD:

Q Do you have that page in front of you?

A Which page are you directing me to?

Q 21.

A Yes. I see the page.

Q Okay. And do you see -- we don't have it up yet. And by the way, can you tell by looking at that page 76 -- excuse me, page 21 of Exhibit 76, the additional employees listed there?

A Yeah. So this outlines incremental FTEs that were required.

Q And that incremental, i.e., additional number of employees,

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is 12?

A For this particular implementation there were an incremental 12 on my team specifically.

Q Okay. Well, do you know how many employees total, were incremental to the shared savings OCM program?

A So from this document I know what was added to my team. There was another out-of-network affordability team at the time that added five. So there were 17 within network. There was additional staff that was added in our member and provider services organization. I don't know those numbers.

Q Okay. So 17, that you know of?

A Seventeen that were specifically in our out-of-network space.

Q And to be clear, you are over the out-of-network programs, correct?

A Yes, I am.

Q Okay. And you talked about other things that went into the support for the shared savings program you mentioned phones, right? Legal claims processing, infrastructure, all of those you would have had in place before shared savings, right?

A Well, that's not entirely accurate. We did have to make technology changes. There are always technology changes when we're implementing a new program. There's, you know, standard processing procedures that have to be updated, it's a fairly large undertaking.

Q I mean, you didn't add any lawyers, as a result of it?

A I don't recall that we added any lawyers, but it was

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additional work on the existing lawyers.

Q Now you were asked, also, about the switch to total cost of care. To be clear were you all switching to total cost of care, because clients were complaining about the large fees they were paying on shared savings, and you were looking for something to retain that revenue?

A I wouldn't entirely characterize it that way. As I stated in my prior testimony today, the concept of total cost of care was about bundling all of our value together and charging a fee for it. It wasn't in specifically due to any client complaints about their out-of-network fees.

Q But let's be clear, there were complaints, right, the shared savings fees are making United uncompetitive, right?

A There were. It's an industry practice to share -- I'm sorry, charge percent of savings, and we were hearing from some clients, about their fees, yes.

Q That it was making United uncompetitive though, shared savings fees, right?

A That terminology may have been used in the organization, yes.

Q May have been used? Well, we can look at Exhibit 342, page 2.

MR. AHMAD: We can just pull up that summary.

BY MR. AHMAD:

Q And I think it's the first bullet point. "Shared Savings are making United" -- "UHC uncompetitive causing earnings squeeze," that's

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United's earnings, right?

A I see that bullet, yes.

Q Okay. And then the purpose of switching over to TCOC or Naviguard was part of that, right?

A Naviguard was one component that was under concept during the total cost of care. It wasn't a direct result of the total cost of care initiative.

Q The idea behind Naviguard was to retain earnings from Shared Savings, correct?

A The idea of Naviguard, yes, was to develop an additional solution for our clients and contemplate a different way to charge our clients for those solutions.

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Q In other words, you were trying to retain your earnings from Shared Savings by going to Naviguard and TCOC --

A Yes.

Q -- correct?

A We were trying to retain the fees that we earn that offset the cost of our programs.

Q Yes. I mean we can look at this on page 5. It talks about, first line, "Retaining revenue holds customers, holds customers harmless," right?

A That's what it says.

Q Now, if we go to Exhibit 236 and page 11, I think it talks about how Naviguard is going to retain those earnings. And the TCOC model, right? And if we look at the far right box --

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MR. AHMAD: Going down. If you could pull up that box.
BY MR. AHMAD:
Q And it says at the bottom, right, it says, "Well, objective. Thank you for that. Create UAC as ACO model to contract the clients on TCOC and extract economics through admin fee," right?
A That's what it states. And as I've explained before, total cost of care was broader than Naviguard. Naviguard was well under the way in conceptual design prior to TCOC. But as the organization was talking about, all the value we were driving, it was put under that umbrella to capture all the value beyond out-of-network programs. So when we talk about an admin fee related to total cost of care, that that admin fee would have been for all the value. It was not specific to out-of-network programs.
Q But the admin fee, and you say in the next bullet point, is targeted ultimately to be able to replace all of those out-of-network, that one billion in shared savings economics over time, right?
A Yes. As I was explaining, the concept of TL -- TCOC and creating an admin fee, that admin fee would be replacing all of our a la carte. It was not specific to out-of-network.
Q Well, this says you're trying to replace your out-of-network shared savings economics, right?
A This was an out-of-network specific presentation. So, yes, it was focused on out-of-network. But the TCOC concept was not specific to out-of-network.
Q Yes. Now, you were also asked -- I'm going to switch to

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another topic. I think you were also asked about whether emergency room claims ever had to be paid reasonable and customary or usual and customary. Do you remember that?

A I do.

Q Is it your testimony that emergency room claims never had to be paid in usual and customary?

A My testimony has been our physician reasonable and customary program does not apply to ER services.

Q Did you all ever have to pay ER claims at usual and customary?

A I am unaware of a specific situation. What I can state is the actual program is not built to administer on ER services.

Q Okay. The program is not built to administer that?

A The physician R&C program only applies to out-of-network benefit level claims. It --

Q And I don't want to get caught up in semantics. Let's talk about usual and customary. Did you all ever pay ER claims at usual and customary?

MR. BLALACK: Object to form. Vague as to term.

THE COURT: Well, just define the time frame.

BY MR. AHMAD:

Q Well, ever, to your knowledge?

MR. BLALACK: Your Honor -- Your Honor, my objection is vague, because I don't know what he's referring to as usual and customary in this question.

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BY MR. AHMAD:

Q Well, I'll just -- I'll just show you an exhibit and --

THE COURT: We've had a lot of testimony on that. Overruled.

MR. BLALACK: I just don't know if she knows what he's referring to.

MR. AHMAD: Sure.

BY MR. AHMAD:

Q Well, let's look at Exhibit 146 at page 42. And, by the way, if you're not aware of paying ER claims at usual and customary, just let me know.

A I'm sorry. What page are we looking at.

Q Page 42 of Exhibit 146.

A Okay.

Q Does that look like you're paying emergency room, and it says at the higher of usual, reasonable and customary?

A Well, the terminology here is not referencing our physician R&C program. And I believe -- I'm sure there's been testimony this week that the terms usual, reasonable, and customary get used many, many different ways. What I can state is to physician R&C, reasonable and customary, program would not have applied in this situation.

Q Well, this says -- and I'm just -- the language itself says, "Emergency health services provided by a non-network provider," right?

A That's what the sentence states.

Q A physician is a provider, right?

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A Correct.
Q So this would apply?
A Well, what would apply is the greater of those three things. I don't see a definition of what usual, reasonable, and customary means.
Q Okay. But using this language it says that usual, reasonable, and customary amounts?
A Well, it specifically says the greater of. And if usual and customary and reasonable is not defined, I'm unsure what that prong would suggest as the price.
Q I agree with that. It says the higher of the amount. And I'm pretty sure it will be the higher of the amount. But be that as it may, this is the language that applies for the emergency room physician, right?
A In this benefit plan, it is suggesting usual, reasonable, and customary is one of the three prongs. It -- I don't see a definition on this page of what that means. And I know for a fact our physician reasonable and customary specific program does not apply in ER services.
Q Well, you have to follow this, right?
A Well, of course we have to follow it.
Q Okay. Let's look at Exhibit 363. Do you see at the top those terms, reasonable and customary, usual, customary, and reasonable amount? Do you see that?
A I see those terms.
Q 363, by the way, is United's website?
A Was that --
Q Is that right?

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A Was that a question?
Q Yes.
A Yes. This is off of an old version off our website, yes.
Q And how old?
A I believe this was first put out there, I don't know, early 2010s. I believe it's been updated in the last year or two years.
Q Well, it's -- my one has a copy, it says 2019, right?
A Correct. This information has been on the website for a period of time.
Q Yes. And you understand that the claims at issue here are 2018, 2019?
A I understand that. And this site is specific to payment for out-of-network benefits. The out-of-network benefit level.
Q Yes. And it says -- in this instance, it says, "The lower of the bill charge for reasonable and customary, usual, customary, and reasonable," correct?
A It does make that statement in that connection.
Q Okay. And United would follow this if the benefit plan has that language, right?
A United administers what the benefit plan language states.
Q Okay. Now, I saw earlier -- I think you were asked by Mr. Blalack -- there was some United pieces and United communications similar to the talking points about how billed charges were going up. Do you remember that?
A Yes, I do.

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Q And it talked about percentages were just going up. Have you actually seen the data on that?

A Well, I'm not an expert on the data. We have a healthcare economics team that compiles that information. So the FAIR Health chart that we reviewed that demonstrated that ten -- trend was put together by our healthcare economic actuaries based on the FAIR Health data.

Q Well, but what I didn't see is that information coming from somebody besides United, and then we'll get to another one, by a MultiPlan, okay, not from FAIR Health, right?

A That's not accurate. So we license the FAIR Health bench marks, and that trend chart used the actual billed benchmark data that we and many other payers license from FAIR Health. So the underlying data was FAIR Health data.

Q Ms. Paradise, there's not one document from FAIR Health in this case saying that.

MR. BLALACK: Object to foundation of the question. The witness is not a lawyer.

THE COURT: Overruled.

THE WITNESS: I believe the chart stated that we used the FAIR Health, that trend chart used the FAIR Health 80th percentile of billed charge data to compile that CMS equivalent chart.

BY MR. AHMAD:

Q That was a United document. I'm asking you is there a FAIR Health document that has that data in this case?

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A I'm unaware of all the documents that were produced in this case. I've not seen the exhibit list.

Q Okay. Now, when we get to MultiPlan, I think you mentioned that they have a lot of metrics that they use to come up with the allowed amount, right?

A Well, they have methodologies they use to develop their allowed amounts that support their programs.

Q Okay. And do you have any idea on any given code -- I mean we have, as you know, five or six codes for emergency room, right? Do you have any idea what those numbers are, how MultiPlan or Data iSight comes up with the numbers for any of those codes?

A Are you asking me if I understand the Data iSight methodology?

Q Well, let's start with that.

A Okay. Well, I believe we just reviewed the physician methodology earlier, that they're going to use relative value units and apply a conversion factor that's based on the par median accepted rates by providers in the industry. So that would apply for those codes as well.

Q Anything else?

A Then I believe in the calculation they also apply that geographic and labor index.

Q Anything else?

A I'm not an expert in the methodology. That's my high-level understanding of how that calculation works.

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Q And I -- and fair enough. I know you're not an expert. And I'm just trying to understand everything that goes into that methodology so that we can figure out how Data iSight arrives at a number for any of these codes. Can you tell us what that number is for any of the codes in this case?

A The specific Data iSight number, no, I do not know it for a specific code because it's going to vary by code by geographic locality.

Q Okay. Have you seen any document in this case that actually gives us a Data iSight -- I don't expect you to memorize. But have you actually ever seen any document which gives you the Data iSight rate as reflected by this methodology?

A In preparation for this trial, I don't recall seeing that document. I'm not sure if that exists in the exhibits.

Q Well, I know you were asked, you know, did I show you 11,000 claims to demonstrate or 1,000 claims, however many Data iSight did, to demonstrate that their methodology and their result is never shown, it's just the 250 or 350?

A I -- can you --

Q Do you remember being asked that?

A I remember being asked that.

Q And the truth is in all of your preparation, all of your preparation from depositions in this case in the summer, you still haven't seen one claim where the allowed amount was anything other than 250 or 350?

A I believe my testimony was I am not reviewing any claim. I

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didn't review any of the thousands of claims that are at -- at issue in this case. So I can't be certain whether or not the Data iSight rate was actually used.

Q To your knowledge, has anyone checked?

A I am sure there's data on that. I don't recall that right now.

Q Well, let me go back. You were asked also about Exhibit 444.

MR. AHMAD: Put that up. And if we go to the top of page 2 -- yeah, the top part of page 2. And I just want to make sure that this is right. It says, "The member that was paid provided by out-of-network provider." And it says, "We paid the provider according to your benefits and data provided by Data iSight." What data did Data iSight provide to pay this claim at 250 percent of Medicare?

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A Well, there would've been the compare where they would've laid out what the Data iSight rate was. They compared it to the override, and they would've returned the higher value back to us.

Q It says, "We paid it." They just paid it according to the override, right?

A If they used the override, that's because the override was higher than the Data iSight rate, and the Data iSight tool would actually calculate the dollar amount, the 250 percent times CMS. So they're going to price that and return it to United for a claim payment.

Q Okay. And to be clear, to your knowledge, you haven't seen one yet where the Data iSight number is actually revealed in that comparison, right?

A The actual comparison is an automated process, so if they're

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going to return the recommended price to us. Certainly, if we would ask for a detailed summary on a claim-by-claim basis, they would be able to provide that.

Q Okay. Have you ever seen that in any of these claims?

A At the claims at issue in this trial?

Q Sure.

A I have not reviewed every document that's been produced, so I can't be certain if something like that exists.

Q And have you ever seen a -- and it says, "also, according to your benefit." Have you ever seen a benefit plan that listed the 350 or 250?

A I think we talked about that earlier. It would be very difficult to develop benefit plan language that would specifically list a rate that only applied to certain codes. Data iSight is used for thousands of other codes, and all of those rates vary based on the underlying data.

Q Well, I understand, but let's be very clear. There are six codes for ER and the 250 is going to apply to all the ER, and you're telling me that language that lasts 100 pages, you can't put under ER that there is an override of 250 percent as it pertains to ER codes?

A Well, those rates -- again, the 250 percent of CMS is going to end up being a different result. It is very complicated to list specific rates in a benefit plan because of the length of the document, so if we have to put it in there for ER, then the next provider type would ask us to be listing discreetly what the rates are for those thousands of other codes.

Q But you do list out by specialty, right?

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A The provision in the SPD that's calling out ER, I believe, is due to some requirements about how we treat ER and ensuring our members understand how those services are covered and paid.

Q Got it. Is there any other override, by the way, that applies to other doctors other than the 350, 250?

A There might be one other scenario where there's an override, out of all of the provider types that are paid through this tool.

Q Just one other one?

A Yes.

Q Okay. So you don't have to go listing a whole bunch of different override numbers, because there's only one other one, right?

A Understood, but then if we're listing the override rates specific to services, what it -- you know, we should then be listing all of the rates for all services. It's just not -- we wouldn't be able to administer that.

Q Yeah, but I mean -- now, providers don't necessarily have the SPD, right? I mean, because there could be SPDs for, you know -- well, it could be everybody's different, right? You could have an employee that comes on one plan, the next employee comes on another plan, and I haven't even gotten to the uninsured and Medicare, and it's not like they go through these benefit plans.

A Understood, but lots of providers use billing companies or have administration arms that are setting their billing practices. They're also calling in to determine eligibility for providing services and are able to ask for and obtain either on our portal or via our provider's services

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line information about the benefit plan language.

Q Okay. In any event, you've never seen this override in here?

A The override is not specifically listed in a plan document.

Q Okay. Now, let's talk about -- I think you were shown some documents, and it may be Exhibit 4048, if we can go to that. And I believe -- I'm not sure which page it is, but there's a page indicating that 90 percent of providers are in-network; is that right? Do you remember seeing that document?

A I believe that document says 90 to 95 percent of our doctors are in-network, yes.

Q And that's a United document, correct?

A Well, yes, it's a United document. They manage the network for UnitedHealthcare.

Q That's for all -- I think we're about ready. I think we had it on the screen briefly. But in any event, that's not for ER doctors, right?

A No.

Q That's for all --

A And --

Q -- providers?

A And I don't believe this slide is representing that it is. It's stating about our entire network.

Q Do you have any idea what the rate is for ER doctors being in-network?

A I do not know that stat.

Q It's a lot less than that; isn't it?

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A I don't have any data in front of me to show me if it is or it isn't.

Q Now, I know you were provided a lot of mathematical calculations, showing how fair health has gone up, using assumptions. Do you remember going through that, ma'am?

A Yes, I do.

Q Now, again, we have six codes in this case. Have you seen the data with respect to these codes; 99281 through 99285, and 99291? Have you seen any of the FAIR Health data on those codes?

A In this trial, no, but during my normal work, yes.

Q And have you seen that those rates in Nevada have gone up?

A Yes.

Q And how much have they gone up?

A I don't recall the specific percentage, but it is a trend we're seeing across hospital-based providers. Specifically, staffing company hospital-based provider types.

Q Well, now let's be very clear and talk about, again, TeamHealth. You know that our bills and the ER bills have largely remained stable in the last several years --

A Team --

Q -- isn't that right, for our codes?

A TeamHealth across the nation?

Q TeamHealth in Nevada. And I'm specifically using that because those are the Plaintiffs in this case. And I want to stick to the Plaintiffs in this case.

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A So I've seen, broadly, TeamHealth bill rates that are accelerated. I haven't seen something specific to Nevada, but broadly, staffing companies, like TeamHealth, especially TeamHealth, we do see increasing charges.

Q You haven't seen that in Fremont?

A Specifically, in preparation for this trial, I don't believe I've seen that document.

Q Well, even if it's not in preparation for this trial.

A Well, sir, when I'm evaluating things, I typically am not looking provider by provider. We are looking broadly across the category because our solutions are rolled out at a national level. They may be a provider type specific, but typically, they're not provider specific.

Q Well, this is not provider specific. I'm talking about an entire entity that has 40 positions and many more nurse practitioners and PAs, and that is the subject of this case. Fremont, along with Team Physicians, along with Ruby Crest.

A I think you just stated you're asking me to answer that question about a specific provider, and I stated, typically, when I'm reviewing those types of trends, we're looking at a macro level because our programs are rolled out on a national level, and they're not geared at a specific provider. We're looking across a provider type to understand the trends and the practices that we're seeing for that provider type to evaluate solutions.

Q Now, you were the corporate representative of United in this

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case during depositions, right?

A Yes, I was.

Q And by the way, you said that the rates for ER doctors in Nevada have risen, and you don't know how much. Have you seen any evidence in this case demonstrating what that increase has been like in the last five, eight years?

A In preparing for this trial, I don't recall seeing a specific document.

Q Do you remember seeing something indicating that Nevada ER reimbursement rates are some of the lowest in this country?

A I don't recall seeing a document like that, sir. I've reviewed a number of documents. I don't recall.

Q Well, let me ask you this. You're familiar with Medicare rates, right?

A I'm aware of Medicare rates. I don't have them memorized for these specific E&M codes.

Q Well, generally speaking, you know that they don't go up, right?

A Well, there may be changes to Medicare rates from time to time, I believe.

Q Well, they're pretty stable year after year. Are they not?

A I can't -- I don't review Medicare rates in detail on a typical basis, right? We have a healthcare economics team that crunches the numbers for us and helps us understand those rates.

Q Well, would you be surprised that between 2016 and 2019 for

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the 99281 through 85, they essentially either didn't go up at all or went down?

A Well, I think that probably reflects that Medicare is a better estimate of what the cost of those services are, and they don't change significantly, unlike staffing companies ramping up their bill charges in an attempt to get paid more.

Q Well, I know you keep saying that, and I know that's part of the talking points, but I keep waiting to hear where Fremont, Ruby Crest, or Team Physicians has done that, or any evidence of that in this case, because I keep hearing about it. Do you have that data?

A I personally don't have that data at my fingerprints. There were thousands of documents produced as part of this case, and I did not review every single one.

Q Well, the one thing we do know is that you have taken Medicare, which is largely flat, and gone from 350 percent to 250 percent.

MR. BLALACK: Object to form. Counsel is testifying about Medicare.

THE COURT: Overruled.

BY MR. AHMAD:

Q Well, isn't that what you've done?

A We made an adjustment to the rate, yes.

Q That is a significant decrease; isn't that right?

A I don't think that's a significant decrease as the percentage. We're still paying a multiple of the Medicare rate.

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Q Well, sure, but let me be very clear. That is a significant decrease in the reimbursements to the healthcare providers; is it not?

A I believe you stated earlier the Medicare rate for one of the codes was $170, so instead of three and a half times, it was two and a half times, so it's $150.

Q I'm just asking, is it a significant decrease?

A I don't believe we feel like that's a significant decrease. There are plenty of providers who are accepting below the 250 percent of CMS.

Q You don't think that has a significant impact on the physicians, and the healthcare providers, and the Plaintiffs in this case?

A I don't think it's the physicians who are specifically developing the fee schedules. I think it's their administrative companies or staffing companies that are developing their chargemasters.

Q You don't think it has an impact?

A What do you mean by impact?

MR. BLALACK: Impact on who, Your Honor?

THE COURT: Yeah, clarify.

BY MR. AHMAD:

Q Impact on the Plaintiffs?

A Well, the Plaintiffs is a staffing company. It's not the actual ER docs providing the services.

Q But you know -- and I heard -- and you know, we'll fix this later. I heard some testimony about how the ER doctors were independent contractors, but in fact, you know, those ER doctors are

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employees. That's who we are, right? You know that?

A Well, the staffing companies, I believe, are the ones who are developing the chargemasters. It's not the ER docs. The ER docs are providing valuable services. No doubt.

Q And their rate of reimbursement, the Plaintiffs rate of reimbursement, has gone down significantly; has it not?

A We've had to adjust our reimbursement levels due to the billing practices of staffing companies who are ramping up their charges. And specifically, in relation to the efforts they make to go after our clients and our members for full bill charges.

Q Well, let me just -- let me see if I've got this right. You've decreased the rate from 350 to 250 because bill charges were going up? Is that what you just said?

A You're providing an additional reimbursement action for our clients. We adjusted the rate to appropriately reflect what was being accepted in the market, and that suggested we change the reimbursement level from 350 percent of CMS to 250 percent of CMS.

Q Did you decrease the rate because what you were seeing, bill charges, were increasing?

A We continued to see providers leveraging their bill charge to go after our members and balance bill, send them to collections. We saw a variety of behaviors that were resulting in continued high payments, so we reduced the rate then.

Q I mean, you say that -- and again, more talking points, but Fremont Emergency Physicians, Team Physicians, Ruby Crest. They

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have a balance billed on any of these 11,000 charges, right?

A I don't know that because I haven't seen every single claim, and I'm unsure what the administrative record is, so I can't say for certain. That's you making that statement.

Q Well, you heard that there was a public statement that they wouldn't balance bill? You did hear that?

A I understand, TeamHealth, broadly -- the staffing company -- made a statement to the public that they would not balance bill, but I have seen TeamHealth Physicians, maybe not Fremont Health, but the variety -- some of their other businesses that are balance billing our members.

Q None of the ones here?

A I'm certain if it's anyone -- any of the ones here that are 11,000 claims at issue. I have not reviewed all 11,000 claims.

Q Okay. Well, let me just go back to this point. If a provider goes from 1,000, right -- and let's just say they double it to 2,000, right? And if the Medicare rate is, let's say, $600, which is 350, or three and a half times, you're saying because this is going to this, you're going to go lower? Is that what you're saying?

A That's not what I'm saying. Providers were increasing their bill charge, so there was a bigger differential so they could go after our members and/or our clients and continue to try to attempt to collect the differential. So either 400 or now 1400 if they went up to 2,000.

Q Okay. So when you went from, let's say, 600 to, I don't know, 400 and something here, that doesn't have anything to do with

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this, right? You're just decreasing it, no matter what they do, right?

A No, I wouldn't characterize it that way.

Q Really. So you did this 350 to 250 across the board to all providers.

A That's not an accurate statement. The change was for ER physicians only.

Q Well, yes. ER physicians only. You did that to all of them, right?

A For those specific codes it was not -- remember the ER override does not apply to any of the other services that are typically billed on those claims when you're visiting an ER. So it was for, you know --

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Q Yes.

A -- the handful of codes. And it's only a code that's the evaluation of the situation. It's not the code that gets billed to represent all of the interventions that were made on that patient.

Q Ma'am, you did this for all ER physicians. It didn't matter whether they increased their bills or decreased their bills, right?

A We were evaluating our reimbursements for ER, and we did drop the rate. And we dropped the rate again, to more reasonably reflect the rates being accepted in the market. There were plenty of providers accepting lower rates, as we've stated. If the Data iSight rate was lower, we were paying the higher rate. Other payors are using that solution and using the Data iSight rate, which is lower than our override.

Q Do you remember what my question was?

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A You asked me if we lowered the rate.

Q I asked --

A Yes, we lowered the rate.

Q -- you if you lowered the rate no matter how much the physician's providers charges went up and down.

A Well, again, as I stated, the provider bill charges, we did lower the rate, yes. Provider bill charges were still escalating and the providers -- well, the administrative groups, not the providers specifically, were continuing to go after our clients or our members for that differential.

Q So it didn't matter whether the provider's charges went up or down, you were still going lower?

A Well, the Data iSight tool is only used for our outlier cost management program. I don't believe that a good portion of the claims in this case, I think it's a small portion, used the Data iSight tool. So it was for one program for a handful of codes.

MR. AHMAD: I'll pass the witness, Your Honor.

MR. BLALACK: Your Honor, I have just one question. One follow-up and then I think we can let the witness go.

RECROSS-EXAMINATION

BY MR. BLALACK:

Q Can you bring up Plaintiff's Exhibit 146?

A 146?

Q I believe it's 146. This was the certificate of coverage for [indiscernible] that Mr. Ahmad just showed you dated January 1st, 2020.

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And that's why you're getting that [indiscernible] to refresh the jury recollection of what is a certificate of coverage?

A What is a certificate of coverage? A certificate of coverage is the benefit plan document for a fully insured plan, that's filed and approved in a state.

Q And could you look at that document, ma'am, and just give the jury a sense of how long it is [indiscernible].

A This document is 183 pages.

Q And I think Mr. Ahmad showed you page 40.

MR. BLALACK: Shane can we get page 40 put up?

BY MR. BLALACK:

Q I think there was discussion about expenses at the bottom [indiscernible].

MR. BLALACK: No, that's actually not what I wanted to show. Could you pull out a little bit [indiscernible]?

MR. AHMAD: It's on page 42.

MR. BLALACK: 42?

MR. AHMAD: Yes.

MR. BLALACK: Thank you very much.

BY MR. BLALACK:

Q All right. So here's the reference that Mr. Ahmad showed you when he directed you to the usual and reasonable and customary. Do you recall that?

A Yes.

Q Okay. And I think -- and tell me if I'm wrong, but in trying to

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answer this question, you were having trouble with determining what would have been the appropriate program to apply, given this language?

A That's accurate.

Q Would you have had to look at other language, either in this document or maybe in another plan document to answer that question with confidence?

A Yes, I would.

Q Okay. Let me -- I don't -- I have not looked at every single page of this document, but let me show you a passage on page 40, which is where we started, and this under eligible expenses. There's a header for network benefits and for non-network benefits. Do you see that?

A I see that section.

Q Read that to yourself, ma'am. And tell me is -- would this information be relevant at all in determining what programs might be used to determine how to reimburse an out-of-network emergency service?

A Yes, it would.

Q In what way?

A Well, under the network benefits section, eligible expenses, bullet number 2, outlines that when services are received from a non-network provider, the eligible expenses will be an amount negotiated by us or an amount permitted by law. And then, you know, the last bullet, we will not pay excessive charges or amounts you're not legally obligated to pay.

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Q Okay. Why would that language potentially be informative in assessing a circumstance when you're reimbursing based upon an out-of-network emergency?

MR. AHMAD: Your Honor, I think we're trying to get into a contractual interpretation of the document. That's evidence of that. Use the document itself.

THE COURT: You can rephrase the question.

BY MR. BLALACK:

Q My question, ma'am, is why did this information become relevant to you in deciding how to answer Mr. Ahmad's question?

A Well, this information's informative because it helps explain, or that language helps indicate to me what programs might be set up on this benefit plan.

Q Okay. And why is that?

A The language that's there that talks about how the eligible expense will be determined, as well as not paying excessive charges.

Q And how does the language that Mr. Ahmad showed you, with respect to the three prongs for out-of-network emergency -- why is that connected to this in some --

MR. AHMAD: Your Honor, we're now interpreting a contractual legal document.

THE COURT: You can rephrase.

MR. BLALACK: All right. Your Honor, just to be clear, Mr. Ahmad showed her language out of a plan document and asked her to interpret it. I'm trying to have the jury have the full understanding is all

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I'm trying to do.

MR. AHMAD: Your Honor, I did not ask this witness to interpret it. I was just mentioning that this is what the document said.

THE COURT: All right. So rephrase.

BY MR. BLALACK:

Q Okay. I'll ask it this way, ma'am. Is there -- having seen this language plus the language that Mr. Ahmad showed you, is there anything that you see here that suggests to you that the physician reasonable and customary program established by FAIR Health would be used to reimburse and out-of-network emergency service under this plan?

A No.

MR. BLALACK: Okay, that's all I've got.

THE COURT: All right. Any redirect?

MR. AHMAD: Nothing further, Your Honor.

THE COURT: Thank you. Does the jury have any questions for Ms. Paradise? If so, please reduce those to writing now. I don't see anybody writing. Do we have one? Thank you, Mr. Cabrelas. Counsel, please approach.

[Sidebar at 12:37 p.m., ending at 12:40 p.m., not transcribed]

THE COURT: All right. So thank you for the question, and I get to ask the question.

When adjudicating a claim, what other "certain circumstances or other factors would be considered when deviating from payments suggested by/indicated by benefit plan, other than client

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request?

THE WITNESS: That's a great question. There are other edits or reviews that our organization might undertake in evaluating a claim. Those could be additional, what we would call waste and abuse editing. It may be looking at coding or codes. Typically codes may be bundled. Is there an attempt to unbundle those codes? Are there any special processing instructions, you know, for additional clinical editing? So there are additional reviews that can occur that determine whether or not that claim will be paid.

THE COURT: Thank you. Follow up questions based on the juror's question?

MR. AHMAD: None here, Your Honor.

MR. BLALACK: Just one, Your Honor.

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FURTHER RECROSS-EXAMINATION

BY MR. BLALACK:

Q The things you just described, ma'am, did they relate to the rate or price that they pay on the claim, or whether the claim would be covered at all?

A They could determine if the claim is going to be paid. They could also provide additional information on whether or not that claim line would be paid. If there was an issue with re-evaluating the claim lines, that claim would actually be resent to price again, and then attempted to adjudicate again.

Q But is that different than the sort of things we've been talking about today with the jury about pricing?

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A Yes. That happens post -- that initial pricing. And back at United, and its claim adjudicating system.

MR. BLALACK: Thank you.

THE COURT: Anything on redirect?

MR. AHMAD: Nothing further, Your Honor.

THE COURT: All right. So Ms. Paradise, you may step down. You are not excused from being recalled as a witness later, but you may now step down from the stand.

THE WITNESS: Okay. Thank you.

THE COURT: All right. So let me give you an admonishment so you can get a well-deserved lunch.

So during the recess, don't talk with each other or anyone else on any subject connected with the trial. Don't read, watch, or listen to any report of or any commentary on the trial. Don't discuss this case with anyone connected to it by any medium of information, including without limitation, newspaper, television, radio, internet, cell phone, or texting.

Don't conduct any research on your own relating to the case. Don't consult the dictionary, use the internet, or use reference materials. Don't do any social media with regard to the trial. Don't talk, text, tweet, Google, or conduct any other type of research with regard to any issue, party, witness, or attorney involved in this case.

Most importantly, and importantly, do not form or express any opinion on any subject connected with the trial until the matter is submitted to the jury.

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Thank you for a great morning. And it is -- we'll see you at 1:15.

THE MARSHAL: All rise for the jury.

[Jury out at 12:44 p.m.]

[Outside the presence of the jury]

THE COURT: All right. So I would like to take a break. Why don't you guys come back at 1:10?

MR. AHMAD: Yes, Your Honor.

MR. BLALACK: 1:10, Your Honor?

THE COURT: 1:10. And just for the record, at the bench here I told you that some of the parking passes didn't work Friday for the jurors. We're looking into it with jury services. We have 26 people on Blue Jeans. The Chief Judge will take my calendar Wednesday and Thursday to give you full days. And you're going to get deposition designations to me.

MR. MCMANIS: I have them right here, Your Honor.

THE COURT: Wonderful. Thank you. And then we'll make a record on your objection to the question. Any other thing that we need to make a record on?

MR. ZAVITSANOS: I'm not going to make an objection on the question, Your Honor.

THE COURT: Okay. It's okay.

MR. ZAVITSANOS: No, no, it's fine. I think Mr. --

THE COURT: All right.

MR. ZAVITSANOS: I think Mr. Blalack cleared it up, so --

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THE COURT: Thanks guys.

MR. MCMANIS: And Your Honor, the flags and the highlights are just where there are objections.

THE COURT: Got it. Thank you.

[Recess taken from 12:45 p.m. to 1:17 p.m.]

[Outside the presence of the jury]

THE COURT: All right. So calling the case of Fremont Emergency v. UnitedHealth Group. Plaintiff, please call your next witness.

MR. AHMAD: Your Honor, at this time we would call Dr. Scott Scherr.

THE COURT: Okay. And then there is an issue, Mr. Roberts, that you would like to address?

MR. ROBERTS: Yes. Thank you, Your Honor. I'll be handling the cross of Dr. Scherr. And it's our contention that the door has been opened to information, which was originally excluded about the tort, both with Mr. Haben and with Ms. Paradise, they asked both of the witnesses, did you set 350 percent of Medicare as a rate that you were paying at first in order to slash reimbursement, and then you slashed it again to 250 percent of Medicare. And both those witnesses were asked that question, and the implication was raised that United was cutting rates to get to 350 and then to 250. And that was impacting Fremont.

Dr. Scherr, I took his deposition on his own correspondence, and he knows that Fremont was being paid and had agreed to accept 170 percent of Medicare, less than 350, less than 250. And that when

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Fremont terminated its network contract with United, they actually got increased reimbursements of 1.1 million over a certain period of time. So I think I am now entitled to rebut their contention --

THE COURT: But all of that was related to the negotiations, right?

MR. ZAVITSANOS: Yes.

MR. AHMAD: Yes, Your Honor.

MR. ROBERTS: Your Honor, it was related to the fact that they terminated the contract. They were submitting as an out-of-network provider, and then they were getting paid more than they were receiving in-network. But the point is is regardless of whether you leave that network or not -- and I don't need to talk about networks. I will need to talk about the fact there was a network agreement. But the fact is they've left an impression with this jury that Fremont's rates were being continuously cut over this period of time by United when in fact, they were going up during this period of time and the reimbursements were going up over $1.1 million.

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THE COURT: Thank you.

MR. AHMAD: And if I may say this, Your Honor, when I tried to even suggest what the impact was on TeamHealth, Your Honor, I believe at the end of the day yesterday, you said that I could not because it would open the door. I did not.

MR. ZAVITSANOS: And Your Honor, the only other thing that I'll say because I don't want to keep the jury waiting is we had a bench conference and we talked about the ACA on this issue of 350 and

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250. And I approached the bench to raise this issue because I thought they were opening the door on this. They backed off and so we backed off. This -- there's no way the door has been opened, Your Honor. It's ridiculous.

THE COURT: Yeah. I'm going to overrule your request because it would fly in the face of my ruling on the negotiations. I just don't think the door has been opened. I think you've made a sufficient record, but if you'd like to respond.

MR. ROBERTS: No, Your Honor. I don't need to respond. Thank you very much.

THE COURT: Good enough. Then as soon as I get the high sign from the marshal -- yep. Okay.

MR. ROBERTS: Your Honor, I do have one question.

THE COURT: Yes.

MR. ROBERTS: Would it be acceptable to simply say you were here at the table; you heard the allegation that --

THE MARSHAL: All rise for the jury.

THE COURT: We'll take it up.

MR. ROBERTS: Okay.

[Jury in at 1:21 p.m.]

MR. ZAVITSANOS: Your Honor, may I be excused for one second? You don't need to wait on me. Mr. Ahmad is doing --

THE COURT: Yes, of course. Thank you. Please be seated. Plaintiff, please call your next witness.

MR. AHMAD: Your Honor, at this time, we would call Dr.

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Scott Scherr.

THE COURT: Thank you.

DR. SCOTT SCHERR, PLAINTIFFS' WITNESS, SWORN

THE CLERK: If you could please state and spell your first and last name for the record.

THE WITNESS: Scott Scherr, S-C-H-E-R-R.

THE COURT: And if you'll spell that, please?

THE WITNESS: First name, S-C-O-T-T, last name is S-C-H-E-R-R.

THE COURT: Thank you. You can go ahead, please.

MR. AHMAD: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. AHMAD:

Q Doctor, tell us a little bit, first of all, about yourself, starting maybe with some of your educational background.

A Sure. Again, my name is Scott Scherr. I moved to Las Vegas in the early '90s, actually, to play baseball at UNLV. And I've been out there -- here ever since. I went to medical school at University of Nevada. Left for a brief period of time for medical training at Emory University in Atlanta, Georgia, and then moved back in 2010.

Q And why did you move back?

A My wife, who I met in college here, is born and raised here. And she had finished her training around the same time I did. She's also a physician. And we decided to move back to be closer to family.

Q Okay. You said your wife is a physician. Is she emergency

room, as well? Or is one enough in the --

A One is definitely enough. She's a pediatric gastroenterologist and a professor at UNLV School of Medicine.

Q Great. And tell us about your job right now. How are you employed right now?

A So I am the regional medical director for TeamHealth and Fremont Emergency Services. I manage, between southern Nevada and northern Nevada, northern California, southern California, 14 emergency contracts as well as hospital medicine contracts.

Q And do you see patients?

A Yes. I work around 8 to 10 medical shifts a month here in -- in Las Vegas.

Q And where do you work those shifts?

A Primarily at the HCA hospital. So Sunrise, MountainView, ER at the Lakes, ER at Aliante, Southern Hills.

Q Okay. I may be having a hard time hearing. Maybe if you slow down or speak up.

A Sure. Sure.

Q Or both. And how long have you held this job as regional medical director?

A I believe since 2016. Prior to that, I was the facility medical director at Sunrise as well as Southern Hills Hospital.

Q Okay. And by the way, who is the medical director at Sunrise right now?

A I have some of my medical directors here in the courthouse.

Dr. Jaime Primerano. She is the medical director at Sunrise. And then Dr. Clarence Dunagan. He's the medical director of MountainView. And also Dr. Crystal Sturgis. Dr. Dunagan has been here for 18 years and Primerano has been here in the valley for 12 years.

Q And Dr. Primerano, is she the one that replaced you as medical director at Sunrise?

A She did.

Q Okay. And did you see patients when you were the medical director at Sunrise?

A Yes.

Q And prior to that, how were you employed?

A Prior to that, I was with Fremont Emergency Services. But I was the medical director at Sunrise from 2011 until 2018.

Q Okay. And then, like I said, ever since then, you've been regional director?

A Yes.

Q And who are you employed by?

A Employed by Fremont Emergency Services and TeamHealth.

Q Okay. I'll show you the -- United said something in opening statement, if I could put it up. And they said -- and by the way, you have been here the entire time, have you not?

A Yes.

Q I'm sure it's been an educational experience.

A It's a much different pace than the normal job.

Q I can imagine. I apologize to the extent that I'm responsible

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for that. And so, in the opening, I think they talked about how the TeamHealth --

[Counsel confer]

BY MR. AHMAD:

Q Well, I'll just quote it for now. Do you remember United saying that the proof will show that the TeamHealth Plaintiffs hired ER doctors as independent contractors, not employees?

A Yeah, I remember that claim.

Q Are you an employee?

A I am an employee.

Q Do you get benefits?

A Yes.

Q What about the other physicians, let's say at Sunrise?

A All of my physicians and nurse practitioners and physician's assistants here in Las Vegas are all employees that receive benefits.

Q Okay. And now, you have responsibility, I think you said, for the Fremont facilities. Do you have responsibility over Ruby Crest or TeamHealth as well?

A Just Ruby Crest. Northeastern Nevada Regional Hospital reports to me.

Q Okay. And between the ones you have responsibility for, Ruby Crest and Fremont, how many physicians are we talking about?

A It's about 90 physicians.

Q And how many of them are employees?

A A little over 80.

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Q And how about the other healthcare providers? Do you have physician's assistants?

A Yeah. All of -- all of the physician's assistants and nurse practitioners are all employees.

Q Let me just ask you what does a physician's assistant mean in terms of what they do?

A So it's what we call them, advanced practice clinicians. And the physician's assistants and nurse practitioners kind of roll up into that. They help the physicians on a day-to-day basis in the ERs.

Q And what about nurse practitioners?

A It's the same thing. It's a registered nurse who had additional schooling and training that acts as an advanced practice clinician to help us in the emergency department.

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Q Do nurse practitioners actually do nurse duties on the floor?

A Sometimes. The hospitals have been, you know, have asked us to provide additional help using our nurse practitioners when they're short nurses.

Q Okay. Tell us a little bit -- and I know you and I went by there. But tell us a -- tell the jury, at least, a little bit about what it's like to work in an emergency room.

A Yeah.

Q Starting off with can you give us a variety of the different types of conditions or situations that you would see?

A Yeah. So obviously --

Q And start from --

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A Yeah.
Q -- fundamentally no understanding of how it works.
A Right. So --
MR. ROBERTS: Objection, Your Honor, 48th out of the 25.
THE COURT: And? You'll have to explain that for me.
MR. ROBERTS: Yes. May we approach, Your Honor?
THE COURT: You may.
MR. ROBERTS: Thank you.
[Sidebar at 1:30 p.m., ending at 1:31 p.m., not transcribed]
THE COURT: Okay. I've sustained the objection. I'm sorry, whoa. Overruled the objection. Oh, it's Monday. Sorry.
MR. ROBERTS: Thank you, Your Honor.
THE COURT: As hard as you guys are working and as hard as they are, we're all tired at this point. So my apologies.
MR. AHMAD: Well, I'll try to be even quicker, Your Honor.
BY MR. AHMAD:
Q So tell us about some of the things that you'd see in the emergency room.
A So first, I mean -- can you guys hear me okay? The emergency department in most communities, especially in our community, it's, you know, we consider it a safety net in the community. ER docs work 24 hours a day, 7 days a week, holidays, weekends, nights, available for every emergency that comes through the door.
We treat patients regardless of their ability to pay, and we take care of some of the most severe things that we have to act really fast on, such

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as, like, heart attacks, gun shots, drownings, here in the valley, you know, snake bites, chest pain, abdominal pain, aortic injuries. Some of the things that we need to -- as a profession, we need to recognize fast and make fast decisions and treatment outcomes for those patients.

Q I seem to think, and I obviously don't know, that you would get a lot of car crashes?

A Yes.

Q What about fire?

A Car crashes, you know. Sunrise is one of the only two burn centers here in Las Vegas, so we get burns. Emergency medicine is unlike any other practice because in our training, we have to know a lot of stuff, you know, because we're taking care of pediatric patients to geriatric patients to trauma to medical emergencies to toxicology emergency. That's actually pretty important here in Las Vegas.

Q Are you talking about overdoses?

A Overdoses and --

Q Do you get some of those?

A Yeah. Yeah. And now, the drug depends on the weekend, too, so.

Q And speaking of that, do you tend to see any patterns depending on what day or even time of night it is?

A Yeah. Las Vegas is actually kind of unique. Especially Sunrise is typically Mondays are the busiest days in the emergency department. However, Friday and Saturday night, as you can guess, at Sunrise are busier. And then, we track, you know, basically from time of

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day, day of week, month to month what our arrival patterns look like so we can staff appropriately. Sunrise is the busiest ER in the State of Nevada and one of the busiest emergency departments in the country. And they see, on average, about 150 ambulances per day.

Q Okay. So about how many -- well, what's the most you've ever seen in an hour period? I mean, can you see 20, 30 an hour?

A Thirty to forty in an hour.

Q Okay. How many people staff the ER at one given time?

A Are you talking about nurses or physicians or?

Q Either one.

A Sure. At Sunrise, we have a little over 90 hours of physician coverage and around 50 to 60 hours of nurse practitioner and physician's assistant coverage.

Q And I think you mentioned you treat everybody. I know going to the doctor sometimes, people are asked -- the first question they're asked is about insurance. Do you all do that?

A No, we don't. We -- in fact, by law, the EMTALA law, we have to provide rapid medical evaluation, medical stabilization, prior to anybody asking for insurance information. And it wouldn't be us providers that ask for insurance information. It's the registrars at the hospital.

Q Now, as part of your responsibilities, do you recruit physicians, PAs, nurse practitioners for Fremont, Ruby Crest?

A Yes.

MR. ROBERTS: Objection. Relevance.

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MR. AHMAD: I mean, I'm just going to ask him the characteristics of a good ER doctor.

THE COURT: I'm inclined to sustain that objection.

MR. AHMAD: Okay.

BY MR. AHMAD:

Q And then I may go just to the question of what makes a good ER doctor, what characteristics do you have to have? So I'll ask you that. What characteristics do you need to have to be a good emergency room physician?

A You know, I kind of have three attributes when I do my recruiting is smart, fast, and nice. You know, you have to be fast and be able to work and think on your feet and make rapid decisions. Part of that, you have to be smart because you have to be able to identify those life-threatening illnesses in a rapid fashion. And then you have to be nice. I mean, I think, you know, everybody in healthcare, especially, you know, my providers, emergency medicine providers, I always ask them to treat the patients just like they would treat their friends and family.

Q And do you have to know a little bit about everything?

A Yeah. Our residency is comprised of rotations in ENT, and obstetrics, and trauma, and ICU, pediatrics. You know, we -- you know, we don't know what's going to come through the door. So I mean, every day in the emergency department is completely different. And so we have to be ready for any type of an emergency that could come through the doors.

Q Tell me a little bit about the pressure or stress in the

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emergency room.

A There -- you know, in my industry, there's a lot of burnout, as you can imagine. It -- you know, being kind of on and being available nights, weekends, holidays, you know, away from family, and understanding that if we make the wrong decision at the wrong time, it could affect somebody's life.

Q Now, some of your charges, Doctor, as a provider when you were seeing patients are at issue in this case. Are you aware of that?

A Yes. And I'm still seeing patients.

Q I'm sorry?

A And I'm still seeing patients.

Q And -- yes, thank you. Do you have any idea how many of your charges are at issue in this case?

A I think you mentioned around 200.

Q Okay.

MR. ROBERTS: Objection. Hearsay. Move to strike.

MR. AHMAD: I'll ask another question.

THE COURT: Yeah.

BY MR. AHMAD:

Q Do you -- have you seen any --

THE COURT: Sustained. New question.

BY MR. AHMAD:

Q Yeah. Have you seen any records of your billed charges?

A Yes. I've seen the list.

Q Okay. I'm not going to ask you to count the number, but

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obviously it was more than a dozen?

A Yes.

Q Tell us a little bit about the coding. First of all, do you know the various codes that the emergency room will put down depending upon the nature of the treatment?

A Yeah. I know the visit codes. So when you talk about the 99285, I know what those codes are. I don't know, of course, all of the procedural codes.

Q Well, let me talk about the visit codes 99281 through 99285. Can you walk us through that starting with 99285?

A Sure. So 99285 is a code for our most critical patients or possibly the most critical patients. So this would include, you know, chest pain, gunshot, burns, things like that. So the -- that's the, you know, high complexity type of patient. 99284 could be abdominal pain, vomiting, GI illness, you know, things of that nature. It could still be a significant injury or a significant disease process, but it's considered less complicated. And then it kind of bats its way down to -- all the way to the 99281.

Q And going down to 99281, what would you -- what would that typically be?

A So 99281 is a very low acute patient. That's important for us here in the State of Nevada. You know, we're 48th in the -- in the United States in primary care physicians per capita. So we do see quite a few patients that don't have the ability to follow up with their primary care physician. So this would be, you know, a blood pressure check,

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nosebleed, et cetera.

Q And so 99281 would be the least severe, 99285, the most?

A Yes.

Q Is that a fair way of saying it?

A Yeah, that's correct.

Q What about a code 99291?

A So 99291 is an additional code that we call critical care. So if we have a patient that is severely unstable and we're providing direct bedside resuscitation on the patient, we can bill for that time that we stand at the bedside. And it's in increments of, like, 30 minutes.

Q Okay. Now, I think you heard some examples in this trial where you can have one code, a visit code, along with a 99291. Do you remember that?

A Yeah. I think it was 99285 or 99291.

Q Correct. Yes, I'm sorry. That's what I meant to say. And does that happen?

A Yeah. You know, so in the case of a 99285, which would be like a chest pain, so you know, a heart attack, a pulmonary emboli, a blood clot in the lung, you know, an aortic injury, a collapsed lung. So let's just say if the patient came in with chest pain and it ended up being a collapsed lung, or a tension pneumothorax, to where we needed to perform a chest thoracostomy tube, that would be an additional procedure code. And the importance of that procedure is that type of tension pneumothorax causes cardiovascular collapse and we -- and if we don't do that, the patient could die.

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Q Okay. Well, you may be over my head a little bit. But let me ask you this: are there serious situations, and I'll just use the layperson's term, for example, a heart attack, where you just bill for the visit code and not that additional 99291?

A Yeah. You know, a lot of times with a heart attack, we wouldn't add the 99291. Or chest pain, we wouldn't add the 99291 because the 99285 in and of itself, when we're working up a patient with chest pain to make sure that they don't have a heart attack or a blood clot in their lungs or those causes of chest pain that can kill you, includes an EKG, a chest X-ray, blood work, multiple reevaluations, and medical decision-making. And that kind of is encompassed in the 99285.

Q Okay. So there could be serious situations where you just get one billing code?

A Yes.

Q And that's all you guys get for that?

A That's correct.

Q Now, let me talk specifically about billing. And we've heard a little bit about TeamHealth. And tell us what TeamHealth is.

A So TeamHealth, I guess I would consider TeamHealth as our parent company. They provide a lot of support, administrative support, educational support, process improvement support for us to do our jobs effectively as emergency physicians.

Q And how about billing?

A They control all the billing.

Q And do you do the billing?

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A No.
Q What do you focus on?
A I focus on patient care and process improvement and quality matters in the emergency department.
Q In addition to being able to focus not on billing issues, do they help out on quality of care?
A Yes, they do.
Q And how do they do that?
A So there's multiple areas within TeamHealth. One, you know, including what we call a PIC team. So performance improvement council. They help us with things of improving sepsis care, improving STEMI care, trauma care, and also throughput in the emergency department. TeamHealth is a -- is a large organization that has a lot of benefits to help improve the quality and the patient experience in the ED.
Q Well, I'm going to ask you about a demonstrative that I -- that we've made. And --
THE COURT: Has that been shown to your opposing counsel?
MR. AHMAD: Here it is. It's just a dashboard.
BY MR. AHMAD:
Q Okay. Do you recognize this?
A Yeah. This is what we call the ED master view at my Las Vegas sites. And this is Sunrise Hospital's master view at one point in time.
Q Okay. And how does this relate to the quality of care?

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A So this is basically a snapshot of what -- what's going on in the emergency department. It helps us kind of see, you know, pressure points, any barriers to care. It helps us identify any critical lab values. Also, it helps us create a good flow model and make sure that we're practicing efficiently in the emergency department.

Q And where is this shown? This is a snapshot, obviously. Where is this shown?

A It's virtually everywhere in the emergency department. It's -- most of our providers have split screens, so they have usually this running on one side and their -- and their electronic health record running on the other side. There's flatscreen TVs all over the place, so everybody can kind of see what is going on and kind of help follow the flow of the emergency department and understand where we need to allocate resources.

Q Okay. And by the way, what involvement did you have in developing this dashboard?

A Myself and some IT folks, as well as one of my nursing directors, they took our clinical brain and put it into a computer thought process. And I helped develop this in 2014 when we changed over from a different electronic health record to the current electronic health record that we have now in order to improve patient safety, so we didn't miss anything. It actually won a Patient Safety Award for HCA in 2014.

Q Okay. Now, I'm going to talk about or ask you to talk about some of these numbers. But fair to say these numbers and these colors change?

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A Yes. So --

Q And this is just a snapshot of one given point in time.

A That's correct.

Q Okay. Well, starting with this. And you probably can't see it, but it says "Door to Greet" at the top. What does this mean?

A So we have a goal with all of our emergency departments here in Nevada to greet patients, which means the time that they set foot in our emergency department to the time they get seen by an emergency provider in less than ten minutes. And that's the dashboard showing that and kind of what our results are.

So on the bottom right of that column, where it says 86, that's the number of -- that's the number of patients that are currently in the emergency department. So quite a few folks in the emergency department during that point in time. And then, zero to -- I believe it's six minutes or seven minutes. And then the next one is seven to ten, I believe. And the other one is 11-plus.

So that tells us that of those 86 patients, that we've greeted 35 of them within less than 7 minutes. And then the yellow, because, you know, yellow is close to red. We want to make sure we avoid that. That's why that style is that -- is there. And then, 29 patients were greeted after 11 minutes. And I'd like to say that, I mean, it doesn't show you kind of --

Q The average?

A -- how we perform on average. On average, all of our emergency departments in Las Vegas see patients in less than ten

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minutes.

Q And how many, again, physicians do you have at any given time?

A At -- you know, when it's -- when it's the busiest four or five physicians and three nurse practitioners or PAs.

Q Okay. And is there somebody in a -- there's, like, an emergency room bay, I guess. Sometimes people come in by ambulance, right?

A Yes.

Q Is there anybody at the bay to receive the gurney from the ambulance?

A Yeah. And all of my hospitals here in Las Vegas, we have physicians that are stationed at the EMS bay. It will -- if we talk about Sunrise, Sunrise sees about 25 percent of the market share of all ambulance traffic in the valley. And the reason why we were able to --

Q And I'm sorry. You may be going a little too fast for me.

A Sure. Sure.

Q How much?

A Twenty-five percent of all ambulance deliveries in the valley per day. So it's quite a bit. So that's why I said we see about 150 ambulances a day. And you've got 150 ambulances a day, and Dr. Primerano has created a really good process to where we have rotating physicians at the ambulance bay at all times.

Q Okay. And so can you tell us what's going on to the right over here, that's still at the top?

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A Yes, so the one with the bottom, you know, the red ten on the left, that, that kind of shows us, you know --

Q This here or there?

A It's on -- yeah, where you just pointed, yup.

Q Okay.

A So that kind of shows us kind of where our opportunities or our log jams are in the department. It also flashes if somebody in our department has critical lab values, so we can address those critical lab values, and so that what that red ten is. So there's ten people currently in the emergency department during that time that have critical lab values.

And then it goes through, you know, CT scans, radiology orders, so let's just say you -- that CT scan order went up to 15 or 20, that gives us the ability to identify that we have opportunity to either open up another scanner, to call in a new tech, to get resources over to radiology during that time, and the same thing with the labs, etcetera, in that, in that -- in that continuum. It just -- it helps us be more efficient.

Q Okay. And what are the different categories here, because I see ultrasound?

A Yup.

Q And I actually can't read the -- I see labs are --

A Yeah, so that's lab orders, and I believe the next one's radiology orders. RT orders, that's respiratory therapy orders. CT orders is the 12. Is that EKG? Yeah. So the EKG, the reason why that's high is our EKG machine doesn't interface with this, it just shows the number of

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EKG's that we've done since midnight. Ultrasound orders, and I can't see what that one on the bottom right is. And then urinalysis. I mean, urinalysis is something that's, you know, important driver of the efficiencies in the emergency department. So it just kind of shows us what's pending and what needs to be -- where we need to put resources in the ED.

Q Okay. Anything on the remainder on the top there? I see registration.

A Yeah, a lot of that is just administrative, administrative tiles, so this, this is meant to be used by all parties in the emergency department, you know, so that's why you see registration there, etcetera.

Q Okay. And what else do you use down here as an overview for patient safety or --

A Yup.

Q -- patient duration?

A So we track number of admitted patients in the emergency department, and those are patients --

Q Right here?

A Yeah, Right there, because those are patients that have met the disposition of being admitted to the hospital but are waiting for a bed upstairs. In Las Vegas, you know, we have a tremendous ER overcrowding due to our population and limited resources, so we track that so we know that 29 of the patients that are currently in the emergency department, 29 of 86 are admitted to the floor, so creatively, we can come up with ways to take care of the patients that are not

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admitted, because those are usually your next sickest patients, are the ones that you don't know about, and you haven't been able to process them.

Q Okay. Anything else on the remainder of this chart?

A Yeah, we aggressively track discharge length of stay, so the amount of time a patient --

Q And which one is that?

A That's going to be right above the 136, in the middle.

Q Okay. Up here? Oh.

A Yeah.

Q And that's a time number, I mean, I can see it's -- said one -- I don't know if it's one minute and 54 seconds, or one hour and 54 minutes?

A I wish it was one minute and 54 seconds. It's one hour and 54 minutes, and the reason why we track this number, the discharge length of stay as well as what we call the low acuity length of stay is the more efficiently we can see patients that are not critically ill, it creates more capacity in the emergency department. So if we're more efficient getting those folks out that need to go home in a more rapid fashion, then it creates more space for us to take care of the more critically ill patients.

Q Okay. And what else?

A And then in the bottom is just kind of the patient numbers by, I guess you would call it pod, you know, since, you know, Sunrise Hospital's about the size of two football fields, so it just lets us know

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where the patients are at.

Q So this is the number of patients you have in each pod?

A Yes.

Q Okay. So I -- and I think you said this is pretty much visible no matter where you are?

A It is.

Q Throughout the ER?

A It is. And I think the most important thing on the pods is we -- in Las Vegas, we have a pretty disastrous mental health issue here and we've got a large behavioral health which is -- which is mental health emergencies, and we're able to see how many mental health emergencies we have in the ED at a given.

Q Is that the psychiatric ward?

A Yes. It's a place where we medically clear them. If they're a danger to self or others, we medically clear them, and then they, hopefully over time, go to a psych -- acute psychiatric facility.

Q And, I mean, I noticed we talked about how long people are here and wanting, you know, think of low acuity, you know, to treat them, and I think that's 1:54, or one hour, 54 minutes. How would a person in the psychiatric ward compare to that kind of duration?

A Yeah. They typically are in our emergency department for up to two to four days before they find a facility that will accept them, just because there's not that many facilities here in Las Vegas, and there's a high number of uninsured or underinsured psychiatric emergencies.

Q Okay. Thank you for that, Doctor. Anything else you want to

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point out before I take it down?

A No, I think this was probably 9:00 in the morning, so that 136 is the number of patients we have seen since midnight, and as Dr. Primerano will attest, we kind of look at that just to kind of see what the day looks like. It usually grows pretty fast.

Q During the day?

A Yup.

Q Now I take it some of the resources that we just saw -- well, let me just ask you; how do you get support from TeamHealth regarding some of these issues and the quality of care?

A Yeah, it --

MR. ROBERTS: Objection. Relevance.

THE COURT: And your response, please?

MR. AHMAD: Well, I mean, I suppose I don't need to go into it if they're not going to be talking about TeamHealth. If they're not, I won't go into it, but if they are, I obviously want to talk about what they do.

THE COURT: Do you -- are you going to go there?

MR. ROBERTS: Obviously, everyone's already talked about TeamHealth, Your Honor.

THE COURT: All right. So overruled.

BY MR. AHMAD:

Q Go ahead.

A It's -- so as you could see what that -- with that dashboard, it's all about process, improvement, and flow. TeamHealth gives us

support in best practices in order to kind of reach those goals of the hospital, improve the quality and the flow of the patient through the emergency department. One of the things that we use especially in a very busy, very complex emergency department is a software called Cognition, and that Cognition software looks at the arrival pattern and the level of acuity or how sick the patients are on a given day of the week, given hour, given month, and we look at patterns, and we try to match our, what we call our demand to capacity model, based not only on number of patients that we're going to be seeing per hour, but the complexity of those patients, and that's something that we're able to look at on a -- on a somewhat weekly to monthly level.

Q And how do you feel that the level of patience care, and I'll just ask about Fremont, since you've, you know, you were there I think since 2011 as a medical director?

A Yes.

Q How do you think the medical care -- how much has it improved since, say 2015 or 2016?

A Well, we have a lot more resources available to us, you know, things like that Cognition, you know, folks that are industry leaders on how to set up and stand up a low acuity area your hospital, industry leaders on improving STEMI, stroke, trauma care. Just an example, we use a website called Zenith, that's kind of like our communication tool, and there's over 300,000 hours of what we call CME, Continuous Medical Education in there, to things as, you know, like, like trauma, mass casualty, incident preparedness, et cetera.

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Q And who provides all that?

A TeamHealth does.

Q Last question I have for you, you know, we talked about some facilities like Sunrise, can you tell us about some of the other facilities here in Las Vegas --

A Sure.

Q -- that are a part of Fremont Emergency Services?

A Yeah, so Mountainview Hospital is part of Fremont Emergency Services. That's actually where our graduate medical education is. You know, three-plus years ago we started an emergency medicine training program there which is -- I mean, as I told you before, you know, we just continue to get busier and busier here in Vegas, so we're now up to 11 residents per year, and some of them actually work for us now. They see anywhere between 70 to 80,000 visits per year, all age groups, around the valley.

Then you have Southern Hills Hospital which is kind of up in the Summerlin area. They see between 40 and 45,000 visits per year, and that's where we help with graduate medical education and neurology residents, family practice residents, transitional residents. And we've talked about Sunrise, but Sunrise sees about 120,000 visits per year, adult only, level two trauma center, burn center.

And then the other sites are what we call our freestanding emergency departments which is ER at the Lakes, ER Aliante, ER at Sky Canyon, and ER at the South Las Vegas Boulevard.

Q Okay. And you mentioned Mountainview?

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A Yes, Mountainview.

Q Okay. And what about for Ruby Crest? What are some of the facilities up there?

A Well, it's in Elko, Nevada, Elko County, so there' only one hospital; it's Northeastern Nevada Regional Hospital. It's pretty -- area's pretty remote. It's about a little over a four-hour drive from both Salt Lake City and Reno, Nevada. A lot of the patients that need to be transferred out there for a higher level of acuity actually have to go by fixed wing or airplane, so it's a pretty rural site.

Q Is it the major facility for ER in Elko?

A It's the only facility for ER in Elko.

Q Okay. Thank you, Doctor.

MR. AHMAD: I'll pass the witness.

THE COURT: Okay. Cross examination.

MR. ROBERTS: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. ROBERTS:

Q You just listed a number of departments that were staffed by TeamHealth in Las Vegas?

A Yes, sir.

Q Were you here in voir dire when your counsel, I was talking to the jury about staffing contracts at Dignity Health, including Siena Campus, San Martin, and Rose de Lima?

A Yes, we used to have those contracts.

Q Okay. And you no longer have those contracts; is that

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correct?

A That's correct. We no longer have those.

Q And why is that?

A You know, it's part of our industry. Things change. Sometimes, hospital administration wants to go in a different direction, and you know, it's not uncommon for contracts to take place.

MR. AHMAD: Judge, I'll object. I mean, I don't mind his answer, but I'll object to the relevance of this in terms of the -- any type of contract negotiations of hospitals.

MR. ROBERTS: I'll move on, Your Honor.

THE COURT: All right. So objection's sustained.

BY MR. ROBERTS:

Q Are you familiar with a gentleman by the name of Kent Bristow?

A I've heard his name before. I don't -- I'm not sure exactly what he does.

Q Is he a part of the TeamHealth organization?

A I believe so.

Q Do you know if he's above you in the hierarchy of the company?

A I don't believe he's a physician.

Q Do you know whether Mr. Bristow has previously testified that the emergency room physicians employed by TeamHealth are typically independent contractors?

MR. AHMAD: Your Honor, I'm going to object. He can't

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really comment on what another witness said.

THE COURT: Overruled.

THE WITNESS: Could you repeat that question?

BY MR. ROBERTS:

Q Yes. You have any knowledge of whether he's previously testified under oath that emergency room physicians employed by TeamHealth are independent contractors?

MR. AHMAD: And Judge, I will also object to the relevance because we're talking about Fremont, Ruby Crest, and Team Physicians, and particularly testimony and trying to impeach with that testimony isn't relevant.

THE COURT: Overruled.

MR. ROBERTS: Counsel called out --

THE COURT: Overruled.

MR. ROBERTS: Thank you, Your Honor.

THE WITNESS: I'm not aware.

BY MR. ROBERTS:

Q Okay. Do you think it would be reasonable for us to rely on his testimony under oath in regard to that relationship?

A I can't answer that.

Q Let me ask you a little bit about some of the things you were telling the jury about. You mentioned saving lives, heart attacks, gunshots, drownings, car crashes, fires?

A Yes.

Q Now when you said you've looked at some of these claims

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that are before the jury, right?

A Just the numbers.

Q Right. And is the jury going to be able to tell by looking at those numbers which one is a gunshot, which one is a crash, which one saved someone's life, and which one didn't?

A No, it just shows the CPT code.

Q Let me ask you a hypothetical. Someone comes into the emergency room department with a gunshot wound. They are triaged by the nurse, the emergency doctor sees them, says he needs surgery, let's admit him and get him up to the surgeon.

A Yes.

Q Is that a plausible scenario?

A Yes, it can be.

Q And would that be coded as a 99285?

A Yes.

Q And would that bill for 99285 include the charges of the surgeon?

A No.

Q The anesthesiologist?

A No.

Q The facility?

A No.

Q I'm not going to ask to put it up again, but I believe that was demonstrative marked Trial Exhibit 508 that was up here, the flow chart?

A Yes.

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Q And you told the jury that that demonstrative was of a software program that you developed; is that correct?
A I helped develop it, yes.
Q With IT--
A Yes.
Q -- engineers --
A Uh-huh.
Q -- software guys?
A Yeah. People that understand computers, yes.
Q And you've testified you did that in 2014, correct?
A Yes.
Q So it'd be fair to say that you developed that flow chart and that procedure, you spent all that time going through the jury with, before TeamHealth had anything to do with Fremont?
A It was -- it was developed at 2014, but I can attest that it has evolved, and it continues to evolve, almost on a monthly basis.
Q But it was developed by you before TeamHealth bought Fremont, correct?
A Yes.
Q And you didn't need Fremont to come up with that idea, correct?
A No, it was --
Q I'm sorry. You didn't need TeamHealth to come up with that; you came up with it yourself?
A It was collaborative with the nursing director and others that

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came up with it.

Q What is the current full name of the entity that we've just been talking about as Fremont Emergency Services?

A Fremont Emergency Services, and I believe it now states my last name.

Q And are you the president, director, and secretary that Fremont Emergency Services share?

A No.

Q Have you ever looked at the secretary of state website and see who the registered president of that company is?

A I have not.

MR. AHMAD: Your Honor, I think there's a limine on corporate structure here, and I can't tell where we're going, so I'll object.

THE COURT: Objection sustained.

BY MR. ROBERTS:

Q You mentioned that there were over 12 but there were quite a number of charges in the claims that are being submitted to the jury that you worked on, right?

A Yes.

Q Do you know how much you billed for each of those charges?

A I believe it was on there, but I can't remember.

Q Okay. Do you remember when I took your deposition under oath back in May of 2021?

A Yes.

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Q At that time, did you know how much had been billed for any of the services that you had performed that's on that chart?

A No.

Q At that time, did you know how much United Health Care or any of the other defendants that are over here that I represent had paid on those, for those services?

A No.

Q Did you have any opinion about whether the amount we paid was reasonable?

A At during the time of our deposition?

Q Yes.

A I want to say I've learned quite a bit over the last couple of months, but at that time, no.

Q At that time, no. And that was two years after the lawsuit was filed, right?

A Yes.

Q And your name was on the company both -- were you even asked whether or not you thought this lawsuit should be filed before it was filed?

A No.

MR. ROBERTS: Thank you, Your Honor. That's all I have.

THE COURT: Redirect?

<u>REDIRECT EXAMINATION</u>

BY MR. AHMAD:

Q Well, Dr. Scherr, you were just asked if you agreed with this

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lawsuit when it was filed; how about now?

A Hundred percent, I agree.

Q Has the quality of care, including the dashboard, improved since the time of TeamHealth?

A Yes.

MR. AHMAD: That's all I have, Your Honor.

THE COURT: Okay. Any recross?

MR. ROBERTS: Nothing further, Your Honor.

THE COURT: All right. Does the jury have any questions from Dr. Scherr? If so, this would be your chance. If anybody has a question, give me a high sign. Ms. Landau, you're writing; is it a question?

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JUROR LANDAU: Oh, no, it's not a question.

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THE COURT: Good enough. All right. So may we excuse the witness?

MR. AHMAD: Yes, Your Honor.

THE COURT: You may step down. And Plaintiff, please call your next witness.

MR. MCMANIS: Yes, Your Honor. We call Mr. Scott Ziemer.

MR. BLALACK: Your Honor, I thought we were playing the video deps.

MR. MCMANIS: The video's not ready yet because we just got you all's objections this morning. Sorry.

MR. BLALACK: Your Honor, I'm going to need a few minutes to get Mr. Ziemer from across the street.

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THE COURT: Let's take a very short recess, and you may step out to make a call.

During the recess, don't talk with each other, anyone else, on any subject connected with the trial. Don't read, watch, or listen to any report, offer commentary on the trial, don't discuss this case with anyone connected to it, by any medium of information, including without limitation newspapers, television, radio, internet, cellphones, or texting.

Don't conduct any research on your own relating to the case. Don't consult dictionaries, use the internet, or use reference materials. Don't post on social media with regard to the trial. Don't talk, text, Tweet, Google, or conduct any other type of book or computer research with regard to any issue, party, witness, or attorney involved in this case.

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Most importantly, do not form or express any opinion on any subject connected with the trial until the jury deliberates. It's 2:11. Let's try to be back at 2:25. Thanks, everybody.

THE MARSHAL: All rise.

[Jury out at 2:11 p.m.]

[Outside the presence of the jury]

THE COURT: All right. The room is clear. Plaintiff, do you have anything for the record?

MR. AHMAD: Nothing, Your Honor.

THE COURT: Okay. And Defendant, anything for the record?

MR. BLALACK: No, Your Honor, and I've called over to have him brought over.

THE COURT: Very good.

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MR. BLALACK: Maybe Mr. Roberts does.

THE COURT: Mr. Roberts?

MR. ROBERTS: I just wanted to say, Your Honor, that I understand that you're -- what your preliminary ruling was on corporate structure, but we've obviously gone through this whole trial and we've talked about the fact that TeamHealth owns Fremont, that Blackstone owns TeamHealth, and we got into that, and Mr. -- Dr. Scherr is listed as the president of Fremont on the Secretary of State website, and the fact that the -- a witness is on the stand, and I can't even ask him whether he's an officer.

I understand he apparently doesn't know, but I believe the Court sustained my objection, and it seems that if a witness is on the stand and testifies on behalf of the company, testifying that he's a medical director is relevant to the -- for the jury to know that he's also an officer and a director of that organization.

THE COURT: All right.

MR. AHMAD: Two things, Your Honor. This goes into the corporate practice of medicine, but having said that, before I could object, he actually answered that he didn't know. So the answer came out.

THE COURT: Good enough. Have a good break everybody.

MR. BLALACK: Thank you, Your Honor.

[Recess taken from 2:12 p.m. to 2:24 p.m.]

THE COURT: Thanks, everyone. Please, everyone, be seated. Are we ready?

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MR. ZAVITSANOS: Yeah, we're ready.
THE COURT: Okay.
MR. ROBERTS: Yes, Your Honor. We're ready.
THE COURT: Let's bring in Mr. Ziemer, please. Why don't you just have a seat until I call you, sir?
[Pause]
THE MARSHAL: All rise for the jury.
[Jury in at 2:26 p.m.]
THE COURT: Thank you. Please be seated. Plaintiff, your next witness, please.
MR. MCMANIS: Your Honor, the Plaintiffs call Mr. Scott Ziemer.
THE MARSHAL: Sir, watch your step, please. Step up to the stand.
THE CLERK: Please raise your right hand.
SCOTT ZIEMER, PLAINTIFFS' WITNESS, SWORN
THE CLERK: If you could, please state and spell your first and last name for the record.
THE WITNESS: Scott Ziemer, S-C-O-T-T, Z-I-E-M-E-R.
THE CLERK: Thank you. Have a seat.
THE WITNESS: Thank you.
THE COURT: Go ahead, please.
MR. MCMANIS: May I proceed, Your Honor?
THE COURT: Please.
DIRECT EXAMINATION

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BY MR. MCMANIS:

Q Good afternoon, Mr. Ziemer. How are you today?

A I'm well. How are you?

Q Doing well. My name is Jason McManis. You and I have not met before, have we?

A No, I don't believe so.

Q Okay. And I understand from your counsel that you are the person in this case who is going to tell UMR's story; is that right?

A I am an employee of UMR, yes.

Q Okay. And you're the only witness who is going to testify on behalf of UMR?

MR. GORDON: Objection, Your Honor.

THE COURT: Grounds?

MR. GORDON: He's a witness. He's not an attorney. He's not a lawyer. I understand he is one of the witnesses for our case.

THE COURT: Well, I think it's -- is it just foundational?

MR. MCMANIS: It's just foundational, Your Honor.

THE COURT: Then I'll overrule it.

THE WITNESS: I'm sorry. What's your question?

BY MR. MCMANIS:

Q Well, I'll just ask, do you know whether there are any other witnesses who are going to be testifying on behalf of UMR in this case?

A I am not aware.

Q You are the Vice President of Customer Solutions at UMR; is that right?

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A Yeah. I'm the Vice President in our customer solutions area. I'm responsible for ancillary, our pharmacy, and our network solutions.

Q Okay. And network solutions, that includes out-of-network reimbursements, correct?

A Correct.

Q All right. And as the Vice President, you're the head of that department?

A Correct.

Q Okay. You've been in that position since about 2016?

A Yes, sir.

Q Okay.

A In 2016, I took on some additional responsibilities, I think, related to pharmacy, and then I think in 2018, I probably took on some additional -- or in 2019, took on the ancillary solutions.

Q Okay. Well, for the purpose of my questions, I'm just going to be asking you about the out-of-network reimbursements, all right? Do you understand?

A I understand.

Q Okay. Now, UMR is what's referred to as a third-party administrator or a TPA; is that right?

A Yeah. UMR is a third-party administrator, so what that means is that our clients are employer groups, and they wish to self-fund their benefit plan. So what that means --

UNIDENTIFIED SPEAKER: Are you hearing, Sam [phonetic]?

THE COURT: Okay. There's someone on the phone --

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UNIDENTIFIED SPEAKER: Are you hearing, Sam?

THE COURT: Okay. There's someone on the phone who needs to mute themselves. Who's looking for Sam?

UNIDENTIFIED SPEAKER: I have audio, but no -- video, but no audio.

THE COURT: All right. So you'll have to mute yourself, because we can hear you in the courtroom. Thank you. Mr. McManis, sorry for that. I know that Brynn can try to mute them.

MR. MCMANIS: Thank you, Your Honor. May I continue?

THE COURT: Go ahead, please.

BY MR. MCMANIS:

Q So Mr. Ziemer -- and I can kind of walk you through this --

MR. GORDON: Objection, Your Honor.

THE WITNESS: Can I --

MR. GORDON: He was in the middle of finishing an answer.

THE COURT: Yeah. Go ahead.

MR. GORDON: Let him finish answering his question before he goes onto the next one.

MR. MCMANIS: I'm not sure if his answer was responsive, but that's okay.

THE WITNESS: So UMR is a third-party administrator. I think you asked if we were a third-party administrator, so we are. And what that means is that our clients are employer groups who want to self-fund their benefit plan. And what self-funding means is that they are actually the -- the employer is actually the one that pays the claims, right.

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When your benefit plan pays out 80 percent, it's not an insurance company, it's actually your employer that's paying those claims. So what UMR does is we administer the benefits that the -- that that employer group provides to us.

BY MR. MCMANIS:

Q All right. Mr. Ziemer, you understand how this process works. I have an opportunity to ask you questions right now, right?

A Yes, sir.

Q Okay. And then when I'm finished asking questions, your counsel, he'll have the opportunity to ask you questions, as well, right?

A Yes, sir.

Q Okay. So for the purpose of keeping this on schedule, making sure that we move quickly, can we agree that when I'm asking questions, you answer my questions? Can we agree on that?

A Absolutely. I thought I was.

Q Okay. And when your counsel has the opportunity to ask you questions, you can explain and do whatever you'd like to do; is that all right?

A Sounds good.

Q Okay. So as a TPA, UMR does not actually have any fully insured business where UMR is accepting the premiums and taking the risk; is that correct?

A Yes. We focus primarily on -- we focus on ASO business or self-funded business.

Q All right. So when a client comes to you, let's say Caesar's,

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for example, they come to UMR so that UMR can administer health insurance, where Caesar's is going to take the risk, right?

A Uh-huh.

Q Is that correct?

A I didn't know there was a -- yes. We have customers like Caesar's who will come to us and want us to administer their benefits.

Q Okay, because just generally, I mean, Caesar's is not an insurance company. They don't have the expertise in paying claims, right?

A I would expect that employers are coming to us because they want our claims administration, correct.

Q Because UMR, as an insurance TPA, you all have the expertise to ensure that claims are paid properly, right?

A We work with our clients to identify the benefits that they want us to administer. We work with them to identify how they want those benefits, what their intent is, and then, yes, we administer their claims.

Q Okay. And do you agree with me that it's one of UMR's jobs to ensure that claims are being correctly?

A It's one our primary responsibilities is to ensure that we're paying claims according to their benefit plan and according to their intent.

Q Okay. All right. So one of UMR's jobs is to ensure claims are paid correctly, right?

A Yes, sir.

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Q All right. And that includes claims for emergency room services, correct?

A Yes, sir.

Q Okay. You understand that this case relates to a dispute over the amount of reimbursement for out-of-network emergency room services, right?

A That's my understanding.

Q Okay. And for those out-of-network emergency room services, when UMR is acting as a TPA, you're administrating a claim on behalf of one of your ASO clients, UMR takes a fee off the savings that it achieves for its ASO claims; is that right?

MR. GORDON: Objection, Your Honor.

THE COURT: Grounds, please?

MR. GORDON: Foundation.

THE COURT: Okay. Can you lay a little bit of additional foundation?

BY MR. MCMANIS:

Q Mr. Ziemer, you're the Vice President of the Customer Solutions; is that right?

A Yes, I am.

Q Okay. And in that role, you oversee the methods by which UMR pays and reimburses out-of-network claims, including out-of-network emergency room claims, correct?

A That is correct.

Q And you are familiar with the ASO clients and the

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relationships that UMR has with its ASO clients, right?

A I'm -- at a high level, yes, I'm aware of some of --

Q You were designated to testify --

A -- our relationships.

Q I'm sorry.

A Yes. At a high level, yeah, I'm aware of our relationships; yes.

Q All right. And you were designated to testify on behalf of UMR as a corporate representative in your deposition about those relationships, right?

A I was asked to testify about specific topics related to my work.

Q Okay. You're familiar with, generally, the structure of how UMR makes a revenue for processing claims on behalf of its ASO clients?

A I'm aware of --

MR. GORDON: Objection. Vague.

THE COURT: Overruled.

THE WITNESS: I am aware of how we charge our clients, correct.

BY MR. MCMANIS:

Q Okay. And one of those ways that you charge your clients is by taking a fee on the savings between the bill charge and whatever UMR reimburses an out-of-network claimant, right?

A We have programs that a client can elect to offer, and one of

the ways that we charge for those programs is a percentage of savings.

Q Right, and we'll get to those programs in just a little bit, but right now, I just want to focus on that savings. And when we're talking about making a fee off the savings, what we're talking about is the difference between the provider's bill charge and whatever the reimbursement rate is that UMR pays to the provider, right, or allows to provider.

A I'm sorry, what's your question?

Q When we're talking about the fee --

A Yeah.

Q -- when UMR takes a fee on the savings, all right, the savings in that formula is the difference between the provider's bill charge and the allowed amount that UMR allows for the provider?

A When we charge a percentage of savings for an out-of-network program, the claim has to be eligible, right, so it's something that's reimbursable under the benefit plan, and then if it's an out-of-network claim, then we do charge based on the charge that the provider submits that, you know, providers can charge whatever they want, and then the allowable, which is under the benefit plan.

Q Okay. So is that a yes? The savings is the difference between the bill charge and the allowed amount?

A Yes.

Q Okay, thank you. Now, when you're doing that calculation of the savings, the greater the difference between the bill charge and the allowed amount, the greater your fee, as UMR as the ASO?

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MR. GORDON: Objection. Foundation.

THE COURT: Overruled.

BY MR. MCMANIS:

Q Is that right?

A The -- just to restate your question, the -- if the savings -- if we're able to save our customers more than we get, then our percentage of that would be greater.

Q Well, my question is just a little bit different. So the greater the amount of savings on any particular claim, if you're taking a percentage of those savings, the greater that fee will be to UMR, right? Just simple math.

A Yes, you're correct. There's two ways that -- there's two ways, right? Provider -- we don't control what a provider can charge, but what we can control is what -- or what clients can control, really, is what they're going to allow under their benefit plan.

Q Certainly -- well, so I want to sort of ask you about what you said there. I think you said what clients can control is the amount that's allowed; is that right?

A Right. Clients -- what are clients going to allow under their benefit plan.

Q Okay, all right. Well, I'll ask about that in just a little bit, but right now, I want to talk about the emergency room services. You're familiar at a high level with the five CPT codes for emergency room services that are at issue?

A I'm aware that there are CPT codes for emergency services.

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I'm not familiar with those. I don't write the codes.

Q Okay. Well, do you understand that as you go from the 99281 down to the 99285, that's an increase in the level of severity?

MR. GORDON: Objection. Foundation.

MR. MCMANIS: I'm just asking if he understands, Your Honor.

THE COURT: Overruled.

THE WITNESS: I'm aware that with certain codes, right, there is an increase in severity.

BY MR. MCMANIS:

Q Okay. And the ER doctors, the ER providers, the Plaintiffs in this case, their job is to treat patients and save lives; do you agree with that?

MR. GORDON: Objection, Your Honor. Vague.

THE COURT: Overruled.

THE WITNESS: I think that emergency providers are there to help members, help them get healthier.

BY MR. MCMANIS:

Q They're there to treat patients --

A Help save lives.

Q -- and save lives, right?

A Absolutely. They're there to help people and save lives, yes.

Q All right. So as between the ER doctors, whose job it is to treat patients and save lives, and UMR, whose job it is to ensure claims are paid correctly, who do you think should be paid more for an

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emergency room visit for a 99285, the most serious code?

A Quite honestly, I think that, you know, it's a very difficult comparison, right? I think that in the marketplace, you're going to, you know, the market will bear what it will, but if somebody is saving somebody's life, that's an -- you know, there's no higher cost.

Q So is it your testimony, sir, to the jury, that there are some circumstances where UMR, whose job is to ensure claims are paid directly, deserves to make more on a given emergency room visit than the ER doctors, whose job is to treat patients and save lives? Is that your testimony, sir?

A No. My testimony --

MR. GORDON: Objection. Argumentative, misstates testimony.

THE COURT: Overruled.

THE WITNESS: My testimony is that we agree with our employer, with our customers, what we're going to charge for our services. Just like the provider of emergency services, right, they have -- you know, they can charge whatever they want for their services. I'm not exactly sure that there is a comparison. We don't do the analysis to say, oh, well, we should pay -- we should make sure that our fees are in line. Do I think that the -- in line with what any type of medical provider would pay, but we don't actually control what an emergency room provider actually charges.

BY MR. MCMANIS:

Q Sir, I'm not asking you about what an emergency room

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charges, okay? Let's set charges aside. Are you with me?

A I understand.

Q Okay. I'm just talking about the amount of money that is paid to either UMR, for ensuring claims are paid directly --

A Uh-huh.

Q -- correctly, excuse me, or the ER doctors, whose job is to treat patients and save lives. The amount of money that's paid to them. Who do you think deserves more for an emergency room visit on a 99285?

MR. GORDON: Objection. Asked and answered.

THE COURT: Overruled.

THE WITNESS: I honestly don't know how to answer your question.

MR. MCMANIS: All right. The --

THE WITNESS: A customer is asking us to administer their benefit plan and everything that goes into that. We do that over a period of a year, right? And we agree on those particular fees.

MR. MCMANIS: Sir, I'm not asking about --

THE WITNESS: How that compares to --

THE COURT: Hold on. Let him --

THE WITNESS: -- one emergency room visit; I honestly don't know.

MR. MCMANIS: Okay.

BY MR. MCMANIS:

Q I don't know. Is that your answer?

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A That's not my answer.
Q Well, let's take a look at how it actually works in practice, okay?
A Okay.
Q All right.
MR. MCMANIS: Michelle, could you pull up Plaintiff's Exhibit 473?
BY MR. MCMANIS:
Q All right. Now, Mr. Ziemer, I'm not going to ask you about every entry on this spreadsheet. I know this is a long document --
A Is there somewhere --
Q -- but at any point you want to look at hard copy, I --
MR. GORDON: Hold on, counsel. Is this document in evidence already?
MR. MCMANIS: Yes. It's stipulated and your counsel used it a couple days ago.
MR. GORDON: All right. My apologies, Judge.
MR. MCMANIS: All right.
BY MR. MCMANIS:
Q Mr. Ziemer, I'm not going to walk you thought it. This is a really long PDF that contains a whole bunch of claims, but what I'll represent to you is that Plaintiffs' Exhibit 473 contains all of the disputes claims at issue in this case, including the ones from UMR, all right?
A Uh-huh.
Q And what I want to do is I've got a demonstrative where I'm

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going to pull out some of the claims so we can actually see them on screen, okay?

A Is there somewhere where I can -- you mentioned that there's a hard copy somewhere?

Q There are hard copy binders behind you, but I think this one may still be too hard to read. I'm going to pull up the demonstrative on the screen.

THE WITNESS: Where would I find that?

MR. MCMANIS: So Michelle, if you could flip over to the PowerPoint, please? Well, Mr. Ziemer, I'm about to switch to a different document here that you might be able to see a little bit better.

[Pause]

MR. MCMANIS: Little technical difficulty I think but we'll get it up there for you.

THE WITNESS: Yes, you're correct; the paper copy is not going to -- not going to work.

MR. MCMANIS: All right. Let's do it -- we'll do it the old-fashioned way, all right. They teach you to always be prepared. Could I switch to the document [indiscernible] please?

BY MR. MCMANIS:

Q All right. Is that a little bit easier to read, Mr. Ziemer?

A Yes, sir. Thank you.

Q Okay. And so this is an excerpt from that larger PDF that I just pulled up and what I've done here is I've narrowed this down, you see that it's just CPT codes 99285?

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A I see it's 99285, yes.

Q Okay. And you see the dates of service here are all in the year of 2019?

A Yes, sir. I see that.

Q All right. And then do you also see that over on the far right side, you've got the same employer and the same group number? Do you see that?

A I see that same employer. The group number is cut off, but it looks like the same group number, yes.

Q Okay. Well, from what we can see, all these group numbers match; do you agree with that?

A Yes, sir.

Q Okay. Now, the ASO customer in this excerpt is Lowe's Companies, right?

A Yes, that's the employer name, Lowe's Companies.

Q Okay. And do you happen to know if Lowe's, as part of their administrative services agreement actually has a 35 percent savings fee as opposed to a 30 percent or a 20 percent?

A I do not specifically know what percentage of savings Lowe's is being charged for their out-of-network programs.

Q Okay. Now, 30 percent, is that kind of an average for you guys at UMR?

A At UMR we have a -- we have a number of different programs -- out-of-network programs. Some we charge 30 percent of savings; some we charge 22 percent of savings and some we charge 25

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percent of savings. It's just dependent upon the program.

Q And some are higher than 30, right?

A As a standard access fee, or a standard fee for our out-of-network programs, it's those numbers. However, when an underwriter takes a look at any one case, they're going to underwrite the entire case.

Q Sir, my question is just some are higher than 30 percent, right?

A I thought your question was is do we have programs that were higher?

Q That was my question -- some of the fees are higher than 30 percent; is that right?

A Sometimes there are fees higher than 30 percent.

Q Okay.

MR. MCMANIS: Could we go back to the computer, and I'd like to look -- don't pull it up yet. You don't have an objection to Exhibit 159?

All right. Your Honor, we move for admission of Plaintiffs' Exhibit 159.

THE COURT: Objection?

MR. GORDON: No objection, Your Honor.

THE COURT: Exhibit 159 will be admitted.

[Plaintiffs' Exhibit 159 admitted into evidence]

[Counsel confer]

BY MR. MCMANIS:

Q All right. Sir, while we're waiting for that, do you have a

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hard copy of Exhibit 159 in front of you?

A Yes. It says Lowe's confidential master professional services agreement?

Q Okay. And if we take a look at page 4, do you see in the top paragraph that this is agreement between Lowe's Companies and UMR, Inc? I'm sorry, it's page 5.

A Yes, I see that the master professional services agreement was made and entered into as January 4th -- or I'm sorry, January 1st, 2018 by Lowe's Companies, a North Carolina Corporation and UMR, Inc.

MR. MCMANIS: All right. Then if we could just go to page 31, Michelle, and pull the signatures.

BY MR. MCMANIS:

Q All right. Do you see -- you may be able to see it on your screen as well, sir, that this was signed by UMR and by Lowe's Companies?

A Yes, sir. I see it was signed by Marsha S. Bar, Regional Contract Manager and Lowe's Gregor Touche [phonetic], Vice President.

Q So I want to jump ahead then to page 54.

MR. MCMANIS: And Michelle, just pull out the very top of page 54, just the heading.

BY MR. MCMANIS:

Q All right. Do you see that starting on page 54, we have the schedule of fees for the Lowe's agreement with UMR?

A I'm sorry. What page are you on?

Q So if I say page 54, do you see on the very bottom right-hand

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number of your document --

MR. MCMANIS: May I approach?

THE COURT: You may.

THE WITNESS: Yes, sir.

MR. MCMANIS: So if I say 54, I'm referring to that number --

THE WITNESS: Oh, thank you.

MR. MCMANIS: right there.

BY MR. MCMANIS:

Q And again, it's up on your screen if that's easier for you.

A Thank you.

Q Okay. All right. So you see that we have the schedule of fees for the Lowe's agreement with UMR?

A Yes, sir.

Q All right. And if we look on the next page, 55, as part of the schedule of fees, if you pull out about one-third of the way up from the bottom where it says service code 9938, cost reduction and savings program. Do you see that?

A Yes, sir, I see that.

Q All right. That is a service that you guys have to reduce the amount paid on out-of-network claims including ER services, right?

A Correct. We have -- we have a variety of programs under our cost reduction and savings programs that are designed to help our clients control costs. Correct.

Q All right. And just jumping back now to page 54 then, if you look at the last B item on page 54, see that contains the fees for the cost

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reduction and savings program?

A Yes, sir. I see that.

Q All right. And what is the amount in the Lowe's agreement for the cost reduction and savings program; what's the fee that UMR takes?

A 35 percent of savings.

Q Okay. So if we want to look at the claims for Lowe's that are part of this case, and we want to figure out how much UMR made on those claims, we would take the amount of savings, and we'd look what's 35 percent of that savings, correct?

A You're correct. The only -- the only thing I would say is that again, the basis of the program is that the claims have to eligible under the benefit plan --

Q Sure --

A -- so as long as they're eligible under the benefit plan, then the difference that we would charge on the savings, which would be the difference between the bill charge and what was allowed.

Q Okay. And the fee would be 35 percent, right?

A Correct.

Q Okay. So let's go back if we can to the demonstrative that we had, and I can just do it up here. That's fine. Got it? All right. All right. So can you see that on your screen, Mr. Ziemer?

A Yes, sir.

Q All right. And again, this is the excerpt from Plaintiffs' Exhibit 473, and like we said, these are all 99285s here at Fremont, Clark

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County, 2019, right?

A 2019 dates of service, yes.

Q Okay. And go ahead and do me a favor. Take a quick look at the first page of Exhibit 159 there, and tell me what year that plan is? Try page 5.

A This master professional services agreement is made and entered into as of January 1st, 2018.

Q 2018?

A Yes, sir.

Q Okay. Do you know whether it was amended after that at any point?

A I do not know.

Q Okay. If it were amended, that would be something that UMR had in its records, right?

A Yes, that would have.

Q Okay. So I want to take a look now -- do you see that in column letter M as in Mary, we have the charges for each of these claims; do you see that?

A I see that.

Q All right. And then we have next to that, we have the amount that UMR allowed for each of these 99285 claims, right?

A That's what line M seems to indicate, yes.

Q All right. So if I want to take the savings -- if I want to get the savings, I want to take these charges and subtract the allowed amount, right?

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A That's correct.

Q All right. And so I've gone ahead, I've done that. And if we look at the savings on each of these claims, do you see it's about $1100 savings on each claim?

A It looks like in column AR the savings is between $1,044 and $1,012 --

Q Okay.

A -- roughly.

Q And does anything about that math jump out to you as incorrect based on the numbers you can see on the screen?

A No, this looks appropriate.

Q Okay. Now, if I want to calculate UMR's fee, I'm going to take that 35 percent number that we saw in Exhibit 159, and I'm going to multiply it by the savings we have in column AR, right?

A That is correct.

Q All right. So, if we take a look at UMR's fees on these claims, these 99285s from 2019, it looks like we're about just under $390 per claim to UMR, right?

A That's what's in column AS, correct.

Q All right. So each and every one of these claims that we see for 2019 for Lowe's, UMR is making close to $75 more per claim than the ER doctors who are actually treating the patients; is that right?

A That is correct.

Q Is that reasonable?

A Is it reasonable that we save the client and the member --

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Q No, sir --

A -- $1100?

Q No, sir. Is it reasonable for UMR to make 75 more dollars per 99285 visit than the ER doctors who are treating the patients; is that reasonable?

MR. GORDON: Objection, Your Honor. Argumentative.

THE COURT: Overruled.

THE WITNESS: What we don't control is what -- how much the provider actually charges.

BY MR. MCMANIS:

Q Sir, I'm not asking about charges --

A -- and so we reimbursed a reasonable charge.

Q Sir, I'm going to ask my question one more time. We see here in the excerpt from Plaintiffs' Exhibit 473, UMR is making almost $75 more per claim than the ER doctors who are actually treating the patients who are coming in with the most severe code. That's what this shows, right?

A You have explained that 99285 is the most severe code, correct.

Q And $75 more per claim to UMR than to the ER doctors, right?

A And based on -- based on this, yes. There's $75 more going to UMR.

Q And my question to you, sir, is just is that reasonable --

A I can't --

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Q -- for UMR to make more money on a 99285 patient who comes in than the ER doctor who actually treats the patient? Is that reasonable --

MR. GORDON: Objection. Asked and answered and vague.

THE WITNESS: I can't answer --

THE COURT: Overruled.

THE WITNESS: -- the question. If I had control over how much somebody charged, then I could answer the question. But I don't control a big part of the math. What I've done is -- or what UMR has done is we've agreed for a certain program that we are going to charge a percentage of savings. And we offer them -- we offer our customers different programs. Sometimes customers choose their own program that they want us to administer and when we administer it on a percentage of savings, and we come up with a reasonable amount, there are certain -- there are certain circumstances where this is going to happen. We saved the client and the member a considerable amount of money.

BY MR. MCMANIS:

Q Sir, are you proud of the fact that UMR made more money than the ER doctors who treated the patients for these 99285s that we see on the screen right here?

A I'm proud that we saved our client and our members $1100.

Q I'm asking whether you're proud that you made more than the doctors? Does that make you feel good inside?

MR. GORDON: Objection, Your Honor. Argumentative.

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THE COURT: Objection is sustained. You don't have to answer that. Move on.

BY MR. MCMANIS:

Q All right. You mentioned your programs, so I want to talk about those a little bit.

MR. MCMANIS: Let me just ask, do you all have an objection to Plaintiffs' Exhibit 256?

MR. GORDON: 256?

MR. MCMANIS: Yes.

MR. GORDON: Yes on foundation.

BY MR. MCMANIS:

Q All right. Mr. Ziemer, if you could just find Exhibit 256 and let me know when you've got it? All right. Mr. Ziemer, do you have Exhibit 256 now?

A Yes, sir. Thank you.

Q All right. And do you see from the top third of the --

MR. GORDON: Excuse me, Your Honor. No objection.

THE COURT: All right. So Exhibit 256 will be admitted.

[Plaintiffs' Exhibit 256 admitted into evidence]

MR. MCMANIS: All right. And Michelle, would you just pull out the to/from to start, please, and that middle email near the top right there?

BY MR. MCMANIS:

Q All right. And Mr. Ziemer, do you see this is an email that you wrote on November 19th of 2018?

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A Yes, I see that.

Q All right. And the subject of this is UMR OON, that's out-of-network offerings?

A The subject is new UMR out-of-network offerings.

MR. MCMANIS: Okay. And, Michelle, let's pull that out, and I just wanted the section key notes. Just key notes, the top four bullets.

BY MR. MCMANIS:

Q All right. Now, it looks like here, you've written a brief description of some of the programs that UMR was looking to offer as a continuum of out-of-network solutions, right?

A Yes. I have -- I have outlined three programs.

Q Okay. And I'm going to start at the bottom here with CRS, least aggressive. Do you see that?

A I see that.

Q All right. And CRS, is that short for cost reduction and savings?

A It is, sir.

Q All right. And the CRS when you say -- well, CRS is one of the methods for out-of-network reimbursement at UMR, right?

A We call our different out-of-network programs cost reduction and savings programs.

Q And one of those CRS, is the least aggressive, and it's a secured savings. Do you see that?

A I see that, yes.

Q All right. And what is secured savings?

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A So secured savings is when either -- when we have a contract with a provider either through a network or through fee negotiation. You know, with our CRS product, it relied -- or it relies on networks, it relies on fee negotiation, and in 2018 we were using some non-contracted, or unsecured savings for certain types of claims.

Q Okay. So on the secured savings there's something like, an agreement with a wrap network for example, to accept a certain discount, right?

A Secured savings would be either a contract with a provider, or a negotiation with a provider, where there's no possibility that a paying member could be balance billed.

Q And that's exactly where I'm going. So when you have secured savings, that means no balance billing, right?

A That is -- that is correct.

Q Okay. And CRS in this least aggressive solution that you all offer, that's all secured savings, according to the email that you wrote in 2018, right?

A It relies -- it relies heavily on secured savings. It does not rely entirely on secured savings.

Q Fair enough, okay. So let's talk about the next one, CRS benchmark. Now you describe that as aggressive, right?

A We -- I described these programs in terms of aggressiveness, you can also look at that as what is driving more savings for the member and for the client as well. So --

Q The --

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A -- the most aggressive savings -- or most aggressive would be the -- there would be a lot of savings available to the member and to the customer.

Q And we'll get to that, but right now I'm just asking about CRS benchmark, and the words you wrote was "aggressive," correct?

A I wrote aggressive, yes.

Q Okay. And benchmark is kind of a ceiling that you place so if something doesn't price below the benchmark, it keeps cycling through a few different options until it gets lower and lower, right?

A Our CRS benchmark program uses Multiplan, and it uses Multiplan's network, as well as their fee negotiation services. And so what we ask Multiplan to do is, before they agree, we agree to use the network, or their negotiation, they have to -- they have to agree to a rate that's below a certain Medicare benchmark, otherwise the claim gets priced by Data iSight.

Q Okay. And eventually, if you cycle through the secured options, and you can't get below the benchmark, that's how you end up in the Data iSight world, right?

A That is correct, sir.

Q Okay. And in the Data iSight world, UMR is relying on Multiplan and Data iSight to come up with a reasonable amount for reimbursement; is that right?

A That is correct. We would rely on Multiplan to use their tool, Data iSight, to come up with a reasonable, allowable amount.

Q Okay. And then when you're talking about -- well, let's see,

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you're on the CRS benchmark, we actually introduced non-secured savings with patient advocacy; do you see that?

A I see that, yes.

Q All right. And non-secured savings, if I'm understanding you, means that there's a risk of balance billing; is that right?

A There is a risk of balance building on non-secured savings?

Q Okay. And then that's why you guys have that patient advocacy element?

A When a -- if a claim would be priced by Data iSight, it's not secured savings. So we ask Multiplan to advocate on behalf of the member, if the writer disagrees with the reimbursement that we provided.

Q Balance billing, that's something that you guys want to avoid, right?

A I think that it depends on the customer. We have other programs where out-of-network -- where the client is okay with their members being balance billed, but as it relates to emergency services, right, we know that we need to keep the member from being balance billed.

Q So for emergency services, it's a benefit when your patients are not balance billed?

A It's a benefit when our patients are not being balance billed.

Q Okay. Now the advocacy part here, that's all done by MultiPlan, right?

A MultiPlan provides the advocacy.

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Q Okay.

A They're in the best position to support their product, why they believe it's reasonable to providers that are -- that are not questioning it.

Q And as far as UMR is concerned, when UMR is using Data iSight, UMR doesn't provide Data iSight with a minimum price, or anything like that?

A Can you --

MR. GORDON: Objection. Vague.

THE COURT: Overruled.

THE WITNESS: I'm not sure what you mean by "a minimum price."

BY MR. MCMANIS:

Q Well, for example UMR doesn't tell Data iSight that if we -- if you're going to run the Data iSight program, you've got to come in at or above a floor, UMR doesn't give that kind of instruction; did it, sir?

A Not that I'm aware of. We don't give that type of instruction.

Q All right. And do you happen to know, generally, the --

A If we were to compare Data iSight to a percentage of Medicare for example, do you happen to know, generally, where Data iSight comes in?

MR. GORDON: Objection. Foundation.

THE COURT: Overruled.

THE WITNESS: For just in general, I want to say it's somewhere between, I would be speculating, but my speculation would

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be somewhere around 250 percent of Medicare.
BY MR. MCMANIS:
Q Okay.
A In general.
Q All right. You guys don't have any instruction to Data iSight, that if it comes in below that, that they have to pay up at that 250 percent amount, correct?
A We -- to my knowledge we have not told MultiPlan or Data iSight to bring up a reimbursement. We rely on their tool. They use publicly available information. They have their own algorithm to determine their reasonable amount.
Q All right. Let's come back here to 256, and let's take a look at this last program here. NPC^2, is short for non-par cost containment?
A Yes, it is.
Q All right. Is that also referred to as NPC squared?
A Yes, it is.
Q All right. And in the email that you wrote here in Exhibit 256, you describe NPC squared as the most aggressive of the three programs that you outlined, right?
A Yes, I did.
Q All right. The description here --
[Court and court recorder confer]
THE COURT: Go ahead, please, Mr. McManis.
MR. MCMANIS: Thank you, Your Honor.
BY MR. MCMANIS:

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Q All right. So Mr. Ziemer, we just talked about NPC[2], it's the most aggressive. And here it says, "non-secured savings with minimal patient advocacy." Do you see that?

A I see that.

Q All right. And so by the time you get to non-par cost containment, we've dropped out the secured savings, right?

A Actually, that's not correct.

Q And so even though you wrote here --

A The --

Q -- "non-secured savings," what you meant was that there are secured savings as well?

A Correct.

Q Okay. And we've got minimal patient advocacy, right? Is that what you wrote?

A I wrote "minimal patient advocacy." We provide advocacy for the claims that rarely run through our benchmark product, our CRS benchmark product.

Q All right. And so if we wanted to just put these on a continuum, we've got least aggressive at the top, most aggressive at the bottom, right?

A I think in our continuum we talk about what is going to drive the most savings, and then we also talk about what the potential is for balance billing --

Q Well --

A -- and so that's how we have continuum, it's another way to

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look at it.

Q I'm just talking about, and the words that you used in real time, in November of 2018, you used least aggressive, aggressive, most aggressive; those were your words, right, sir?

A Those are my words on the paper.

Q Okay. And I organized those correctly on this chart, in order from least aggressive to most aggressive, using your words?

A You've organized those on the chart, based on what's in this email, correct.

Q Okay. And now you mentioned in terms of savings to the customer, but when we're looking at the least aggressive secure savings here, just regular CRS, okay, we want to compare that to the most aggressive, non-par cost containment, non-secured savings. It's true, isn't it, that the amount of reimbursement to the doctors will be less down here, than it is up here?

A The amount of savings to the customer increases, the amount of reimbursement to the physician or to the facility would decrease.

Q Okay. So if I want to organize this from least money to the doctors, most money to doctors, it never goes the other way, right?

MR. GORDON: Objection, Your Honor. It calls for speculation.

THE COURT: overruled.

THE WITNESS: I think in terms of any one claim, it's difficult to make that assertation. If you take a look at the entire program, then

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based on the savings, the overall savings for the program, the more savings that we would generate the less we would pay to an out-of-network physician or facility.

Q Okay. And when you say "most aggressive" that's what you mean, you mean most savings, right?

A Most savings, most stability that contain costs for our client and the member, yes.

Q And least money to the doctors, right?

A At least -- correct. We would save more, and that would go to the members and the clients, it would not go to the physicians, or the facilities.

Q Okay. And I want to take a look now at the next bullet right underneath this, which talks about your strategy at this point in time, in 2018, okay? Right there. All right. And what this says, is we are going to use CRS benchmark and non-par cost containment programs, at standard offerings, starting in Q2, 2019, do you see that?

A I see that.

Q In other words, the standard offerings by second quarter of 2019 are going to be the two more aggressive options, right?

A What that means is that we were leading with CRS benchmark and non-par cost containment programs, yes.

Q And CRS, this secured savings with no risk of balance billing, that was going to be default only if the customer required it, right?

A Correct. CRS to be used as a default, if the customer requires that solution.

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Q Now, sir, are you aware, one way or the other, whether, for any of the UMR claims that are part of this case, whether there's even a single patient who received a balance bill, from any one of the Plaintiffs?

A Can you restate your question?

Q For any of the UMR claims that are part of this case; are you with me?

A Yes.

Q All right. For any one of those claims are you aware of even a single balance bill that one of those patients received from the Plaintiffs?

A I'm not aware.

Q All right. I want to talk a little bit about the plans that UMR has with its ASO customers, okay.

A What do you mean by "the plans"?

Q Well, as a TPA, UMR administers summary plan descriptions, or SPDs, right?

A Correct.

Q And it's those SPDs that contain the language that tells UMR how to pay, for example, an out-of-network emergency room provider, right?

A The plan document governs how UMR processes the benefits. I'm not familiar if they get into specifics to that detail, about how to process the out-of-network claims -- or I'm sorry the emergency claims I think was yours, other than to say, yeah, we need to pay it at, you know, deductible co-insurance.

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Q Sure. And I just mean, you know, at a high level, it's the plan that determines how UMR is going to administer the claim, right?

A That is correct.

Q All right. And within those SPDs, who chooses the reasonable rate for the doctor services, is the client, or is UMR?

A The client -- the client determines how they -- how they view usual and customary.

Q All right. So if the plan document says for out-of-network emergency room services, we're only going to reimburse $27. Did UMR allow more than that?

MR. GORDON: Objection. Calls for speculation.

THE COURT: Overruled.

THE WITNESS: I think that that would be very unlikely, but if that's what the plan document, and that's what the benefit was, we would -- we would follow the plan document.

BY MR. MCMANIS:

Q And so whatever the plan says, that's what's reasonable?

A Correct.

Q And UMR has to follow that plan for every single claim, right?

A UMR uses the plan document. We also sit with the client when we implement the benefit plan, so we understand their intent. A plan document isn't a -- you know, it's a very broad document, so we want to understand their intent. We give them choices as to how they want their benefits processed, then that's how we set up our system so

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that we can administer not only their benefit plan, but their intent that they talk to us about, as part of that implementation.

Q Right. And you set up sophisticated systems to ensure that each claim is processed appropriately, right?

A Our goal is to process claims accurately.

Q All right. And you do that -- is it computerized?

A We have a claim processing system that we utilize, yes.

Q Right. In other words, there's not somebody sitting at a desk, filing through each claim and saying, okay, this one gets paid this way, and this one gets paid that way. It's run through a computer system to make sure it gets everything right?

A We have a claim processing system. We try to automate as many -- as much of the benefit as we possibly can, but there are always going to be things, right, that you need to have somebody take a look at, to make sure that they're administering the appropriate benefit. You know, we try to do our best to process claims correctly, it doesn't happen all the time, but when we make mistakes, then we -- then we fix them.

Q Okay. So if I could get the document camera here. I want to take a look at a slide that was used by your counsel during opening statements, okay? And if we were just going to sort of change this be a UMR slide, you know, we'd say, plan A over here, let's call this non par cost containment, provider reimbursed $200. Do you see that? These are just hypothetical numbers.

A Okay.

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Q Right. And plan B over here, let's say this is CRS, and I think what's being illustrated here is that if you have a plan that calls for non-par cost containment, for example, compared to a plan that calls for CRS, you may have different reimbursements even though it's the same doctor, around the same doctor for the same code; is that generally accurate?

A An employer group -- I'm just seeing this for the first time. An employer group can choose a different -- you know, they can choose whatever out-of-network program they want. In the situation of an emergency provider, right, with NPC squared, there's the possibility that we would take a MultiPlan network rate. There would be a chance that MultiPlan could fee negotiate it or there's a chance that we would have Data iSight.

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With CRS, our CRS program, we use three different networks. We use First Health, we use MultiPlan, we use Change Healthcare. In a situation -- again, one claim, sir, we would reimburse exactly the same thing because it's a MultiPlan contract that beats our threshold, or there could be situations where the reimbursement is different.

Q Okay, fair enough. So it could be different, but depending on the plan, there might be some overlap here and there?

A Depending upon the program that the plan is selected, there could be overlap.

Q All right. So if we are -- if we're going to change this. Let's say this time, it's CRS Benchmark, all right? And we make this one CRS benchmark. Are you with me?

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A I understand what you've written.

Q Okay. And then if we've got the same plan for the same type of claim, the same time frame, we should get the same reimbursement amount, right? It should be -- if it's CRS Benchmark, it's setting the reimbursement, and it's the same provider, then we should have 200 on the left and 200 on the right; do you agree with that?

A If a -- if a client chose the CRS -- if two clients chose the CRS Benchmark Program, they both had the same -- the same claim happen with the same provider on the same day, and they both have that same out-of-network program, then one would expect that the reimbursement would be -- would be the same.

Q Okay. So can I put $200 here?

A Sure.

Q Okay. And I just want to see if we kind of agree on the basic principle. All right. And so if you've got the same type of claim, plus the same plan. I don't even mean -- I don't even mean two companies with different plans, but one company, one group, okay? Same plan. You've got same type of claim and the same plan, then it should be the same reimbursement level, right?

A So your scenario is two members under the same plan. They both go to see an emergency room physician. They perform the exact same services, right? So the claim is exactly alike. They do it on the same day. And would we expect that the -- that the reimbursement would be the same?

Q Yes.

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A Under those conditions, we would expect the reimbursement to be the same.

Q Okay. So now, you put something -- you put something in your answer there that I want to -- I want in on, which is "the same day". But even if it's not the exact same day, as long as it's still within the same plan year and the same benefit, then we should still expect to see the same level of reimbursement, right, because the terms of the plan haven't changed?

A I don't know how to answer your question. If we're talking about a contracted rate or a negotiated rate, right? Those don't run based on the plan's year. That's based on, you know, the agreement between the provider and the contracting entity. That can change. And, you know, with other types of services like Data iSight, I can't say for certain how often they update their information.

If they do that more often than on a yearly basis, but they could update their information, and that could cause something to change based on the date of the claim. So I think there's a variety of different scenarios that could happen where, you know, if you have a different time period or date of service when the claim took place, you could wind up with different reimbursements.

Q All right. But we can at least agree that if the same plan is in place, that the same reimbursement, whether it's CRS Benchmark, non-par cost containment, whatever it is. As along as the same plan is in place, it's going to be run through the same solution, right?

A The --

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MR. GORDON: Objection. Asked and answered.

THE COURT: Overruled.

THE WITNESS: The plan chooses the out-of-network program that they want to have administered or they tell us what out-of-network program they want to have administered for their particular plan. Unless we make changes, meaning the client directs us to make a change midyear, then we would expect to run through the same out-of-network process.

BY MR. MCMANIS:

Q All right. So what I want to do is I want to take a look again at some of the data from Plaintiffs' Exhibit 473 and see how this plays out on actual claims that are in this case, okay?

A Okay.

MR. MCMANIS: All right. So can we go back to the PowerPoint?

BY MR. MCMANIS:

Q All right. So I've got another example here out of Plaintiffs' Exhibit 473. And I've filtered this down to 99285 codes. Do you see that? This is a 99285.

A 99285. Yes, I see that.

Q Okay. And the employer, do you see, that's Las Vegas Sands?

A I see that.

Q Okay. And is Las Vegas Sands an ASO client of UMR?

A I couldn't tell you one way or the other.

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MR. MCMANIS: Do you have an objection to 296?
MR. GORDON: No objection.
MR. MCMANIS: Your Honor, I move to admit Exhibit 296.
THE COURT: Exhibit 296 will be admitted.
[Plaintiffs' Exhibit 296 admitted into evidence]
BY MR. MCMANIS:
Q And to save you the trouble of looking, I'm just going to hand you a copy, okay?
A Thank you.
Q All right. And if you take a look there on -- it looks like we're on page 2. Do you see that this is a summary plan description for Las Vegas Sands Corp?
A I see that. Thank you.
Q And do you see that there is a -- well, this is a UMR plan, right?
A This is Las Vegas Sands, Las Vegas, Nevada, administered by UMR, correct.
Q Okay. And that means that Las Vegas Sands is an ASO client of UMR's under this plan, this SPD?
A Yes, sir. That's what that means.
Q Okay. And this is the January 1st, 2019 version, right?
A It says that it was restated January 1st, 2019. Yes.
Q Okay. And these SPDs; they may be updated annually or biannually depending on the client?
A The client -- the client controls when they want to update

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their plan document.

Q Okay. And do you see there's a number right there under the summary health benefits summary plan description?

A Yes, I see that.

Q All right. And would that be the group number?

A I believe that that's actually the plan number.

Q Okay. Well, let's just take down there -- because I don't want to forget it. Just write it here in the bottom. The last six -- can you just read the last six digits for me?

A 410018.

Q All right. I just want to make sure that we get that up there. So let's actually -- let's go back to the PowerPoint. All right. And it's a -- it might be a little hard to see on your screen. All right. So do you see the group number there?

A Yes, I see the group number.

Q And I'll just hand you a printed copy. Can you verify that those last six numbers match this 410018?

A Yes, they match.

Q Okay. And the employer there is Las Vegas Sands, like the exhibit we just looked at, right?

A Correct.

Q Okay. And let's -- so we've got the employer and the group number there over in -- on W and X. Can you see that on your screen, sir?

A I do.

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Q All right. And then we've got the bill CPT there as a 99285, right?

A Correct.

Q Okay. You see the charges are there in column M again?

A Correct.

Q All right. And then we have the allowed amount here in row N, right?

A Allowed amount is in row N.

Q All right. And what's the allowed amount under the Las Vegas Sands plan ending in 410018 for this claim on May 6- -- from May 16th, 2019?

A So that's the group number. And I'm not, again, familiar with Las Vegas Sands. But Las Vegas Sands can have a number of different plans, right? So I believe in the document that you gave me, like the zero, zero were first the actual plan. There could be a 01, a 02, 03. So just want to --

Q Okay.

A I just want to make sure that we're talking about the same thing.

Q Sir, do you know who John Haben is?

A I know who John Haben is.

Q Pretty smart guy, right?

MR. GORDON: Objection, Your Honor.

THE COURT: Objection sustained.

BY MR. MCMANIS:

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Q He's pretty -- he was pretty high up at United; do you recall that?

A I know --

MR. GORDON: Objection, Your Honor. Vague.

THE COURT: Overruled.

THE WITNESS: I know that -- I know that John was responsible for United's out-of-network programs.

BY MR. MCMANIS:

Q Okay. And I'll just tell you he was here testifying for four or five days, okay?

MR. MCMANIS: And Michelle, I want to pull up day 10, page 210, lines 1 through 4.

MS. RIVERS: I'm sorry. What's the page?

MR. MCMANIS: Page 210, lines 1 through 4.

BY MR. MCMANIS:

Q All right. And what Mr. Haben said under oath from the same chair that you're in when he was asked by his counsel was that, "If you want to know what specific plan was connected to this patient and this claim, what information would be helpful to track that down?"

And his answer was group number --

MR. GORDON: Objection, Your Honor. We have foundation, different entities.

THE COURT: Overruled.

MR. MCMANIS: Thank you.

BY MR. MCMANIS:

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Q And his answer was, "The group number would be the most specific." Do you see that?

A I see that.

Q Okay. So we're just going by what Mr. Haben said, okay? We've got the group number, and it matches. 410018, right?

A I believe that Mr. --

MR. MCMANIS: Can we go back to the PowerPoint?

THE WITNESS: I believe that Mr. Haben was talking about UnitedHealthcare, and we're here to talk about UMR.

BY MR. MCMANIS:

Q UMR is part of the UnitedHealth Group, right?

A UMR is part of the UnitedHealth Group.

Q Right. In fact, while you were there, you actually worked with Mr. Haben and with Ms. Rebecca Paradise, right?

A We collaborate with our partners at UnitedHealthcare.

Q Yeah, that's right. You collaborate and you want to work and make sure that the production programs that we looked at, the three programs, that you have similar offerings to what UnitedHealthcare has. That's something you did, right?

MR. GORDON: Objection, Your Honor. No foundation.

THE WITNESS: We want to -- we want to make --

THE COURT: Overruled. Hang on. You have to give me a chance to rule on the --

THE WITNESS: I apologize.

THE COURT: Okay. Overruled. And don't interrupt.

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THE WITNESS: Oh, I'm sorry.

THE COURT: It wasn't you. It was him.

MR. MCMANIS: I'll take the blame.

THE COURT: All right. So you can answer the question now.

THE WITNESS: Can someone read the question back, please?

BY MR. MCMANIS:

Q Oh, I'll just ask the question again. While you were -- while Mr. Haben was at United, and in your role at UMR, you had occasion to work together and collaborate with Mr. Haben or Ms. Paradise about the types of plans that you all were offering to ensure that you had similar types of offerings, right?

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A UMR is a subsidiary of UnitedHealthcare. We can learn a lot form each other. We can actually learn a lot from our competitors. And then we also learn a lot from our customers and what it is that is concerning them. So yes, we work together. We work together with our vendor partners, right.

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Some of the partners that we work with at UMR are similar or the same as the ones that United works with. Some of them are different. And then we come up with our solutions. Those solutions are going to be similar in some ways, but in some ways, they're also going to be different because we have different systems, we have different vendors, we have different capabilities.

Q All right. Well --

THE COURT: Mr. McManis, I'm going to ask to take our

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afternoon recess. We've gone about 80 minutes, and it's 3:45.

So to the members of the jury, during this recess, don't talk with each other or anyone else on any subject connected with the trial. Don't read, watch or listen to any report of or commentary on the trial. Don't discuss this case with anyone connected to it by any medium of information, including without limitation newspapers, television, radio, internet, cell phones or texting.

Don't conduct any research on your own relating to the case. You may not consult dictionaries, use the internet or use reference materials. During the recess, don't post any social media about the trial. Don't talk, text, tweet, Google issues or conduct any other type of research with regard to any issue, party, witness or attorney involved in the case.

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Most importantly, do not form or express any opinion on any subject connected with the trial until the matter is submitted to the jury.

It's 3:46. Please be ready at 4 p.m. It will be our last break for the day.

THE MARSHAL: All rise for the jury.

THE COURT: Sir, you may step down during the recess.

THE WITNESS: Okay. Thank you.

[Jury out at 3:46 p.m.]

[Outside the presence of the jury]

THE WITNESS: Judge, am I -- do I have any restrictions?

THE COURT: The lawyers will tell you if they do. They won't talk to you about the case pursuant to our Local Rules. I have no concern

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about that.

THE WITNESS: Okay. All right, thank you.

THE MARSHAL: Jury is clear, Your Honor.

THE COURT: The witness is still in the room, but thank you.

MR. ZAVITSANOS: Your Honor, I do have one matter to bring up, but I'll wait until this witness is out of the room.

THE COURT: Mr. Ziemer, if you'll please be outside? The room is clear. Mr. Zavitsanos?

MR. ZAVITSANOS: Your Honor, I'll be very brief. I know we are going to take up the issue of scheduling at the end of the day. Your Honor, I'm sitting there watching this; it is so painfully obvious to me what's going on here with this witness. I counted four times that he answered one of Mr. McManis' questions directly, and the same was true with Ms. Paradise, but particularly, this gentleman here.

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And Mr. McManis has -- I think he's more courteous than I am. He has not -- he has not tried to kind of reign it in or whatever, but we should not be penalized for what is obviously stalling.

THE COURT: Would the Defendant like to put something on the record in response?

MR. BLALACK: I'm going to let Mr. Gordon handle this one because he's not my witness, Your Honor. And I think best that I'm not engaged.

THE COURT: And just stand so that I can make eye contact with you, please.

MR. GORDON: Is this better, Your Honor?

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