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., Appellants, *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

MOTION TO SEAL UNREDACTED OPENING BRIEF AND APPENDIX VOLUMES

and

MOTION FOR LEAVE TO FILE REDACTED VERSION OF OPENING BRIEF

Portions of appellants' opening brief include information that

respondents disclosed in the district court under the terms of a protective order. That information includes numerical figures offered in negotiations over reimbursement rates, which respondents designated as confidential and/or attorneys' eyes only in the district court. Appellants therefore request permission to file the unredacted brief under seal and to redact those portions of the brief in the public filing to comply with the terms of the protective order. *See* SRCR 3(4)(b). (7 App. 1520–34.) (Exhibit A.)

The appendix also contains documents that were sealed in the district court or are subject to this Court's order staying unsealing. Appellants ask permission to file volumes 78–144 under seal. SRCR 3(4)(b).

DATED this 18th day of April, 2023.

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

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EXHIBIT A

EXHIBIT A

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

APPEAL
from the Eighth Judicial District Court, Clark County
The Honorable NANCY L. ALLF, District Judge
District Court Case No. A-19-792978

APPELLANTS' OPENING BRIEF (REDACTED)

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NRAP 26.1 DISCLOSURE

The undersigned counsel of record certifies that the following are persons and entities as described in NRAP 26.1(a), and must be disclosed. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

UnitedHealth Group Incorporated is the parent corporation of defendants-appellants UnitedHealthcare Insurance Company, United HealthCare Services, Inc., UMR, Inc., Sierra Health and Life Insurance Company, Inc., and Health Plan of Nevada, Inc. UnitedHealth Group Incorporated is a publicly held company and directly and/or indirectly owns 10% or more of these Appellants' stock.

Appellants have been represented by attorneys at Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC; Lewis Roca Rothgerber Christie, LLP; and O'Melveny & Myers LLP.

Dated this 18th day of April, 2023.

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JURISDICTION

This is an appeal from a final judgment after a jury verdict and various post-judgment orders, including an award of attorneys' fees and costs. Judgment was entered on March 9, 2022. (53App.13,168.) On April 6, 2022, defendants timely moved for a new trial, renewed their motion for judgment as a matter of law, and requested remittitur and to alter or amend the judgment. The district court denied the motion for remittitur and to alter or amend the judgment on July 18, 2022. (71App.17,692.) It awarded fees and costs in separate orders on August 2, 2022, followed by an order awarding supplemental attorneys' fees on October 10, 2022. (71App.17,710-73; 73App.18,008.) The district court denied both the motion for a new trial and the renewed motion for judgment as a matter of law on October 12, 2022. (73App.18,019; 73App.18,090.) Defendants timely filed their notice of appeal on October 12, 2022. (73App.18,126.) This Court has jurisdiction under NRAP 3A(b)(1), NRAP 3A(b)(2), and NRAP 3A(b)(8).

This appeal also encompasses the rulings concerning the sealing of confidential documents addressed in the proceedings at Docket

85656, which this Court's Order No. 23-9597 consolidated with the instant appeal for purposes of briefing and argument.

ROUTING STATEMENT

This case is presumptively retained by the Supreme Court under NRAP 17(a)(9) because it is a case originating in business court. It also raises questions of statewide importance involving the Insurance Code's Unfair Claims Practices Act, the Prompt Pay Act for health insurers and health plan administrators, the interpretation of the punitive damages cap statute, preemption pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), and the limits on punitive damages imposed by state statute and the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution.

STATEMENT OF THE ISSUES

1. Whether defendants are entitled to a new trial because the district court erred (a) in excluding evidence directly relevant to the central issue in dispute and (b) in giving the jury an unsupported and inflammatory spoliation instruction.

2. Whether defendants are entitled to judgment as a matter of law because plaintiffs failed to prove (a) the existence of an implied-in-

fact contract; (b) the elements of unjust enrichment; and (c) the elements required for recovery under the Unfair Claims Practices Act.

3. Whether the district court erred in awarding attorneys' fees and interest under the Prompt Pay Act because plaintiffs failed to prove the elements required for recovery under that Act.

4. Whether the $60 million punitive damages award must be reversed as a matter of law or reduced to comply with federal and state limitations on such awards.

5. Whether plaintiffs' state-law causes of action are preempted by ERISA.

6. Whether the district court erred in refusing to seal defendants' confidential business and trade secret information.

INTRODUCTION

This case is a commercial dispute between two sophisticated business entities. Plaintiffs are three affiliates of one of the nation's largest healthcare provider staffing companies. Defendants are insurers or third-party administrators of employee health benefit plans. Plaintiffs alleged that clinicians they hired to staff emergency rooms in Nevada hospitals rendered emergency medicine services to patients who were members of health plans insured or administered by defendants. Plaintiffs contended that defendants' reimbursements were inadequate because even though they indisputably adhered to the requirements of the plans, the reimbursements violated a distinct legal obligation to pay plaintiffs the full amounts they unilaterally charged for the services. A jury only partially agreed, awarding plaintiffs just $2.65 million of the over $10 million in additional reimbursements they sought. But the jury then astonishingly awarded $60 million in punitive damages, more than *23 times* the compensatory damages award, in a case that involves nothing more than a business disagreement.

That indefensible outcome is a result of litigation that went awry

from the start, due to the district court's fundamental misunderstanding of the most important factual dispute in the case. Because plaintiffs here had no express contracts with defendants specifying the amounts owed, the entire case—including every cause of action plaintiffs asserted—turned on whether plaintiffs received "reasonable value" for the services at issue. And courts in similar cases have consistently identified various market- and cost-based factors relevant to determining reasonable value, including:

- amounts the plaintiffs have been paid by similarly-situated payors;
- amounts the defendants have allowed for payment to similarly-situated providers;
- the parties' prior course of dealing; and
- the actual costs of the services rendered.

Breaking sharply with this uniform judicial consensus, the district court in this case declared all evidence concerning the foregoing factors to be *categorically irrelevant* to determining the reasonable value of the disputed services. In the court's view, this case was analogous to a "bank collections case," where a bank simply seeks to collect on a loan or other credit facility. According to the district court, plaintiffs sought

merely to collect their full billed charges for the services provided, and just as the borrower in a collection action would have no right to pursue evidence about other credit agreements, defendants here had no right to pursue evidence about other contracts and payments for the same services.

That analysis is obviously wrong. Unlike in a "bank collections case," there is nothing here like a written credit agreement identifying the specific amount owed. Just the opposite: the whole dispute exists precisely because plaintiffs *lacked* such express agreements. In their absence, the dispute could be resolved only by fairly assessing the reasonable value of the disputed services through the factors enumerated above. But the court barred all inquiry into those factors. The court instead simply presumed that plaintiffs' full billed charges were themselves equivalent to the amount owed under a written contract, thereby assuming away the issue most centrally in dispute and excluding evidence critical to its resolution. Jurors thus were denied evidence showing, for example, that plaintiffs had entered many other contracts (including with defendants) setting reimbursement for the same type of services at rates in the range of 200% of Medicare

rates or lower—rates far below the 763% of the Medicare rate that the collective full billed charges represented. As numerous appellate cases have held, such evidence is essential to determining the reasonable value of emergency medicine services. But jurors saw none of it.

In fact, the jury never should have been involved in the first place. The reimbursement issues here are properly adjudicated under the framework set forth in the federal statute that was enacted to ensure nationally uniform administration of private employee health benefit plans: ERISA. When a healthcare provider treats a member of an ERISA-governed plan, the provider can obtain an assignment of the patient's claim for plan benefits, and then assert a claim under ERISA for payment of those benefits. In this case and many like it, however, the plaintiff explicitly *disclaims* any effort to assert an assigned claim to recover plan benefits under ERISA. The plaintiffs instead seek payments *beyond* what the patient's plan would provide, on the theory that the plan's insurer or administrator has some "independent" duty under state law to pay providers more than the patient's own plan requires.

Defendants submit that ERISA provides the only legal framework

for resolving such disputes. But even if there were a truly "independent" state-law claim available in theory here, the proceedings below illustrate how *not* to fairly adjudicate such a claim and determine the reasonable value of the services rendered. The particular state-law causes of action that plaintiffs pleaded were legally defective from the start, and they should not have been tried before a jury that was prohibited from considering large swaths of evidence directly relevant to the most important issue in the case. The unfair trial proceeding in turn resulted in an inflated $60 million punitive damages award. That award contravenes Nevada law barring *any* punitive damages in a case like this, as well as state and federal standards restricting the size of such awards, especially in cases involving only economic loss by a corporate entity with no physical or emotional harm of any kind.

Judgment should be entered for defendants. At a minimum, the case should be remanded for retrial on a viable legal claim (if the Court concludes any such claim exists) with a properly developed evidentiary record.

STATEMENT OF THE CASE

This is an appeal following a jury trial presided over by the Honorable Nancy L. Allf.

The action stems from a disagreement about the payments that Team Health Holdings, Inc., and certain affiliates (collectively, "TeamHealth") should receive in reimbursement from health benefit plans insured or administered by defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services, Inc. ("UHCS"), UMR, Inc. ("UMR"), Sierra Health and Life Insurance Company, Inc. ("SHL"), and Health Plan of Nevada, Inc. ("HPN") (referred to collectively as "United," unless otherwise indicated). After TeamHealth and its private equity owners were unable to achieve the reimbursement rates they sought in negotiations for written contracts with United, TeamHealth terminated the existing contracts that one of the plaintiffs had with defendants and invoked litigation, hoping the courts would grant them payment rates they could not obtain at the bargaining table. In fact, TeamHealth sought much *more* from the courts than it had ever obtained through negotiations or even proposed in negotiations. According to TeamHealth, when there is no contract

governing the provision of emergency medicine services rendered to members of health benefit plans insured or administered by United, Nevada law requires United to pay TeamHealth's *full billed charges*, whatever they may be. TeamHealth applied that theory to challenge reimbursements it received from health benefit plans insured or administered by United for health benefit claims with dates of service between July 2017 and January 2020.

The case went to trial on four causes of action: (1) breach of implied-in-fact contract; (2) an alternative claim for unjust enrichment; (3) violations of the Unfair Claims Practices Act ("UCPA"); and (4) violations of the Prompt Pay Act ("PPA"). TeamHealth also sought punitive damages.

The jury found in favor of TeamHealth on each count, but it disagreed that TeamHealth's full billed charges constituted a reasonable value for the services. Rather than awarding the more than $10 million in billed charges that TeamHealth sought, the jury awarded only $2.65 million as additional compensation for the services. But the jury then awarded $60 million in punitive damages, based on the UCPA and unjust enrichment counts. The district court then added a more

than $800,000 special interest penalty under the PPA, for a total final judgment of $63,429,873.96. The district court separately awarded TeamHealth more than $12 million in attorneys' fees under the PPA and almost $888,000 in costs.

Following trial, the district court denied United's motions for a new trial, for renewed judgment as a matter of law, for remittitur and to alter or amend the judgment, and to limit punitive damages. United timely appealed.

In addition to the forgoing rulings and issues, this appeal encompasses rulings concerning the sealing of confidential United documents, which are addressed in the proceedings at Docket No. 85656. The "Statement of the Case" pertinent to those issues is set forth in United's Petition for a Writ of Mandamus ("Mandamus Pet."), Docket No. 85656, at 7-23, incorporated herein by reference pursuant to this Court's Order No. 23-9597.

STATEMENT OF FACTS

A. The Parties and Their Course of Dealing

The named plaintiffs staff hospital emergency departments and are owned by TeamHealth. (21App.5,247–48; 20App.4,942, 4,945,

4,962, 4,968; 98App.24,320–23; 98App.24,337.) TeamHealth is a for-profit company that provides emergency department staffing and claim billing services in Nevada and elsewhere. (20App.4,944–47; 67App.16,517–19.) It is one of the largest physician staffing companies in the country and is fully owned by Blackstone Inc., one of the largest private equity firms in the world.[1] (98App.24,337).

The United defendants are insurers or third-party administrators ("TPAs") of employer and union sponsored health benefit plans. (21App.5,248–49.) In these distinct roles, the United entities either issue insurance policies to employer/union-sponsored health benefit plans that pay benefits through those insurance policies, or they provide administrative services to "self-funded" or "self-insured" plans where

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[1] *See* https://www.blackstone.com/news/press/teamhealth-to-be-acquired-by-the-blackstone-group/ (Oct. 2005) (TeamHealth's "'management team . . . built [a] physician staffing company'"); https://www.teamhealth.com/news-and-resources/press-release/blackstone/ (Feb. 2017) (TeamHealth staffing services include "more than 20,000 affiliated physicians").

benefits are paid by the plan sponsors themselves. (21App.5,248–49, 5,251; 36App.8,953; 39App.9,705–06; 119App.29,553.)

Two defendants, UHS and UMR, are solely TPAs for self-funded plans. (36App.8,853–54; 39App.9,704–07.) UHIC wears two hats: sometimes it is an insurer and other times it is only a TPA. (36App.8,956.) A self-funded plan sponsor pays a fee to a TPA to build provider networks, maintain records, communicate with members, review claims, handle appeals, and so on, but the sponsor—not the TPA—is financially responsible for paying benefit claims incurred by plan members. (36App.8,959.) The sponsor-TPA relationship is governed by an administrative services agreement. (36App.8,961–63.) Private self-funded health benefit plans are exclusively governed by ERISA.

SHL, HPN, and sometimes UHIC, on the other hand, are insurers who issue fully insured plans that employers or unions provide to their employees or members. (40App.9,962–64.) In a fully insured plan, the sponsor pays premiums to the insurer, which both administers the plan and bears the financial risk for plan members' health benefit claims.

(36App.8,958–59.)[2]

The dispute at issue here arises when a patient who is a member of a health plan insured or administered by a United entity receives emergency medicine services at a facility staffed by TeamHealth. Emergency departments are obligated under both federal and state law to treat patients who seek care at their facilities, regardless of insurance status or ability to pay. *See* Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd; NRS 439B.410; 39App.9,675 (under EMTALA, "we have to provide rapid medical [services] prior to anybody asking for insurance information"). Because of the emergent nature of these services, neither the patient nor United had any ability to *choose* the clinician, TeamHealth-affiliated or otherwise, before services were provided. (44App.10,820–22.) Accordingly, unless United has a preexisting contract with TeamHealth providing for treatment of plan members, United has no legal relationship with TeamHealth; its obligations to TeamHealth—if any—

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[2] Even for fully insured plans, plan sponsors are impacted by rising medical costs through increases in health insurance premiums.

instead must derive from its obligations to the plan member under the health plan's terms.

A contract for treatment of plan members is known as a "network contract" and healthcare providers who enter such agreements are known as "network" or "participating" providers. (36App.8,964–65.) A network agreement establishes the terms on which United or a self-funded plan will reimburse a participating provider for covered services. When a plan member receives treatment from a network provider, the member often owes little or nothing for the treatment up to a threshold amount, generally except for a small copayment. (*See* 36App.8,967.) This benefit structure thus incentivizes plan members to obtain treatment from network providers, who have already agreed upon treatment charges and have shown that they provide high quality care.

On the other hand, when a member receives treatment from a *non*-network provider—a provider with whom United has no network contract—the lack of a contract by definition means that United has *not* previously agreed on a payment rate for treatment and/or has doubts about the quality of care. United thus will only reimburse the member a specified amount for the treatment, with the reimbursement

methodology defined in different ways by different plans. (32App.7,960–61; 36App.8,965–66; 39App.9,707.) The provider in that scenario has a contractual relationship only with the patient/member—the sole obligation of the self-funded plan or insurer is a contractual duty to its member to offset the member's liability to the provider by reimbursing her the plan-prescribed benefit for non-network services. (32App.7,960–61; 39App.9,705–06.) But because the plan and insurer have no network contract with the provider, it is the patient who remains financially responsible for the services she received (unless a statute precludes billing the patient directly). (31App.7,641; 36App.8,965–67; 40App.9,887.)

TeamHealth plaintiff Fremont began terminating its network agreements with United in 2017. (106App.26,209.) TeamHealth, through Fremont, filed this lawsuit after the July 2017 contract was terminated. (1.App.1.) Eventually, TeamHealth named two more entities as plaintiffs and Fremont terminated its last remaining contract with United on February 25, 2019. (106App.26,206–07.) TeamHealth plaintiffs were then non-network providers with all of the United defendants. (31App.7,641.)

Accordingly, when patients of health plans insured or administered by United received treatment from July 1, 2017 to January 31, 2020[3] at one of the facilities staffed by TeamHealth, United and TeamHealth had not agreed upon the amount that TeamHealth would accept as full satisfaction of its bills.

B. The Parties' Dispute and Subsequent Network Negotiations

Before and after TeamHealth terminated plaintiff Fremont's network agreements, the parties engaged in extensive negotiations to enter new network agreements. (*See generally* 109App.27,100–110App.27,287 (Omnibus Offer of Proof).) The negotiations took place first in the Nevada market and later at the national level for all

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[3] Beginning January 1, 2020, Nevada's Surprise Billing Act defined the obligations between insurers and health care providers who rendered emergency medicine services in the state. That law created a comprehensive framework for resolving payment disputes between out-of-network providers of emergency medicine services and third-party payors like United. NRS 439B.160; NRS 439B.700 *et seq*. In particular, it establishes a mandatory and exclusive process for contesting reimbursement rates for certain categories of health benefit claims, which must consider network rates in the relevant geographic area. The act also makes reimbursement claims subject to binding arbitration. NRS 439B.754.

TeamHealth and United affiliates nationwide.

Offers were usually expressed as percentages of the Medicare fee schedule, (109App.27,109), and TeamHealth consistently made offers, or expressed willingness to accept reimbursements, in ranges far below [redacted] of the applicable Medicare rates. (109App.27,110–15.) In September 2017, for example, Fremont was willing to accept [redacted] of Medicare for emergency medicine services, and previously would have accepted as low as [redacted] of Medicare before terminating their agreements. (105App.25,981–83.) In October 2017, internal TeamHealth emails show satisfaction with a [redacted] of Medicare reimbursement rate. (105App.26,000.) In May 2018, TeamHealth offered SHL and HPN a per visit rate of [redacted], which equaled [redacted] of Medicare for SHL and [redacted] for HPN, escalating to just [redacted] of Medicare for SHL and [redacted] of Medicare for HPN over three years. (105App.25,992–94.).[4] A month later, Kent Bristow, a senior vice president of TeamHealth, offered to accept [redacted] of Medicare as

[4] Medicare rates vary across regions, which can cause the same dollar amount to be expressed as different percentages of Medicare.

reimbursement for all emergency medicine services in Nevada. (105App.25,989, 25,992–94.)

Before an April 2019 negotiation meeting, TeamHealth's CEO, Leif Murphy, provided United with materials concerning the cost of providing emergency medicine services and TeamHealth's network and non-network payment rates with other payors, including United's competitors. (106App.26,187.) Murphy reported that TeamHealth's average cost to provide clinicians in an emergency department was $150 per patient encounter. (106App.26,151.) He also reported that TeamHealth's average collection amount was [redacted] per patient visit for Medicare and [redacted] per patient visit for commercial insurers. (106App.26,151.) But Murphy reported to United that TeamHealth accepted a reimbursement rate from Blue Cross Blue Shield ("BCBS")—one of United's largest competitors—that was less than [redacted] and [redacted] of Medicare in 2017 and 2018, respectively. (106App.26,156.) BCBS allowed payment on average of [redacted] per patient visit. (106App.26,165.)[5]

[5] By comparison, United's average amount allowed per visit was

After TeamHealth terminated the contracts between plaintiff Fremont and certain United entities, between 2017 and 2019, TeamHealth also separately negotiated some agreements directly with United's clients, *i.e.*, self-funded employers in Nevada. (105App.26139–43.) For example, an agreement with MGM Resorts provided for an [redacted] per emergency department visit, which equated to [redacted] of Medicare. (106App.26,189, 26,201.)

Throughout this negotiation period, TeamHealth continued to submit reimbursement claims to United, which determined allowable amounts based on the terms of the applicable health benefit plans. (37App.9,025–26, 9,057; 39App.9,707.) Out of the more than 75,000 benefit claims that TeamHealth submitted to United from July 1, 2017 to January 31, 2021, TeamHealth cherry-picked 11,563 to dispute; United allowed $2.84 million in payments to TeamHealth based on the health benefit plans for each of the patients who received care from providers affiliated with TeamHealth. (42App.10,329; 92App.26,680–

[redacted] for the claims at issue in this case. (106App.26,299 (expert rebuttal report of Bruce Deal).)

81.) For those disputed benefit claims, TeamHealth's billed charges were approximately $13.24 million. (42App.10,329.) The $2.84 million that United allowed for the disputed benefit claims was equivalent to 164% of Medicare, while TeamHealth's full billed charges equated to 763% of Medicare. (48App.11,831; 43App.10,708.)

C. TeamHealth's Lawsuit

After terminating the parties' written contracts, TeamHealth began to run what one TeamHealth executive described as its litigation "playbook" to challenge the reimbursements United allowed for now-out-of-network services provided by TeamHealth-affiliated clinicians. 144App.35,711–13. On April 15, 2019, TeamHealth plaintiff Fremont filed suit. (1App.1.) On May 15, 2020, TeamHealth filed its first amended complaint ("FAC"), adding the other two named plaintiffs. (4App.973.) Following United's motion for summary judgment, and on the eve of trial, TeamHealth filed a second amended complaint ("SAC"). (21App.5,246.)

1. The FAC Seeks 75-90% of Billed Charges

The FAC alleged that three TeamHealth Nevada affiliates were "non-participating" or "out-of-network" providers beginning on July 1,

2017, for an unspecified number of benefit claims involving members of health plans insured or administered by United. (4App.979–80.) The FAC alleged that the disputed benefit claims had been "adjudicated as covered, and allowed as payable" by United, but were approved "at rates below the billed charges and a reasonable payment for the services rendered," as "measured by the community where they were performed and by the person who provided them." (4App.982.)

The FAC further alleged that the "well-established" reasonable rate of reimbursement for the services was 75-90% of TeamHealth's unilaterally set billed charges. (4App.983.) That payment rate, the FAC asserted, was the amount United "traditionally allowed," citing non-network benefit claims allegedly allowed at that rate between 2008 and 2017. (4App.983.) That "longstanding history," the FAC alleged, "establishe[d] that a reasonable reimbursement rate" for the at-issue claims was 75-90% of the billed charges. (4App.983.)

2. United's ERISA Preemption Motion Is Denied

United moved to dismiss the FAC on the ground that all causes of action were preempted by ERISA. (5App.1,027–57; *see also* 3App.553–83.) The district court denied the motion, asserting that TeamHealth's

causes of action all involved only the "rate of payment" rather than a "right to payment" and thus did not require a factfinder to consult the plans' terms, which would trigger ERISA preemption. (6App.1,475–96.)

United petitioned this Court for extraordinary review, but a panel of this Court denied the petition. *United Healthcare Insurance Company v. Eighth Judicial District Court*, Docket No. 81680, *4 (Order Denying Petition July 1, 2021). The panel reasoned that United could renew its arguments in the district court and on appeal after development of the factual record, and observed that "[b]ecause the case must continue, at least partially, judicial economy is not well served by considering the writ." *Id.* The panel also observed that "some of the providers' claims appear questionable." *Id.* As explained further below, the facts established at trial do not support the allegations this Court accepted as true in denying United's petition.

3. The District Court Denies United Discovery Directly Relevant to the Reasonable Value of the Emergency Medicine Services at Issue

In a series of rulings, the district court denied United basic discovery of evidence necessary to challenge TeamHealth's allegations and to enable the jury to determine whether TeamHealth had already

received payments for the value of the disputed emergency medicine services. (85App.20,904–05.) The categories of evidence the court declared to be irrelevant during discovery included:

- TeamHealth's network reimbursement rates and agreements demonstrating the payment rates it would accept for emergency medicine services from commercial health insurers and health plans;
- previous reimbursement rates for emergency medicine services in network agreements between TeamHealth and United, as well as negotiations about reimbursement rates between TeamHealth and United;
- Medicare or non-commercial reimbursement rates;
- How TeamHealth sets its billed charges and the costs of providing emergency medicine services;
- the profit TeamHealth realized from emergency medicine services; and
- TeamHealth's corporate structure and how it distributes profits (*i.e.*, whether the reimbursement passed to the doctors and nurses that provided the disputed services or not).

(37App.9,165–68.)

TeamHealth even began instructing its witnesses not to answer deposition questions about documents that TeamHealth itself produced during discovery on the unilateral basis that those documents related to subjects that that court had ruled irrelevant. (19App.4,501–12.) The district court later endorsed that practice, ruling that plaintiffs'

"corporate structure, rates, the excessive charges, their profitability, their business model, billings, agreements, negotiations, all of that is simply irrelevant to the defense in this case." (19App.4,513–14.)

The court also prohibited discovery of clinical records underlying TeamHealth's reimbursement claims, which United sought as relevant to understanding whether, why, and how the services were actually performed, which in turn was probative of the services' reasonable value. (8App.1,998–9App.2,016.) The court ruled that the clinical records were categorically irrelevant, (11App.2,674–80), and instead allowed TeamHealth to rely on a spreadsheet of its disputed claims that merely denoted what CPT code[6] TeamHealth itself applied to the service to determine how much reimbursement was owed, (*see* 31App.7,633 ("You're not going to have to see a medical file . . . . What we're going to present to you in large part are Excel spreadsheets.");

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[6] Current Procedural Terminology ("CPT") codes are published by the American Medical Association. They supply a uniform "language for coding medical services and procedures to streamline reporting" and are "used for administrative management purposes such as claims processing." https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval.

39App.9,694–65.).

The court's order barring discovery of clinical records became the template for many of its other discovery and evidentiary rulings. According to the court, clinical records underlying TeamHealth's benefit claims were irrelevant because this is simply "a rate of pay case," (11App.2,675 (cleaned up)), where the "relevant inquiry" is "the proper rate of reimbursement," which in turn is based only on "the amount billed by the Health Care Providers and the amount paid by United," (11App.2,679.) That key premise—that jurors would need only to know how much TeamHealth charged and how much reimbursement it received from health plans insured or administered by United—laid the groundwork for an entire proceeding in which United was denied the right to discover or present evidence showing that the reasonable value of TeamHealth's services was far less than its self-determined billed charges.

While denying United discovery of clinical records underlying TeamHealth's benefit claims, the district court granted TeamHealth incredibly broad discovery into the administrative records underlying the very same claims. On September 28, 2020, the district court

ordered United to produce the claims files for every one of the disputed benefit claims, which at that time was 15,210 claims. (9App.2,188–89.) TeamHealth would later inflate its disputed claims list to approximately 23,000 before excising thousands of errantly included benefit claims while trial was underway to settle on the 11,563 disputed claims presented to the jury. (20App.4,772–73, 4,789–94; 42App.10,389–94; 46App.11,415–20.)

The district court ordered that massive production despite United's showing that it would take roughly *two hours per claims file* to comply with the discovery request, for a total of 30,420 hours of employee labor (with 15,210 claims in dispute)—the equivalent of four full-time employees working solely on that task for three years. (9App.2,190; *see also* 41App.10,039 (TeamHealth's expert testifying at trial that "many" of the disputed benefit claims "have very large data sets" and that "this case has a tremendous amount of—there's 11,000 claims, but there's really many, many more actual records associated with those claims").) Then, in November 2020, the district court ordered United to begin producing a minimum of 2,000 claims files per month. (12App.2,779.)

4. The District Court's One-Sided Discovery Rulings Become One-Sided Evidentiary Exclusions

As an extension of its discovery orders, the district court later granted TeamHealth's motion *in limine* to transmute the discovery orders into evidentiary rulings, excluding from trial all of the evidence subject to discovery bars. (*See* 37App.9,165–68.)

Not only did the court thus exclude vast swaths of evidence critical to assessing reasonable value, but it applied its narrow interpretation of relevance in an entirely one-sided fashion. United filed numerous motions *in limine* seeking approval to introduce evidence relevant to reasonable value and other disputed issues of fact, often pairing the motion with an alternative motion requesting that the court at least apply its reasoning equally to exclude TeamHealth's corresponding counter-evidence. *See generally* Defs' MIL Nos. 1-14. The district court refused, expressly rejecting United's contention that "what is good for the goose ought to be good for the gander" because, in the court's view, TeamHealth needed additional leeway to "to prove that they were under-reimbursed." (24App.5,890–91.)

The court applied that asymmetrical analysis to deny all of the

following paired motions *in limine*:

- United moved for admission of evidence relating to TeamHealth's agreements with other payors and related negotiations (20App.4,805, MIL No. 1), and in the alternative sought to preclude TeamHealth from presenting evidence of United's agreements with other providers and related negotiations (20App.4,830, MIL No. 2).

- United moved for admission of evidence relating to TeamHealth's process for determining its own billed charges (86App.21,260, MIL No. 3) and in the alternative, sought to preclude TeamHealth from introducing evidence relating to United's process for determining its reimbursement rates for non-network services (20App.4,853, MIL No. 4).

- United moved for admission of evidence regarding the unreasonableness of TeamHealth's billed charges (86App.21,314, MIL No. 5), and in the alternative sought to preclude TeamHealth from arguing that its charges were reasonable (86App.21,344, MIL No. 6).

- United moved for admission of evidence related to the actual costs of services provided by TeamHealth (20App.4,973, MIL No. 7), and in the alternative sought to preclude evidence of the nonmonetary or qualitative value of TeamHealth's services (21App.5,031, MIL No. 8).

- United moved for admission of evidence relating to TeamHealth's negotiations with United over reimbursement rates (96App.23,802, MIL No. 11), and in the alternative sought to preclude TeamHealth from discussing United's determination of reimbursement rates (96App.23,860, MIL No. 12).

- United moved for admission of evidence relating to TeamHealth's use of a vendor to determine whether additional

reimbursements were owed on the disputed benefit claims and to pursue them from health plans insured or administered by United (20App.4,886, MIL No. 13), and in the alternative sought to preclude evidence relating to United's use of a vendor to help determine reimbursement amounts for the disputed benefit claims (20App.4,919, MIL No. 14).

The court's denial of the foregoing motions ensured that while TeamHealth could admit the evidence it wanted to tell its side of the story, United—and the jury—would be denied the rebuttal evidence needed for a full and fair understanding of the disputed factual issues at the heart of the case.

5. TeamHealth Amends Its Complaint to Demand Payment of Full Billed Charges

After the close of discovery, at the same time as the motions *in limine*, United moved for partial summary judgment to narrow the issues at trial. (20App.4,770.) In response, TeamHealth filed a second amended complaint ("SAC"), which mooted all but two issues in the summary judgment motion. (21App.5,246.)

Among other things, the SAC abandoned four of the previously asserted causes of action—claims for breach of the duty of good faith and fair dealing (essentially a bad-faith claim), consumer fraud and deceptive trade practices, and racketeering. (22App.5,256–62;

107App.26,500.) The counts remaining for trial were: (1) breach of an implied-in-fact contract; (2) unjust enrichment; (3) UCPA violations; and (4) PPA violations. (22App.5,256–62.)

The FAC previously had sought damages based on allegations that the "well established" reasonable value of the emergency medicine services was 75-90% of the billed charges. (4App.983.) Emboldened by the district court's rulings, the SAC asserted a new theory that the "reasonable value" of the disputed services was in fact the full billed charge, which the SAC alleged was the "usual and customary" amount paid in the market.

6. The District Court Denies United's Motion for Summary Judgment on Punitive Damages

The SAC included only one allegation regarding punitive damages, asserted only under the UCPA. TeamHealth alleged that "Defendants have acted in bad faith regarding their obligations to pay the usual and customary fee; therefore, the Health Care Providers are entitled to recover punitive damages against Defendants." (22App.5,260.)

United moved for summary judgment on punitive damages,

arguing among other things that punitive damages are not available in a commercial dispute between large and sophisticated actors, especially over a subject—underpayment of reimbursement claims—that is routinely and openly negotiated by the parties, and where any economic loss can easily be remedied through money damages. (20App.4,773, 4,801–02.)

The district court denied the motion, holding that TeamHealth "should be allowed an attempt at convincing the jury whether Defendants have been guilty of oppression, fraud or malice." (25App.6,121.)

D. The Trial Proceedings—Liability and Damages Phase

Trial was divided into an initial liability phase, followed by a one-day punitive damages phase. Each of the causes of action at trial turned on the same underlying question: whether TeamHealth's full billed charges constituted the reasonable value that United-insured or -administered health plans must pay for non-network services rendered to plan members.

1. TeamHealth Invokes Irrelevant Issues to Stoke Jurors' Passion and Prejudice

Even though United had been denied discovery into clinical

documentation underlying the healthcare services at issue, TeamHealth persistently argued during trial that United was responsible for reducing the quality of that care, and indeed all healthcare in Nevada. TeamHealth's counsel advised jurors that they had "an opportunity to do something very special in this case." (31App.7,628.) Although "most cases are about money, passing money from one pocketbook to another," they said, "this case is about a little more." (31App.7,628.) "[I]t's about the quality of healthcare in Nevada, not simply here in southern Nevada, but across the State of Nevada, particularly about the quality of emergency medical care." (31App.7,628; 43App.10,569 ("if reimbursement is not adequate . . . it can undermine the care and the community for the safety net of emergency medicine").) With their verdict, TeamHealth argued, jurors could "say enough is enough" to United and "pull Nevada up from the bottom" of the nation. (31App.7,629.)

Meanwhile, the discovery and *in limine* rulings deprived United of much of the best evidence and arguments to answer TeamHealth's complaints about allegedly inadequate reimbursements. The rulings prohibited United from showing that TeamHealth's billed charges were

excessive, from demonstrating that the reimbursements covered the costs of rendering the emergency medicine services at issue and thus did not undermine the quality of care, and from showing that TeamHealth funnels all money it receives above those costs to itself and its private equity owner, Blackstone, rather than the doctors and nurses who rendered the services. *See supra* Facts at C.3–4. At times, United's witnesses were even prohibited from fully answering questions that TeamHealth itself asked them—*e.g.*, how United determined its reimbursement rates. *See infra* at I.A.2.c. In short, when TeamHealth would "open the door" on an issue, the court would promptly close it on United. United was left with the sole defense that the payments it allowed were consistent with the health plan documents underlying TeamHealth's disputed benefit claims.

2. Court Gives Highly Prejudicial Spoliation Instruction Regarding Plan Documents Underlying the At-Issue Claims

Before closing argument, the court gave jurors an instruction based on two categories of documents that, according to TeamHealth, United had willfully suppressed: (1) documents corroborating United's defense that its self-funded employer clients *wanted* their plans'

non-network payments to constrain rising health care costs, and (2) administrative records for some of the benefit claims at issue. (48App.11,755–56.)

As noted, the district court ordered United to produce all underlying administrative records for the many thousands of disputed benefit claims, notwithstanding the Herculean effort such production required. *See supra* Facts at C.3. After convincing the court to impose this undue burden, TeamHealth's list of disputed claims ballooned to more than *23,000*. (46App.11,415.). In July 2021, there were still more than 19,000 disputed claims. (42App.10,389; 46App.11,417.) In or around September 2021, TeamHealth reduced the list of disputed benefit claims to 12,558 and then 12,081. (42App.10,389–91; 46App.11,418.) It was not until trial was underway that TeamHealth finalized the number of disputed claims at just 11,563. (41App.10,074–75; 43App.10,538.)

The burden to produce the administrative records for each disputed claim was enormous, and United had to meet the obligation by mid-April 2021. Most of the documents had to be manually generated or retrieved on a claim-by-claim basis. (8App.1,848–53, 1,856–59.)

United was forced to devote extensive employee labor and to develop brand new administrative record search technologies, all at great expense. (16App.3,921.) The burden was not so onerous for SHL and HPN, which issued fully insured plans and thus had ready access to their plans and underlying documents associated with every at-issue claim. 146App.36,175:3–16. But for UHIC, UHC, and UMR, which acted as TPAs to plans sponsored and funded by employers and unions, it was vastly more burdensome to produce plan documents, which were largely in the possession, custody, and control of the plan sponsors. As a result, some were not produced in time for trial. United did, however, ultimately produce more than 200,000 pages of administrative records, including more than 7,000 plan documents and explanation of benefit forms associated with almost 16,446 unique benefit claims, more than were ultimately submitted to the jury at trial. 146 App. 36,175:4–7.

Although United thus produced administrative records for many more disputed benefit claims than TeamHealth ultimately took to trial, TeamHealth's constantly-evolving list of disputed claims hindered United's production and precluded it from providing administrative records underlying every single benefit claim submitted to the jury.

The district court nevertheless instructed the jury that United had "willfully suppressed" and "destroyed" evidence the court had ordered it to produce, with "intent to harm" TeamHealth or its case, giving rise to a "rebuttable presumption" that the evidence was adverse to United:

> By an order of this court entered August 3, 2021, certain findings were made by the court at the request of the Plaintiff[s]. One was that the Defendants had failed to comply with certain orders requiring responses to discovery and the Court concluded that the Defendants' conduct was willful. When evidence is willfully suppressed, there is a rebuttable presumption which reads as follows:
>
> When evidence is willfully suppressed, the law creates a rebuttable presumption that the evidence would be adverse to the party suppressing it. Willful suppression means the willful or intentional spoilation of evidence and requires the intent to harm another party or their case through its destruction, not simply the intent to destroy evidence. When a party seeking the presumption's benefit has demonstrated that the evidence was destroyed with intent to harm another party or their case, the presumption that the evidence was adverse applies, and the burden of proof shifts to the party who destroyed the evidence.
>
> To rebut the presumption, the destroying party must then prove, by a preponderance of the evidence, that the destroyed evidence was not unfavorable. If not rebutted, the jury is required to presume that the evidence was adverse to the destroying party.
>
> The Order also gave Defendants a deadline of April

> 15, 2021 at 5 p.m. to supplement outstanding discovery requests. If you believe that the Defendants have not rebutted evidence introduced by Plaintiff[s], that relevant evidence was suppressed, you are required to presume that the evidence was adverse to the Defendants.

(48App.11,972, Jury Instruction No. 15.)

Although the court had previously held—in denying United's motion to dismiss—that analysis of the benefit plan was irrelevant to the jury's resolution of the case, (*see* 6App.1,475–96), the court's spoliation order told jurors not only that United had "destroyed" the plan documents, but that doing so would harm TeamHealth's case.

3. The Jury's Verdict

TeamHealth asked the jury to award compensatory damages of $10.5 million, which was the difference between its full billed charges and the amount United already allowed for the disputed benefit claims pursuant to the applicable health plans. (48App.11,770, 11,804.) United asked the jury to find that the amounts TeamHealth already received constituted the reasonable value of the disputed services.

The jury's verdict found United liable on all four causes of action and for punitive damages under the UCPA and unjust enrichment

counts. (49App.12,035–46.) In total, the jury found that United underpaid TeamHealth by $2,650,512 and awarded damages in that amount on the breach of implied contract, unjust enrichment, and UCPA claims. (49App.12,035–46.)

E. Trial Proceedings—Punitive Damages Phase

The liability phase of trial was followed by a single-day punitive damages proceeding. TeamHealth first called Rebecca Paradise, UHS's vice president of out-of-network payment strategy, to discuss United's financial net worth. (49App.12,158–71.) TeamHealth counsel also badgered Ms. Paradise about whether United had implemented policy or operational changes in response to the verdict issued just days earlier. (49App.12,175–93.) Counsel repeatedly asked Ms. Paradise whether she believed any of United's conduct in the case was reprehensible, malicious, oppressive, or fraudulent, and whether she or anyone at United agreed with the jurors' verdict. (49App.12,187–93.) Without any evidence in the record, TeamHealth further implied that the punitive damages award would affect how United's competitors did business, because they would see the award and fear similar results if they underpaid emergency medicine claims. (49App.12,199–200.)

Given the court's *in limine* rulings, Ms. Paradise was unable to explain why United believed the payments were not reprehensible. In fact, her excluded testimony and other evidence would have shown that United's payments were wholly consistent with payment rates TeamHealth itself had previously accepted from United for the same type of services, with rates TeamHealth had agreed to accept for those services during network negotiations with United, and with rates TeamHealth was accepting from United's competitors. (49App.12,231.) United also was barred from showing that the payments TeamHealth received were above the costs required to deliver the services at issue. *Id.* As in the first phase, that evidence was declared irrelevant.

The district court instructed the jury to consider two questions when determining punitive damages: (1) the reprehensibility of United's conduct, and (2) the amount of punitive damages that would "serve the purposes of punishment and deterrence, taking into account the defendant's [sic] financial condition." (49App.12,145 (Jury Instruction No. 43). Doubling down on the prior spoliation order, and over United's objection, the court also instructed the jury that "[t]he previous instruction regarding presuming that relevant evidence that was not

produced is adverse to the Defendants is still in effect." (49App.12,148 (Jury Instruction No. 46).)

In the closing arguments on punitive damages, TeamHealth again relied on the spoliation instruction to argue that United's conduct was reprehensible because it was seeking to decrease provider reimbursement no matter what the plan terms required. Because United was not able to produce the plans for all 11,563 disputed benefit claims, TeamHealth argued, the jury was "required to assume those plans would be harmful." (49App.12,250; *see also* 50App.12,254 (arguing that "the problem is we don't have the plans, right?" and that plans say the opposite of what United claimed).) TeamHealth even argued that in the week between the jury verdict and the punitive damages phase, United should have appeared with the additional missing plan documents. (50App.12,255–56.)

Further, despite previous assurances that TeamHealth would not rely on spoliation as a basis for punitive damages, (*see* 49App.12,108–09), its counsel directly tied the spoliation ruling to the reprehensibility of United's conduct:

> The Court concluded the Defendants' conduct was

> willful. Now, we're talking about reprehensibility, the first prong of how much to assess against them, right? And this was the other part of the adverse inference, okay? If you believe that they've not rebutted the evidence, then you are required to presume that the evidence was adverse to the Defendants. That was for phase one. And now, Her Honor has instructed you that this remains in effect. And they did not rebut it.

(50App.12,256.)

TeamHealth hinted that the jury should award as much as $500 million but ultimately requested at least $100 million in punitive damages. (50App.12,258–59, 12,261.) Without any evidence, its counsel warned ominously that United was "gobbling up doctor's practices all over" and that Nevadans were going to be treated by doctors who report to an insurance executive whose job it is to cut costs. (50App.12,262.) The jury awarded a combined total of $60 million in punitive damages. (49App.12,150–52.)

F. Post-Trial Proceedings

Following trial, United moved to apply the statutory cap under NRS 42.005 to the punitive damages award because TeamHealth had not asserted an insurer bad-faith claim, as required to invoke the cap's exemption for an insurer's bad faith denial of coverage to an insured.

See NRS 42.005(1)(b) (allowing uncapped punitive damages when insurer "acts in bad faith regarding its obligations to provide insurance coverage" to an insured). Indeed, TeamHealth told the district court during the final charging conference that it was "not pursuing bad faith as a basis for punitive damages." (47App.11,582.)

On January 5, 2022, the district court entered a written order denying United's motion for judgment as a matter of law made at trial. (51App.12,715.) On March 9, 2022, the court denied United's motion to apply the punitive damages cap. (53App.13,182.) The judgment was entered the same day. (53App.13171.) The district court itself calculated the damages under the PPA for the special interest allowed by statute in an amount just under $800,000. *Id.*

TeamHealth moved for an award of attorneys' fees because it prevailed on the PPA claim. (62App.15,389.) It requested $12,683,044.41 in attorneys' fees, followed by a "notice of supplemental attorney fees" requesting an additional $835,041. (70App.17,470.) The district court awarded 90% of the requested fees, for a total amount of $12,164,363.47. (73App.18010.)

Following judgment, United moved for remittitur and to alter or

amend the judgment, contending that the $60 million punitive damages award violated the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution. (66App.16,382–96.) United also moved for a new trial and renewed its motion for judgment as a matter of law. (66App.16,449 (Mot. for New Trial); 66App.16,400 (Renewed Mot. for JMOL).)

The district court denied the motion for remittitur and to alter or amend the judgment. (71App.17,692.) The district court also denied the renewed motion for judgment as a matter of law and the request for a new trial. (73App.18,090 (JMOL); 73App.18,019 (New Trial).)

United timely appealed. (73App.18,126.)

SUMMARY OF THE ARGUMENT

I. United did not receive a fair trial. The district court denied United necessary discovery and then excluded from trial the most probative evidence of the reasonable value of the emergency medicine services at issue, including evidence of payment rates TeamHealth was accepting for in-network contracts with United's competitors and self-funded clients, the rates United was paying other providers for the same services, the parties' own prior course of dealing, and the costs of

providing the services.

The district court also gave the jury an unjustified and severely prejudicial spoliation instruction that wrongly told jurors that the district court already found that United willfully destroyed key evidence, which the court had not found and was not true.

II. Trial errors aside, the district court should have never allowed the jury to decide TeamHealth's causes of action.

TeamHealth failed to establish an implied-in-fact contract. After their network agreements were terminated, the parties never reached any agreement—express or implied—on the reimbursements United would allow for emergency medicine services. Quite the contrary, the parties affirmatively *agreed to disagree* on reimbursement rates for emergency medicine services. And TeamHealth did not provide United any benefit that served as consideration for the non-existent promise.

Nor did TeamHealth assert a valid quasi-contract claim based on unjust enrichment. First, the unjust enrichment judgment cannot stand if the breach of contract judgment is affirmed. Second, the judgment fails on its own terms in any event, because TeamHealth conferred no benefit on United requiring compensation for TeamHealth.

The UCPA does not apply, either. The UCPA only creates liability between an insurer and an insured, and TeamHealth is indisputably not an insured. Three of the United defendants are not even insurers; they are third-party claim administrators.

III. The awards of attorneys' fees and penalty interest must be reversed because they are based on the PPA, which has no application here. TeamHealth did not exhaust its administrative remedies, as the PPA requires. And the PPA applies only when an insurer fails to make *prompt* payment on fully-approved benefit claims. It is undisputed that TeamHealth received prompt payments on all approved reimbursements. TeamHealth argues only that United should have allowed *higher* reimbursements, which is not a dispute within the scope of the PPA.

IV. Even if some or all of the damages verdict stands, the punitive damages award must be reversed. Nevada law does not allow punitive damages in a purely commercial dispute with no physical harm and no indicia of fraud, oppression, or malice. And neither the UCPA nor the unjust enrichment claim permits punitive damages here.

Even if *some* amount of punitive damages were permissible, the

award here vastly exceeds federal due process limitations and Nevada's statutory cap. If not reversed entirely, the award should be reduced to an amount well below the $2.65 million compensatory damages award.

V. TeamHealth's causes of action also are preempted by ERISA both because they relate to benefit plans and because they seek to impose supplemental remedies for allegedly improper benefit processing and plan administration.

VI. The district court's refusal to ensure protection of United's confidential and proprietary documents is erroneous for the reasons set forth in United's briefing in consolidated Docket No. 85656.

ARGUMENT

I.

UNITED IS PLAINLY ENTITLED TO A NEW TRIAL

A court may grant a motion for a new trial on various grounds "materially affecting the substantial rights of the moving party." NRCP 59(a)(1). Those grounds include "irregularity in the proceedings of the court . . . or any abuse of discretion by which either party was prevented from having a fair trial," NRCP 59(a)(1)(A), "excessive damages appearing to have been given under the influence of passion or

prejudice," NRCP 59(a)(1)(F), or "error in law occurring at the trial and objected to by the party making the motion," NRCP 59(a)(1)(G).

An order denying a motion for a new trial is reviewed for an abuse of discretion. *See Langon v. Matamoros*, 121 Nev. 142, 143, 111 P.3d 1077, 1077 (2005). But questions of law within that analysis are reviewed de novo. *Lioce v. Cohen*, 124 Nev. 1, 20, 174 P.3d 970, 982 (2008). Although a trial error considered in isolation might be considered "harmless," the Court should consider the cumulative effect of those errors when determining whether a party was deprived of a fair trial. *See Pertgen v. State*, 110 Nev. 554, 566, 875 P.2d 361, 368 (1994), abrogated on other grounds by *Pellegrini v. State*, 117 Nev. 860, 34 P.3d 519 (2001); *cf. Nelson v. Heer*, 123 Nev. 217, 227, 163 P.3d 420, 427 (2007) (leaving open question whether doctrine of cumulative error applies in civil cases).

A. The Trial Was Fundamentally Unfair Because United Was Barred From Obtaining and Presenting Evidence Directly Relevant to the Reasonable Value of the Services at Issue

In each of its substantive causes of action, TeamHealth sought to prove that United-insured or -administered health plans breached an

obligation to reimburse TeamHealth for the "reasonable value" of the emergency medicine services allegedly provided to plan members. (*See* 21App.5,250 (UCPA); 22App.5,257 (implied-in-fact contract); 22App.5,258 (unjust enrichment).) As TeamHealth's counsel argued to the jury, "[w]e're here to determine reasonable value." (48App.11,790, 11,804, 11,900–01; *see also* 31App.7,651 ("[W]e are here[] [t]o get our bill charges. To get what is reasonable value.").)

The district court, however, prevented United from obtaining, and the jury from considering, evidence of the most reliable determinants of the disputed services' reasonable value. That evidence included payment rates that TeamHealth previously accepted from United for the same type of services in the same locations, payment rates that TeamHealth accepted from other insurers and employers (including United's own self-insured clients) during the period in dispute, and TeamHealth's costs and profits in providing the services. The district court refused to allow inquiry into such facts because it mistakenly assumed that the "proper rate of reimbursement" depends solely on the "the amount billed by [TeamHealth] and the amount paid by United." (73App.18,028 (quoting 11App.2,679.) That foundational

misunderstanding infected the entire proceeding and led to a fundamentally distorted trial on the central question of the reasonable value of the emergency medicine services at issue in this case.

1. "Reasonable Value" Is Determined By a Variety of Objective Factors

The "reasonable value" of a product or service refers to its objective market value. *See Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 381-82, 283 P.3d 250, 256-57 (2012).[7] The market value of a service is the "price which a purchaser, willing but not obliged to buy, would pay an owner willing but not obliged to sell." *Unruh v. Streight*, 96 Nev. 684, 686, 615 P.2d 247, 249 (1980). A jury may consider a wide variety of factors to determine what a willing buyer

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[7] When "nonreturnable benefits have been furnished at the defendants' request, but where the parties made no enforceable agreement as to price," the plaintiff may "usually" recover "the lesser of (i) market value and (ii) a price the defendant has expressed a willingness to pay." *Certified Fire*, 128 Nev. at 382 n.3, 283 P.3d at 257 n.3. As this Court has emphasized, however, that value "is not the only measure of damages available in restitution." *Id.* For other potential measures of damage, the Court in *Certified Fire* cited § 49 of the Restatement (Third) of Restitution and Unjust Enrichment, which states that a "nonreturnable benefit also may be measured by . . . the cost to the claimant of conferring the benefit." *Id.* § 49(3)(b).

would offer and what a willing seller would accept, including, for example, established customs or "customary methods of compensat[ion]" in the relevant industry, *see Flamingo Realty, Inc. v. Midwest Development, Inc.*, 110 Nev. 984, 988-89, 879 P.2d 69, 71-72 (1994), and previous agreements or proposals between the parties themselves, *see Las Vegas Sands Corp. v. Suen*, Docket No. 64594, 132 Nev. 998 (unpublished), 2016 WL 40764211 at *4 (Nev. July 22, 2016).

Ultimately, *any* fact a reasonable buyer or seller would consider in negotiating a price for the service is relevant to determining its "reasonable value." In this Court's words: "In determining fair market value, the trier of fact may consider 'any elements that fairly enter into the question of value which a reasonable businessman would consider when purchasing.'" *McCarran Intern. Airport v. Sisolak*, 122 Nev. 645, 672, 137 P.3d 1110, 1128 (2006 (quoting *State ex rel. Dep't Hwys. v. Linnecke,* 86 Nev. 257, 261-62, 468 P.2d 8, 10-11 (1970)).

Courts across the nation have applied that principle in cases similar to this case and have uniformly held that the reasonable value of emergency medicine services must be determined through multiple objective factors, including especially other payments accepted by the

provider for the same services, not just the provider's own unilaterally billed charges. *See Children's Hospital Cent. Calif. v. Blue Cross of Calif.*, 172 Cal. Rptr. 3d 861, 873-74 (Ct. App. 2014) ("reasonable/market value of the services provided includes the full range of fees . . . charge[d] and accept[ed]"); *In re North Cypress Med. Ctr. Operating Co., Ltd.*, 559 S.W.3d 128, 132-33 (Tex. 2018); *Parkview Hospital, Inc. v. Frost*, 52 N.E.3d 804, 805–06, 810 (Ind. App. 2016); *Bowden v. Medical Center*, 773 S.E.2d 692, 696-97 (Ga. 2015); *Colomar v. Mercy Hosp., Inc.*, 461 F. Supp. 2d 1265, 1271-72 (S.D. Fla. 2006); *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc.*, 832 A.2d 501, 508 (Pa. Super. 2003). These decisions reflect a common sense understanding that the "best proxy for informed bargaining is what similarly situated consumers and providers actually bargain for—namely, the rates negotiated between providers and private insurers." Barak D. Richman et al., Overbilling and Informed Financial Consent—A Contractual Solution, 367 NEW ENG. J. MED. 396, 397 (2012)).

In *Children's Hospital*, for example, the hospital argued—as does TeamHealth here—that in the absence of an agreement between itself and a payor, its full billed charges alone established the reasonable

value of the services. A jury agreed, but the California Court of Appeals reversed the verdict, holding that the trial court had incorrectly refused to allow the jury to consider evidence relevant to determining the reasonable value of the services. 172 Cal. Rptr. 3d at 873-74. The court explained that the recoverable amount is the "'going rate' for the services" or the "'reasonable market value at the current market prices,'" which can only be determined with "'full knowledge of all pertinent facts.'" *Id.* at 872. To determine that value, the court concluded, the jury should have been permitted to consider "agreements to pay and accept a particular price," including written contracts providing for an agreed price, as well as evidence of the "professional's customary charges and earnings." *Id.* at 872. In particular, the California court emphasized that the "market value is not ascertainable from Hospital's full billed charges alone," because those charges merely "reflect what the provider unilaterally says its services are worth," which is "is not necessarily representative of either the cost of providing those services or their market value." *Id.* at 873. Rather, evidence relevant to market value would "include the full range of fees that Hospital both charges and accepts as payment for similar services,"

because the "scope of the rates accepted by or paid to Hospital by other payors indicates the value of the services in the marketplace." *Id.*; *see also Sanjiv Goel, M.D., Inc. v. Regal Medical Group, Inc.*, 217 Cal. Rptr. 3d 908, 915-16 (Ct. App. 2017).

The Supreme Court of Texas reached a similar conclusion in *North Cypress*, rejecting the hospital's argument that payments it accepted for services for patients covered by private health insurance, Medicare, or Medicaid were irrelevant to the reasonable value of the same services when rendered to uninsured patients. 559 S.W.3d at 133. Like the California court in *Children's Hospital*, the Texas Supreme Court emphasized that the hospital's own "charges themselves are not dispositive of what is reasonable," *id.*, in part because hospitals have an incentive to artificially raise their prices to obtain a higher reimbursement, and hospitals "generally expect to recover far less than they officially 'charge.'" *Id.* at 132.[8] For that reason, other evidence

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[8] Other authorities agree that billed charges are arbitrary, inflated figures seldom paid in their full amounts. *See Higgs v. Costa Crociere S.p.A.*, 969 F.3d 1295, 1315 (11th Cir. 2020) (providers "bill arbitrarily large amounts with the knowledge and expectation that no one will ever be required to pay so high a figure"); *Daughters of Charity*

must be considered, especially "the amounts a hospital accepts as payment from most of its patients," which can hardly be deemed "wholly irrelevant to the reasonableness of its charges to other patients for the same services." *Id.* at 133.

The analyses and holdings in *North Cypress*, *Children's Hospital*, and the many other judicial decisions cited above is also firmly buttressed by the judgment of the legislative branches of government, both state and federal. The U.S. Congress and the Nevada Legislature each recently enacted statutes specifically addressed to resolving reimbursement disputes concerning out-of-network emergency medicine services of the type at issue here. *See* No Surprises Act, U.S.C. § 300gg-111; Surprise Billing Act., 2 NRS 439B.700 *et seq.* Both statutes deem

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Health Servs. of Waco v. Linnstaedter, 226 S.W.3d 409, 410 (Tex. 2007) ("[A] hospital's 'regular rates,' 'full charges,' or 'list prices' . . . are generally at least double and may be up to eight times what the hospital would accept as payment in full for the same services from . . . private insurers. The labels for these charges, 'regular,' 'full,' or 'list,' are misleading, because in fact they are actually paid by less than five percent of patients nationally."); Uwe E. Reinhardt, *The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy,* 25 Health Aff. 57, 62 (2006) (hospital bills "add up to large totals that do not bear any systematic relationship to the amounts third-party payers actually pay them for the listed services").

network contracted rates a critical factor in determining the rate to be paid for such non-network services. *See* 42 U.S.C. §§ 300gg-111 (a)(3)(E), (c)(5)(C)(i)(I); NRS 439B.748, 439B.751, 439B.754. In fact, under the Nevada statute, the network rate can be *decisive*: if a network contract existed between a provider and payor within 12- or 24-months prior to the dispute, the reimbursement is, respectively, 108% or 115% of the prior network contract's rate. NRS 439B.748(1)(a)-(b). Under the federal statute, the network rate is *highly relevant*: the decisionmaker "shall consider" the "median of the contacted rates recognized by the plan," and by contrast *cannot* consider "the amount that would have been billed." 42 U.S.C. §§ 300gg-111 (a)(3)(E), (c)(5)(C)(i)(I).

Both statutes thus reflect the considered judgment of elected government policymakers that the objective value of emergency medicine services cannot be assessed without considering network contracts.[9] As shown, that judgment is shared by the collective wisdom

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[9] The federal No Surprises Act did not take effect until after the time period in this case, and the Nevada Surprise Billing Act was only in effect for the last month of that period. The point, however, is not

of every other court to have considered the question. United is aware of no decision anywhere endorsing the principle espoused by the district court below that a factfinder determining the reasonable value of medical services cannot consider the provider's other payment agreements for the same type of services. At worst, an argument that payments the providers accepted from other payors somehow do not reflect reasonable value is an argument going to the *weight* of the evidence, not an argument that it is altogether *irrelevant*. *Cf. Sanjiv Goel*, 217 Cal. Rptr. 3d at 915 (holding challenge to probative value "was a reasonable argument to present to the fact finder at trial," but was "not a persuasive reason to adopt an absolute rule precluding the consideration of Medicare rates").

2. The District Court Erroneously Precluded United From Obtaining and Presenting Multiple Categories of Evidence Directly Relevant to Determining Reasonable Value

In a series of pre-trial discovery orders and rulings on motions *in*

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that the statutes directly govern this case—it is that they reflect legislative judgments about how the objective value of emergency medicine services is best determined.

limine, the district court prohibited United from obtaining in discovery, and presenting during trial, multiple categories of evidence directly relevant to determining the objective, reasonable value of the emergency medicine services that TeamHealth provided to United's plan members. As shown above, those categories included:

- payment rates TeamHealth agreed to accept from other payors for the same type of services in the same geographic locations;
- previous agreements and prior contract negotiations between the parties about payment for the same type of services and amounts TeamHealth previously indicated a willingness to accept for those services;
- evidence explaining the role of the Medicare fee schedule in determining reasonable reimbursements; and
- TeamHealth's method for determining its charges, the costs of providing the services, and how TeamHealth distributed its profits on the services.

See supra Facts at C.3–4. Notably, even TeamHealth itself had previously admitted the relevance of many such facts outside the litigation context. Before filing this lawsuit, TeamHealth's CEO sent an internal email reporting on negotiations with United over a new network contract and stated to his colleagues that the usual, customary, and reasonable amount of payment is "ultimately defined by [TeamHealth's] in-network rates with the same payor, rates from other

payors, and rates from the defendant to other providers." (106App.26,369.)

The district court, however, refused to permit United to develop and present such critical evidence, preventing the jury from making any coherent determination of reasonable value. The jurors instead were forced to assess reasonable value based mainly on the *least* probative indicator: TeamHealth's own billed charges themselves, as TeamHealth urged. *See, e.g.*, 31App.7,630 (plaintiffs arguing in opening statements that their "billed charges are reasonable, usual, and customary within the industry"). As numerous other courts have held, such evidence is not a reliable indicator of value because providers "bill arbitrarily large amounts with the knowledge and expectation that no one will ever be required to pay so high a figure." *Higgs*, 969 F.3d at 1315; *see supra* at I.A.1 & n. 8. The evidence proved as much here: TeamHealth's own expert agreed that TeamHealth received its full billed charges in less than *four percent of all claims*, (42App.10,484–87), and its counsel told jurors the figure was actually around *one* percent, (31App.7,659.). Billed charges, in short, are at best a starting point for contract negotiations, not legally mandatory payment rates in

themselves. And if providers can simply force payors to pay their full billed charges when they have no contract, they will have strong incentives to inflate both their charges and their demands in contract negotiations, driving up costs for health benefit plans and their beneficiaries. (*See* 43App.10,739–40; 44App.10,817–24; 92App.22,693–94, 22718–21.) The incentive is especially acute for emergency-room staffing companies like TeamHealth, which gain leverage in contract bargaining from the fact that even if they do not agree on a contract, their volume of patients will not be materially diminished, since plan members rarely can control where they receive emergency services and thus are not subject to the plan's financial incentive to employ network services. (*See* 43App.10,739–40; 44App.10,817–24; 92App.22,693–94, 22,718–21.)

Because the jury was denied the following categories of evidence properly relevant to determining the reasonable value of the services at issue, the jury's verdict is inherently unreliable, requiring a new trial on any count this Court deems legally viable. *See infra* at II.

a. THE DISTRICT COURT ERRONEOUSLY EXCLUDED EVIDENCE OF TEAMHEALTH'S AGREEMENTS WITH OTHER PAYORS

Consistent with the overwhelming caselaw and legislative judgments just discussed, United sought to establish the reasonable value of the services at issue by introducing evidence of the amounts TeamHealth bills and accepts for the same type of services from other payors. This is not a case involving a unique, one-time sale of a good or service. The doctors who contract with TeamHealth routinely provide the same services at issue here and TeamHealth accepts a range of payments for them. The district court, however, excluded all such evidence from the jury. (19App.4,730–39.) In the court's view, TeamHealth's disputed claims were "basically a collection case"—United simply owed whatever TeamHealth claimed—so "the contracts [TeamHealth] had with [its] other partners just isn't relevant." (24App.5,903.)

Jurors thus saw *none* of the evidence other courts and the state and federal legislative branches have deemed crucial to determining reasonable value. For example, jurors did not see the evidence that TeamHealth's nationwide average reimbursement rate for BCBS—one

of United's largest competitors—was [redacted] per emergency room visit. (*See supra* Facts at B; 106App.26,165.) As another example, jurors were not made aware that after TeamHealth plaintiff Fremont terminated its network agreement with United, Fremont entered into a direct agreement with one of United's clients, MGM Resorts International, to accept an "[redacted]" per visit, which United then allowed for the same services. (*See supra* Facts at B; 106App.26,189, 26,201.) Significantly, United allowed TeamHealth reimbursements for other United clients substantially *exceeding* [redacted] per visit. *See* 142App.35,247 (listing multiple disputed benefit claims with allowed amounts exceeding [redacted] per visit for employers including Walmart, Coca Cola, and Caesars Enterprise Services, LLC). In other words, TeamHealth was demanding that jurors punish United severely for the sin of allowing *higher* reimbursements for services provided to Caesars employees than TeamHealth itself had agreed to accept for the same services under its MGM contract. But the court's *in limine* rulings prevented United from asserting that compelling defense to both liability and punitive damages.

Further, United's expert economist, Bruce Deal, was prevented

from testifying that network reimbursement rates like those between TeamHealth and BCBS and between Fremont and MGM are the most economically appropriate basis for determining whether TeamHealth's full billed charges represent fair market value. (92App.22,695–98, 22,702, 22,707; 110App.27281–82.) As Deal would have explained, the negotiated network rates show what a willing buyer and a willing seller would freely accept in an arm's length transaction, before a patient becomes a captive consumer due to emergent circumstances. (43App.10,735 (Deal: "the correct benchmark for a reasonable value analysis is to look at . . . situations where you've got a willing buyer and willing seller, both of whom have alternatives").) But while the district court allowed Deal to tell the jury that he believed United's reimbursements already provided TeamHealth with the reasonable value of their services, the court's rulings prevented jurors from hearing Deal's explanation and reasoning for that core opinion.

b. THE DISTRICT COURT ERRONEOUSLY EXCLUDED EVIDENCE OF TEAMHEALTH'S PRIOR NETWORK CONTRACTS AND NEGOTIATIONS WITH UNITED

The parties' own mutual prior contracts and negotiations were also highly probative of both the reasonable value of TeamHealth's

services and whether there was an implied contract between the parties. But the district court effectively ruled that payment rates that TeamHealth itself had previously accepted (or indicated a willingness to accept) for the same type of services were irrelevant to the reasonable value of the services. And the district court likewise held that evidence concerning the failed contract negotiations between the parties was not probative of whether the parties nevertheless reached an implied agreement on the exact issues they failed to agree on expressly. Neither ruling makes any sense, and both left the jury without critical information needed to determine reasonable value and whether the parties somehow reached an implied agreement that they consciously chose not to enter following direct negotiations.

Before this dispute, TeamHealth plaintiff Fremont was a long-standing network provider with UHC, UHIC, SHL, and HPN. (92App.22,728–32.) Before TeamHealth terminated Fremont's agreements and for more than a year after the agreements ended, TeamHealth and United tried to negotiate a new agreement. In those negotiations, TeamHealth consistently offered to contract at various reimbursement rates well below [redacted] of Medicare, vastly lower than

Fremont's full billed charges, which equated to 778% of Medicare. (*See supra* Facts at B; 92App.22,740.) It was blatant error to exclude that evidence.

The district court's exclusion of prior negotiation evidence also meant that jurors were allowed to determine whether the parties formed an implied-in-fact contract, while being denied access to the one fact most probative of that question: the same parties had tried *and affirmatively declined* to reach an express contract on the very same subject. *Cf. Ramos v. White*, 506 P.3d 319, 2022 WL 831323, at *1 (Nev. March 17, 2022) (holding that "because the parties were merely in preliminary negotiations and had not agreed to any material terms, no valid contract was formed"). This course-of-dealing evidence would have belied TeamHealth's contention that the parties had reached an agreement on payment rates through their conduct.

c. THE DISTRICT COURT ERRONEOUSLY EXCLUDED EVIDENCE EXPLAINING MEDICARE REIMBURSEMENTS

Another category of evidence excluded by the district court involved both parties' use of Medicare reimbursement rates as a baseline for determining what payment rate to accept (TeamHealth) or

allow (United). United sought to introduce such evidence to show how Medicare reimbursements for TeamHealth's services factored into their reasonable value, but the court initially excluded all "evidence, argument or testimony that Medicare or non-commercial reimbursement rates are the reasonable rate, that providers accept it most of the time," and even evidence or argument about "reasonableness based on a percentage of Medicare or non-commercial reimbursement rates." (37App.9,166.) Even TeamHealth recognized, however, that discussion about percentages of Medicare could not be wholly excluded from the trial, given that both parties and indeed the entire industry often discuss reimbursement rates in terms of Medicare percentages. TeamHealth accordingly acquiesced in descriptive references to Medicare percentages. (31App.7,613–14; 33App.8,018, 8,020.)

But TeamHealth did *not* acquiesce in United's efforts to explain to the jury both *why* and *how* United and other industry actors used Medicare rates. Neither did the district court. The court instead allowed just enough discussion of Medicare for TeamHealth to cast aspersions on United's use of Medicare baselines as groundless or

nefarious, *e.g.*, 48App.11,772 (TeamHealth counsel arguing Medicare "is subject to all kinds of political influences" and is "a barebones medical reimbursement"), while simultaneously prohibiting United from responding and explaining why Medicare was a useful reference and indeed regarded as the industry-standard baseline for commercial reimbursement, *including even by TeamHealth itself*. *See supra* Facts at B. The jury was thus left with the misimpression that United's use of Medicare rates as a measuring stick was at best arbitrary, and at worst willfully used to harm TeamHealth.

For example, United's expert Bruce Deal was prepared to explain how Medicare establishes its reimbursement rates and how those rates inform the reasonable value of TeamHealth's services. Using the Medicare fee schedule, the aggregate rate of reimbursement for the disputed benefit claims in this case would have been around $150 per claim, or $1.74 million in total. (92App.22,685–87.)[10] Deal would have

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[10] By agreement, the parties' expert reports were revised in the middle of trial to account for TeamHealth's changes to its disputed benefit claims list. (*See* 22App.5,461; 41App.10,073–89.) Defendants' revised expert report dated 11/14/2021 provides the $150 and $1.74 million figures. (144App.35,719–812.) In the July 30, 2021 report, the

explained how the Medicare program determines fair reimbursement for those services and how those numbers are calculated under the program. He also would have explained why it is an important reference point for determining the reasonable value of the disputed services for commercial health insurers and health plans. He would have explained the prevalence of the use of Medicare reimbursement rates in developing fee schedules, guiding contract negotiations, and determining reasonable reimbursement rates. The district court's order precluded the jury from considering this important testimony in assessing the reasonable value of the services at issue.

It is true that United was permitted to elicit *some* testimony that referenced Medicare. For example, there was testimony that United considered a "reasonable premium above" Medicare as the standard for determining the reasonable value of out-of-network services. (36App.8,969.) And there was testimony that the amounts allowed by United were the equivalent of 164% of Medicare, while TeamHealth's full billed charges equated to 763% of Medicare. (48App.11,831;

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figures are $152 and $2.90 million.

43App.10,708.) But the district court's pretrial rulings prevented United from explaining what any of those percentages meant, how the Medicare reimbursement rates were reached, or why United's reimbursements at a significant premium to the Medicare rate was powerful evidence of the reasonable value of the services at issue.

The confusion spawned by excluding United's explanations of Medicare rates is exemplified by the examination of Leslie Hare, the vice president of claims operations for defendant SHL. (40App.9,952.) Before Hare's testimony, United warned the district court that it was going to be impossible for Hare to defend or even explain SHL's reimbursements under the court's exclusions, but the district court dismissed those concerns. (40App.9,948–50.) The problem that followed arose from the fact that SHL offered health plans with fixed rates for non-network services based on the Affordable Care Act's "Greatest of Three" methodology, which essentially provides reimbursement at the highest of the Medicare rate, prior network rates, and an "eligible medical expenses" rate. (40App.9,948.) The only time SHL *ever* paid full billed charges was when a specific federal government plan *ordered* such payment. (40App.9,966–67.)

TeamHealth's counsel elicited Hare's testimony that SHL's system was configured to pay the "greater of three" rate, (40App.9,967), but then (with the court's support) barred Hare from explaining what the "three" payment baselines were, leaving the false impression that SHL had no defensible reimbursement methodology at all. (40App.9,967–73.) For example, in response to TeamHealth's accusatory question about whether SHL bases payment on a "usual, customary, and reasonable" rate, Hare answered, "I don't think I can fully answer the question with just yes or no. I can describe what is written into our plan documents. Am I allowed to do that?" 40App.9,972:10-12. TeamHealth's counsel responded with a blunt, "No." 40App.9,972:13. Counsel pressed further, asking "[y]ou do not have usual and customary written into any plan document for the covered services that are at issue in this case, correct? Yes or no?" (40App.9,972.) When Hare responded that they "don't use the term 'usual and customary'" but instead "use the term 'eligible medical expenses, a part of our greater of three,'" counsel again reminded Hare of the pretrial orders that constrained her from identifying the "three" payment baselines identified in the plan documents. (40App.9,972.)

The farce came to a head when United's counsel tried to clarify matters with a simple question about the most fundamental issue in the case: "And for out-of-network ER services, could you generally describe the methodology that you and your team use to reimburse such a claim?" (41App.10,021.) At TeamHealth's urging, the court warned against violating the *in limine* rulings, *id.*, and Hare thus could not adequately explain to jurors how United made the very reimbursement determinations the jurors were being asked to judge. A similar charade played out with another United witness. (31App.7,734 (district court prevented John Haben of UHS from explaining that United relied on Medicare to determine reasonableness of non-network reimbursements).)

The exclusion of key facts about Medicare rates—both *why* United and the rest of the industry, including TeamHealth itself, relied on Medicare rates, and *how* they used such rates—was indefensible.

d. THE DISTRICT COURT ERRONEOUSLY EXCLUDED EVIDENCE OF THE COSTS TO PROVIDE THE DISPUTED SERVICES AND ASSOCIATED PROFITS

TeamHealth's theory at trial was that its full billed charges constituted the reasonable value of the disputed services. In the

TeamHealth CEO's words: "We perform the service. We took care of the patients, and our bill charges are fair." (40App.9,884.) Among its other rebuttals and defenses, United sought to challenge the reasonableness of TeamHealth's billed charges on their own terms, by showing jurors that TeamHealth used a flawed process to determine the charges and steered much of its profits into corporate coffers, away from the doctors and nurses who actually performed the disputed services. (40App.9,917–18.) The court's exclusion of such evidence inherently skewed the outcome and warrants a new trial.

Courts broadly agree that "evidence of actual costs is relevant to a determination of reasonable value." *Fairbanks North Star Borough v. Tundra Tours, Inc.*, 719 P.2d 1020, 1030 (Alaska 1986); *see*, *e.g.*, *City of Portland v. Hoffman Construction Co.*, 596 P.2d 1305, 1314 (Or. 1979) ("Evidence of the plaintiff's actual costs and the ordinary industry allowance for overhead and profit is relevant to the jury's determination of the reasonable value of the services and materials which were furnished."); *Dravo Corporation v. L.W. Moses Co.,* 492 P.2d 1058, 1069 (Wash. Ct. App. 1971) ("actual expenditures are relevant on the issue of the reasonable value of [the cross-plaintiff's] performance"). As

this Court observed in *Certified Fire*, 128 Nev. at 382 n.3, 283 P.3d at 257 n.3, § 49 of the Restatement (Third) of Restitution and Unjust Enrichment recognizes several ways to determine the value of the benefit underlying an unjust enrichment claim, including by assessing "the cost to the claimant of conferring the benefit." Restatement (Third) of Restitution and Unjust Enrichment § 49(3)(b)).

The Tennessee Supreme Court applied that principle to this context in *Doe v. HCA Health Services of Tennessee, Inc.*, 46 S.W.3d 191, 199 (Tenn. 2001), which examined the "standards for determining the 'reasonable value' of the medical goods and services provided by [a] hospital to [a] patient." *Id.* at 199. The court agreed with numerous "appellate decisions from other states"—*i.e.*, Indiana, Missouri, Illinois, and New York—holding that "'reasonable value' in such cases is to be determined by considering the hospital's internal factors as well as the similar charges of other hospitals in the community." *Id.* at 198-99. As another court observed in the same context, costs are relevant because, for example, they may undermine a healthcare provider's claim that its full rates reflect reasonable value when the rates have increased: "[R]ate increases untethered to any appreciable increase in costs would

raise questions about the reasonableness of the rate increased and the overall reasonableness of the charges." *Colomar v. Mercy Hosp., Inc.*, 461 F.Supp.2d 1265, 1272-73 (S.D.Fla. 2006); *see North Cypress*, 559 S.W.3d at 136 ("[F]or discovery purposes a hospital's costs surely have some bearing on the reasonableness of its patient charges.").

The probative value of internal cost information was starkly confirmed in another TeamHealth action against United where the court found such information to be relevant and then *sanctioned* TeamHealth for refusing to produce the information in discovery. *Emergency Physician Servs. of N.Y. v. UnitedHealth Group, Inc.*, No. 20-CV-09183-JGK-SN, 2023 WL 2447263, at *1 (S.D.N.Y. Mar. 10, 2023)

And in a similar lawsuit brought by TeamHealth against Aetna, TeamHealth was ordered to produce cost discovery because it "specifically provid[es] information for [Aetna] to craft arguments relating to the reasonable value of services." *Emergency Prof'l Services, Inc. v. Aetna Health, Inc.*, No. 1:19-CV-1224, 2023 WL 1987307, at *1 (N.D. Ohio Feb. 14, 2023).

The district court denied United an opportunity to advance the same arguments here. The court refused to allow United's discovery

requests for internal cost and corporate structure information, finding that "corporate structures, finances, and how the Health Care Providers' charges are determined are not relevant in this case." (15App.3,706–09.) In excluding such evidence, the court relied on *Children's Hospital* and other California decisions for the proposition that a provider's internal costs "need not be considered to determine the reasonableness of billed charges." (73App.18,031.) The court's reliance on those California precedents was misplaced.

To start, those precedents are inconsistent with this Court's decision in *Certified Fire* recognizing that when a plaintiff has allegedly provided a benefit to the defendant, the plaintiff's internal costs *are* a relevant measure of the value of the benefit. *See supra* at I.A.1. Further, in California, a provider's billed charges alone *cannot* be determinative of reasonable value; courts instead *must* consider external, market-based evidence of the amounts other private and government payers are willing to pay. *Children's Hospital*, 172 Cal. Rptr. 3d at 873. To the extent it is logical to bar evidence of a healthcare provider's internal costs where the provider itself cannot rely on its own charges, that logic obviously does not justify allowing a

provider to rely on its own charges while simultaneously *prohibiting any inquiry into the internal basis for those charges*. To the contrary, when a provider insists that its own charges by themselves constitute reasonable value, it is all the *more* essential to examine the basis for those charges on their own terms.

Despite being denied meaningful discovery, United was allowed to make an offer of proof where it relied on documentation provided by TeamHealth during the parties' prior contract negotiations and elicited testimony that the average cost to TeamHealth of an emergency room visit was $150 per encounter around April 2019. (40App.9,936.) That evidence would have been highly relevant in multiple ways, including to support United's contention that the disputed reimbursements—which all parties agreed were an average of $246 per encounter—both covered TeamHealth's actual costs and also provided a reasonable premium. *See Eufaula Hosp. Corp. v. Lawrence*, 32 So.3d 30, 38 (Ala. 2009) (expert testimony that reasonable value of emergency medicine services could be 115% of costs); (92App.2,673.)[11] Yet the jury was not allowed

[11] Defendants' revised expert report provides the $246 figure. In

to assess reasonable value on that basis. In fact, the jury was not allowed to hear the undisputed fact that TeamHealth *itself* considers its costs when determining its billed amounts. (40App.9,902.)[12]

The district court's exclusion order applied not only to costs themselves, but also evidence of TeamHealth's profits on emergency medicine services, and how those profits were distributed not to healthcare providers but instead to TeamHealth and/or its investor(s). Such evidence was directly relevant to rebutting TeamHealth's key trial theme that United's reimbursements were reducing provider pay and thereby harming the quality of medical care throughout Nevada. *See supra* Facts at D.1. To establish that theme, TeamHealth repeatedly stated and implied that awarding greater reimbursement would directly increase physicians' pay. (40App.9,875; 32App.7,755–56, 7,994–95.)

Evidence concerning the amount and distribution of TeamHealth's

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the original July 30, 2021 report, it is $240. *Supra* at n. 10 (explaining expert reports were updated mid-trial by agreement).

[12] TeamHealth's industry expert, Scott Phillips, would have testified that he considered the cost of services one of three key factors relevant to determining the appropriate charge for emergency physician services. (*See* 105App.25,933; 110App.27,268–74.)

profits would have enabled United to show that the principal beneficiary of increased reimbursement is not the doctor who performed the treatment, but TeamHealth's corporate bottom line and its private equity owner, Blackstone. When United attempted to mount that defense by questioning TeamHealth's CEO about TeamHealth's profits, the district court sustained objections based on the *in limine* rulings. (42App.10,395.)[13]

The exclusion of costs and profits evidence warrants a new trial.

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[13] The court's discovery and *in limine* rulings also barred United from developing a defense based on potential "upcoding," *i.e.*, the practice of submitting a CPT code that corresponds to a service with a higher reimbursement rate than the service actually rendered. United sought TeamHealth's underlying clinical records for the benefit claims at issue both to ensure the services were actually performed as billed, and to establish whether TeamHealth properly coded the services, which could affect whether the billed charges were excessive, whether the services were medically necessary, and whether United was entitled to a setoff or recoupment for improperly coded claims. The district court, however, ruled that United was prohibited from presenting any argument or evidence at trial about TeamHealth's improper coding and claims submission practices. (23App.5,539.) That ruling further undermined United's ability to show that TeamHealth's full billed charges were not an adequately accurate or reliable indicator of the reasonable value of the services actually provided.

B. The District Court's Unjustified Spoliation Instruction Requires a New Trial, Especially on Punitive Damages

A new trial is also warranted because the court erroneously instructed the jury that United had "willfully" "destroyed" documents essential to the case, and that the willful destruction required jurors to presume that the documents were adverse to United's position. The instruction referred to two categories of documents: (1) documents showing that United's self-funded clients wanted their non-network reimbursements to constrain rising health care costs, and (2) health plan administrative records related to some of the disputed benefit claims. The instruction falsely stated that the court had found that United had "destroyed" plan documents—the court never made any such finding, and it never happened—and the non-existent destruction was "willfully done." *See supra* Facts at D.2 (quoting full instruction). The error in giving this inflammatory instruction requires a new trial.

"Spoliation occurs when a party fails to preserve evidence it knows or reasonably should know is relevant to actual or anticipated litigation." *MDB Trucking, LLC v. Versa Products Co., Inc.*, 136 Nev. 626, 630, 475 P.3d 397, 402 (2020). "When evidence is willfully

suppressed, NRS 47.250(3), creates a rebuttable presumption that the evidence would be adverse if produced." *Bass-Davis*, 122 Nev. at 448, 134 P.3d at 106. "[W]illful or intentional spoliation of evidence requires the intent to harm another party through the destruction and not simply the intent to destroy evidence." *Id.* The party seeking the instruction has the burden to demonstrate "that the evidence was destroyed with intent to harm." *Id.* at 107, 134 P.3d at 448. A rebuttable presumption instruction "should not be applied when evidence is negligently lost or destroyed, without the intent to harm another party." *Id.* at 449, 134 P.3d at 107.

When evidence is negligently lost, as opposed to willfully destroyed with an intent to harm, an adverse inference is more appropriate. *Id.* "An inference is permissible, not required, and it does not shift the burden of proof." *Id.* "Unlike a rebuttable presumption, an inference has been defined as '[a] logical and reasonable conclusion of a fact not presented by direct evidence but which, by process of logic and reason, a trier of fact may conclude exists from the established facts.'" *Id.* at 448, 134 P.3d at 107 (alteration in original). "The inference is *adverse* to the destroyer not because of any finding of moral culpability,

but because the risk that the evidence would have been detrimental rather than favorable should fall on the party responsible for its loss.'" *Id.* at 449, 134 P.3d at 107 (quoting *Turner v. Hudson Transit Lines, Inc.*, 142 F.R.D. 68, 75 (S.D.N.Y. 1991)); *see also Countrywide Home Loans, Inc. v. Thitchener*, 124 Nev. 725, 744 n.54, 192 P.3d 243, 256 n.54 (2008) (adverse inference permitted where party withheld exonerating evidence).

And this Court recently confirmed that even the less-harsh adverse-inference instruction is appropriate only "when evidence is lost or destroyed"; otherwise, no instruction is appropriate, at all. *Rives v. Farris*, 138 Nev., Adv. Op. 17, 506 P.3d 1064, 1072 n.7 (2022).

Here, there was no evidence that United destroyed any evidence, much less that it did so willfully to harm TeamHealth's case. To the contrary, United produced hundreds of thousands of pages of administrative records underlying TeamHealth's disputed benefit claims, as well as numerous documents showing that its clients wanted United to do a better job of restraining non-network charges from healthcare providers. TeamHealth's only complaint was that United did not produce even *more* evidence in each category.

As to plan administrative records, the work to produce the records was overwhelming, and United's efforts were further hindered by TeamHealth's constantly shifting list of disputed benefit claims. *See supra* Facts at C.3, D.2. United ultimately produced more than 200,000 pages of administrative records, including more than 7,000 plan documents and explanation of benefit forms associated with almost 16,446 unique benefit claims. 146App.36,175:4–7. United thus produced administrative records for many *more* benefit claims than the 11,563 that TeamHealth ultimately presented to the jury at trial. United concedes that it ultimately was unable to collect and produce documents underlying every single benefit claim on the short timeframe the district court prescribed. That shortcoming, however, provided no lawful basis whatsoever for the court's giant inferential leap—and instruction to jurors—that United *willfully destroyed* all the unproduced administrative records. There was exactly zero evidence that United did any such thing. And to be abundantly clear, it did nothing of the sort.

The same is true for its instruction that United *willfully destroyed* internal documents showing that United executives were aware of

clients' concerns about rising healthcare costs. United in fact produced numerous such documents. *See*, *e.g.,* 67App.16,598–99, (quoting DEF280128 ("Our client's costs have continued to rise at alarming rates and are one of the main concerns our clients raise to their account team."), DEF528207 ("Large employers are showing interest in innovative benefits designs around HDHPs to drive down overall healthcare costs."), DEF413948 ("Demand for Cost of Care tools is high driven by consultant marketing, client frustration with limitations of discount tools and competitor promotion of these new tools."), DEF524202, DEF305683, DEF482543, DEF394236); 146App.36,181:8–36,185:1 (same, but during jury instruction hearing); 143App.35,446 ("[C]lients have seen their out-of-network costs increase putting financial strain on both [plan] sponsors and the insurers. . . . . Our client's costs have continued to rise at alarming rates, and [is] one of the main concerns our clients raised to their account teams"); 39App.9,597–98 (United was hearing from client that they "were concerned about the rising medical costs . . . and their ability to provide affordable benefits for their employees"). There is no evidence that United willfully destroyed other documents related to this subject. The very suggestion

is completely illogical: if United could have located other documents showing that clients wanted to keep costs down, its incentive was to produce them, not destroy them.

The spoliation instruction thus was not merely unjustified, it was nonsensical. And it was of course highly prejudicial, especially during the punitive damages phase of the trial. TeamHealth's counsel relied heavily on the instruction to argue to jurors that the court itself had already declared United to be a bad actor, deserving of punishment, when the court found United guilty of willful efforts to harm TeamHealth and its case. *See supra* Facts at D.2. The insupportable spoliation instruction requires a new trial on both liability and punitive damages.

II.

UNITED IS ENTITLED TO JUDGMENT AS A MATTER OF LAW ON ALL COUNTS

Although the district court's discovery orders and evidentiary errors plainly warrant a new trial, the Court should go further and reverse the judgment as a matter of law. This Court "reviews de novo a district court's denial of a motion for judgment as a matter of law."

Wyeth v. Rowatt, 126 Nev. 446, 460, 244 P.3d 765, 775 (2010); *see D&D Tire v. Ouellette*, 131 Nev 462, 466, 352 P.3d 32, 35 (2015). Rulings on pure questions of law are subject to de novo review. *Vredenburg v. Sedgwick CMS*, 124 Nev. 553, 557, 188 P.3d 1084, 1088 (2008). To the extent the motion challenges only the sufficiency of the evidence, the Court "determines whether, after viewing all inferences in favor of the prevailing party, substantial evidence supports the jury verdict." *J.J. Indus., LLC v. Bennett*, 119 Nev. 269, 273, 71 P.3d 1264, 1267 (2003).

TeamHealth asserted four causes of action at trial: (1) a claim for breach of an implied-in-fact contract to pay its full billed charges; (2) a claim that United would be unjustly enriched unless required to pay TeamHealth's full billed charges; (3) a claim that the UCPA required United to reimburse the disputed services at TeamHealth's full billed charges; and (4) a PPA claim for attorneys' fees, costs and interest. Each of those causes of action was either legally defective on its face, or was factually unsupported at trial, or both.[14]

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[14] The PPA claim is discussed below in the section separately addressing attorneys' fees and interest issues. *See infra* at IV.

A. TeamHealth Failed to Establish an Implied-In-Fact Contract with United to Pay Full Billed Charges

As a matter of law, TeamHealth did not establish that United's conduct manifested its implied affirmative agreement to allow payment of TeamHealth's full billed charges. According to TeamHealth, an implied-in-fact contract was formed because TeamHealth treated United-covered patients and did not "balance bill" them, and in exchange, United "agreed to reimburse Plaintiffs for the reasonable value of Plaintiffs' services." (48App.11,982 (Jury Instruction 25).) TeamHealth further contended that United agreed that "reasonable value" constituted the full amount of whatever TeamHealth decided to bill for its services. (40App.9,883–84; 48App.11,827.)

That theory failed as a matter of law for two reasons. First, an *implied* contract requires the same mutual assent and consideration as an *express* contract—the sole difference is in the manifestation of the parties' mutual agreement on terms—and TeamHealth identified no conduct by United in any way manifesting its agreement to allow payment of TeamHealth's full billed charges.

Second, the undisputed evidence showed that TeamHealth

provided no consideration for United's alleged promise to pay full billed charges. TeamHealth's sole affirmative act was to provide emergency medicine services to United-covered patients—treatment that TeamHealth was required to provide *by law*, not because of any agreement with United. That legally mandated treatment could not be consideration for any counter-act by United.

1. TeamHealth Did Not Prove That United Implicitly Agreed to Pay Full Billed Charges for Members' Treatment

"Basic contract principles require, for an enforceable contract, an offer and acceptance, meeting of the minds, and consideration." *Certified Fire*, 128 Nev. at 378, 283 P.3d at 255 (quoting *May v. Anderson*, 121 Nev. 668, 672, 119 P.3d 1254, 1257 (2005)). "A meeting of the minds exists when the parties have agreed upon the contract's essential terms." *Id.* Accordingly, when material terms are *not* agreed upon, "a contract cannot be formed." *Certified Fire*, 128 Nev. at 378, 283 P.3d at 255) (quoting *Nevada Power Co. v. Public Util. Comm'n*¸ 122 Nev. 821, 839-40, 138 P.3d 486, 489-99 (2006)); *see Ramos*, 2022 WL 831323, at *1 (where parties "had not agreed to any material terms, no valid contract was formed").

The same elements apply to express and implied contracts alike—the sole difference is that an express contract's terms "are stated in words," whereas an implied contract's terms "are manifested by conduct." *Smith v. Recrion Corp.*, 91 Nev. 666, 668, 541 P.2d 663, 664 (1975). "The distinction between express and implied in fact contracts relates only to the *manifestation* of assent; both types are based upon the expressed or apparent intention of the parties." *Cashill v. Second Jud. Dist. Ct. of State ex rel. Cty. of Washoe*, 128 Nev. 887, 381 P.3d 600 (2012) (emphasis added); *see* Restatement (Second) of Contracts § 4 cmt. a (1981) (difference between express and implied contracts "lies merely in the mode of manifesting assent"); 1 Williston on Contracts § 1:5 (4th ed.) ("An implied-in-fact contract requires proof of the same elements necessary to evidence an express contract: mutual assent or offer and acceptance, consideration, legal capacity, and a lawful subject matter."); 1 Corbin on Contracts § 1.19 (2021) ("The distinction between an express and an implied contract, therefore, is of little importance, if it can be said to exist at all. The matter that is of importance is the degree of effectiveness of the expression used."). "To find a contract implied-in-fact," then, "the fact-finder must conclude the parties

intended to contract and promises were exchanged, the general obligations for which must be sufficiently clear." *Certified Fire*, 128 Nev. at 379-80, 283 P.3d at 256.

The record evidence precluded any reasonable finding that United ever intended to enter any unwritten contract with TeamHealth, much less one promising to allow payment of TeamHealth's full billed charges. (*See* 37App.9,099–100.) To the contrary, the undisputed evidence established that TeamHealth almost *never* received payment from United in the amount of its full billed charges. Just prior to the period in dispute, for example, United allowed payment to two of the plaintiffs at full billed charges only about 7% of the time. (46App.11,344; *see supra* at I.A.2 (United rarely allowed payment at TeamHealth's full billed charges). Indeed, TeamHealth's *own counsel* declared in opening statement that "the vast majority of the time, [plaintiffs] are not paid the bill charge." (31App.7,659.) It is impossible to conclude from that record that, despite almost *never* paying TeamHealth its full billed charges, United impliedly agreed to *always* pay full billed charges.

For TeamHealth plaintiff Fremont, the parties' contract

negotiations showed an affirmative agreement *not* to enter a contract. (109App.27,102–03, 27,110–15; 110App.27,219 (TeamHealth "providing notice of an intent to terminate the Fremont agreement . . . if a new agreement is not" reached); 106App.26,364–67; 91App.22,640:21–22,641, 92App.22,809:2–22,815:6, 22,817:3–22,822:3, 22,825:14–24, 22,826:19–22,827:20, 22,828:4–14, 22,829:8–22,831:22, 22,832:5–22,833:9, 22,834:8–22,835:15, 22,836:6–15, 22,837:1–14; 96App.23,762; 96App.23,764; 93App.23,119; 93App.23,121; 93App.23,126:20–25; 96App.23,801. The prior Fremont contracts required United to reimburse TeamHealth at less than 200% of Medicare, and during renewal negotiations, TeamHealth expressed—and then rescinded—its agreement to reimbursement at 260% of Medicare. *See supra* Facts at B. Thus, TeamHealth's implied-in-fact contract theory is that United after the parties agreed to terminate negotiations, United *immediately* agreed to an unwritten, implied contract to reimburse the disputed services at full billed charges, *i.e.*, roughly 763% of Medicare—an amount vastly higher than the parties had ever previously agreed to or even discussed. Nevada law cannot possibly recognize an implied-in-fact contract under such circumstances.

TeamHealth argued below that United's promise to pay full billed charges could be implied from evidence showing that some United defendants "acknowledged" an obligation to pay a "reasonable" price for the services. (70App.17,359–60; 73App.18,094.) On its face, however, that statement does not reflect any agreement that the "reasonable" price automatically constitutes TeamHealth's full billed charges. Moreover, the cited statements were made to *plan members* to identify the reimbursement that United would pay on *their* behalf. The statements thus in no way suggested any promise *to TeamHealth* to pay any amount, much less its full billed charges. And because TeamHealth does not purport to be suing on behalf of plan members through assignment or otherwise, *see* 21App.5,247 (disclaiming need for assignment of benefits), TeamHealth cannot contend that statements made to plan members about *their benefits* were effectively promises made to TeamHealth about *its reimbursements*.[15]

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[15] *See also Electrostim Med. Servs., Inc. v. Health Care Service Corp.*, 614 Fed. Appx. 731, 739-40 (5th Cir. 2015) (rejecting hospital's argument that insurer was liable under contract theory simply because "all insurers agree that they will pay their insureds' healthcare providers for covered products and services"); *IV Solutions, Inc. v.*

Given the complete absence of any evidence that the parties agreed on the most essential term of the alleged contract—*i.e.*, the price of the services being rendered—there is no basis for finding an implied-in-fact contract under Nevada law. *See supra* Facts at B. Courts in other jurisdictions have repeatedly applied the same rule to reject implied-in-fact contract claims asserted by TeamHealth and other similar providers. *See Emergency Health Physicians of New York v. UnitedHealth Group, Inc.*, 2021 WL 4437166, at *12 (S.D.N.Y. 2021); *Emergency Dep't Phys. P.C. v. United Healthcare, Inc.*, 507 F. Supp. 3d 814 (E.D. Mich. 2020); *Gulf-to-Bay Anesthesiology Assocs., LLC v. United Healthcare of Fla.*, Case No. 20-CA-008606 (Aug. 11, 2022) (see 28(f) Addendum at 13); *ACS Primary Care Physicians S.W., P.A. v. UnitedHealthcare Insurance Co.*, 514 F. Supp. 3d 927, 933-34 (S.D. Tex. 2021); *Atlantic ER Physicians Team Pediatric Assocs., P.A. v.*

PacifiCare Life & Health Insurance Co., 804 Fed. Appx. 497, 500 (9th Cir. 2020) (medical provider was not third-party beneficiary of contract between insurer and insured); *Prince George's Hosp. Ctr. v. Advantage Healthplan, Inc.*, 985 F. Supp. 2d 38, 48 (D.D.C. 2013) (medical provider was not third-party beneficiary of contract between insurer and insured that incorporated Medicaid obligations to pay).

UnitedHealth Group, Inc., Case No. GLO-L-001196-20 (Aug. 24, 2022) (*see* 28(f) Addendum at 1). There is no basis for a different result here.

2. TeamHealth Did Not Prove That It Provided Adequate Consideration in Exchange for United's Supposed Promise to Pay Full Billed Charges

In addition, TeamHealth independently failed to establish adequate consideration for forming any supposed agreement.

"To constitute consideration, a performance or return promise must be bargained for," meaning that "it is sought by the promisor in exchange for his promise and is given by the promisee in exchange for that promise." *Pink v. Busch*, 100 Nev. 684, 688, 691 P.2d 456, 459 (1984) (quoting Restatement (Second) of Contracts § 71(1), (2) (1982)). "[A] mere pretense of bargain does not suffice, as where there is a false recital of consideration or where the purported consideration is merely nominal." Restatement (Second) of Contracts § 71, *cmt b*. Like mutual assent, consideration requires evidence of an "external manifestation rather than the undisclosed mental state." *Id*. Most importantly here, "[c]onsideration is not adequate when it is a mere promise to perform that which the promisor is already bound to do." *Clark County v. Bonanza No. 1*, 96 Nev. 643, 650-51, 615 P.2d 939, 944 (1980).

TeamHealth proffered two theories below for the consideration it provided in exchange for United's supposed promise to pay its full billed charges for the disputed services. Neither theory survived the trial evidence.

First, TeamHealth argued that it provided consideration because it "agreed to treat United's members." (48App.11,982 (Jury Instruction 25); 70App.17,359–61.) But the emergency medical care rendered to United's plan members was not consideration because TeamHealth-affiliated providers were *legally required* to provide the treatment. (39App.9,675 ("in fact, by law, . . . we have to provide rapid medical [services] prior to anybody asking for insurance information").) Under both federal and state law, a hospital is obligated to provide emergency medicine services to a patient regardless of their financial status. *See* EMTALA, 42 U.S.C. § 1395dd; NRS 439B.410. Because treating plan members thus "is a mere promise to perform that which [plaintiffs are] already bound to do"—a preexisting legal duty—the promise constitutes "inadequate" consideration under Nevada law. *Clark County*, 96 Nev. at 650-51, 615 P.2d at 944.

Other courts have reached the same result under the same legal

rule. Most recently, the court in *Emergency Health Physicians* rejected an implied-contract claim against United on materially identical facts because the plaintiffs "provide healthcare services to patients not in exchange for United's payments but instead out of 'a pre-existing legal obligation,' which 'does not amount to consideration.'" 2021 WL 4437166, at *12 (S.D.N.Y. 2021) (internal quotation marks omitted). A Pennsylvania court likewise found "no exchange of consideration" when the provider "was legally bound to provide emergency care services" pursuant to EMTALA. *Temple Univ. Hosp., Inc. v. Philla.*, No. 1794, 2006 WL 51206, at *3 (Pa. Ct. Com. Pl. Jan. 3, 2006). The same result should obtain here.

Second, TeamHealth argued below that it provided consideration because it promised not to "balance bill" United's members, and in exchange United promised to pay whatever TeamHealth charged for the emergency medicine services. (48App.11,982; 70App.17,359–61.) The alleged promise not to balance bill patients, however, was not made to induce any performance by United, as required for the promise to constitute consideration. *See Pink*, 100 Nev. at 688, 691 P.2d at 459. Rather, TeamHealth's CEO testified that it had "a long standing

policy . . . on not balance billing patients," , which was instituted for "a variety of reasons," *none* of which included inducing United to pay TeamHealth's full billed charges. (40App.9,887.)

Any such inducement would be worthless in any event, which is an independent reason the promise not to balance bill United's plan members cannot constitute adequate consideration. United owed its plan members exactly what the terms of their plans specified. A "balance billing" claim by a non-network provider is, *by definition*, a claim that it should be paid *more* than what the plan authorizes United to pay the provider on the member's behalf. But because United would never be liable to its members for any amount beyond the plan benefit, a TeamHealth promise not to demand that members pay more provides no benefit to United at all. Put differently, a promise not to remove the sleeves from a vest is no promise at all.

In short, TeamHealth gave United nothing, and United agreed to nothing. And nothing exchanged for nothing equals no contract.

B. TeamHealth's Unjust Enrichment Claim Fails as a Matter of Law

TeamHealth's unjust enrichment claim also failed as a matter of

law.

As a threshold matter, the unjust enrichment judgment cannot stand if the Court affirms the implied-in-fact contract judgment. Unjust enrichment—also referred to as quasi-contract, contract implied-at-law, or quantum meruit—applies "where there is no legal contract but where the person sought to be charged is in possession of money or property which in good conscience and justice he should not retain but should deliver to another." *Leasepartners Corp. v. Robert L. Brooks Trust Dated November 12, 1975*, 113 Nev. 747, 755-56, 942 P.2d 182, 187 (1997) (quoting 66 Am. Jur. 2d Restitution § 11 (1973) (alterations in original). But when a contract governs the parties' conduct, there is no need for the equitable unjust enrichment remedy because the terms of the contract govern the parties' mutual rights and obligations. That is, an "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 there is an express agreement." *Id.* The same principle applies when the parties have reached a contract implied in fact, given that such contracts have the same legal force as express contracts. *See supra* at II.A.1. The unjust enrichment judgment thus

necessarily fails if the implied-in-fact contract judgment survives.

The unjust enrichment claim also fails on its own terms. "Unjust enrichment exists when the plaintiff confers a benefit on the defendant, the defendant appreciates such benefit, and there is 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." *Korte Constr. Co. v. Nev. on Relation of the Bd. of Regents of the Nev. Sys. of Higher Educ.*, 137 Nev. 378, 381, 492 P.3d 540, 543 (2021) (quotation omitted). Applying that principle in this factual context, some courts have allowed emergency medicine providers to advance unjust enrichment claims on the theory that by treating the insurer's plan member, the provider confers an indirect or incidental benefit on the insurer by discharging the insurer's obligation to ensure treatment for the member. *See*, *e.g.*, *Emergency Health Physicians*, 2021 WL 4437166, at *12-13. But as another court observed, in many such cases, "the healthcare providers could *only* bill the insurers—*not* the patients—under state law," meaning that "inequity arose . . . because the healthcare provider could not bill anyone other than the insurer." *Emergency Dep't Phys. P.C. v. United*

Healthcare, Inc., 507 F. Supp. 3d 814, 830 (E.D. Mich. 2020). Where the provider is legally allowed to bill its patients directly—as was true in Nevada during the period at issue—there is no inequity that requires the insurer to bear the additional cost. *See id.*

The same principle follows from the related rule that equitable remedies such as unjust enrichment "are generally not available where the plaintiff has a full and adequate remedy at law." *Korte*, 137 Nev. at 378, 492 P.3d at 541. The facts of *Korte* are illustrative. In *Korte*, a property owner leased property to a developer, which in turn contracted with a construction company to erect a building on the property. After a dispute arose between the developer and building contractor, the contractor sued the property owner for payment, alleging that it had been unjustly enriched by the contractor's work. This Court rejected the equitable claim because, *inter alia*, the contractor could have sought recovery at law in a breach of contract action against the developer. 137 Nev. at 380, 492 P.3d at 543. Given the existence of that legal remedy, there was no inequity that justified making the property owner pay the contractor despite the lack of any contractual duty to do so. *Id.*

The same analysis applies here: because Nevada law allowed

TeamHealth to pursue contract remedies against its patients for the services at issue in this case, there is no inequity that justifies forcing United to pay more than is required by its own contractual obligations under the plan documents. To the contrary, the inequity would be suffered *by United*, which would be "placed in a worse position than it bargained for" under its plan terms, just as the property owner in *Korte* would have been made worse off if forced to pay the contractor "in addition to the consideration" it already paid to the developer. 137 Nev. at 544, 492 P.3d at 382.

In addition to the absence of inequity to TeamHealth, there is also an absence of any benefit to United. It is a "fundamental requirement of unjust enrichment" that the defendant "obtain a valuable benefit" from the plaintiff, "without paying anyone for it." *Korte*, 137 Nev. at 382, 492 P.3d at 544 (quotation omitted). No such benefit exists here, as the Texas Supreme Court recognized recently in rejecting a similar quantum meruit claim in litigation involving TeamHealth and United. *See Texas Medicine Resources, LLP v. Molina Healthcare of Texas, Inc.*, 659 S.W.3d 424, 436-37 (Tex. 2023). As that court explained, and as also discussed above, emergency medicine providers are required by law

to render care to individuals who present in emergency rooms; therefore, when the disputed emergency services were rendered in this case, they were not provided for United's benefit. *See supra* Facts at A, II.A.1. Nor does treating a plan member discharge any obligation United owes to members beyond the terms of the applicable health plan. A plan typically promises only to reimburse members for non-network services at a specified rate or methodology. So long as United allows that amount for the non-network service, United and the plan have fully discharged their obligations to the member. The non-network provider's treatment at most secures the *treatment* for the plan member contemplated, but it confers no additional benefit *on United* that requires United to allow an additional payment to the provider, on top of the plan's promised reimbursement. If anything, the rendering of the emergency service creates a *burden* for United by triggering its duty to pay benefits to the member under the plan. As the Texas Supreme Court recently observed in the same context, "a ripened obligation to pay money to the insured . . . hardly can be called a benefit" to the party compelled to pay. *Texas Medicine*, 659 S.W.3d at 437.

For these reasons, the judgment in favor of TeamHealth on the

unjust enrichment claim must be reversed.

C. The UCPA Claim Fails as a Matter of Law

United is also entitled to judgment as a matter of law on TeamHealth's claim under the UCPA, which requires an "insurer" to effectuate "prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear." NRS 686A.310(1)(e).

TeamHealth's UCPA claim fails as a matter of law for three reasons. First, the statute only creates a cause of action for an "*insured*" against its "*insurer*," thereby precluding actions by third parties that—like TeamHealth—are not insured by the defendant. Second, several of the United defendants are not even "insurers," as required for liability under the statute. Finally, even if TeamHealth in theory could state a UCPA claim against each defendant, it failed to adduce evidence sufficient to establish a UCPA violation.

1. Because TeamHealth Is Not "Insured" by United, It Lacks Standing to Sue Under the UCPA

The UCPA is a regulatory statute enacted in 1975, patterned on the model Unfair Claims Settlement Practices Act developed by the National Association of Insurance Commissioners. *Tweet v. Webster*,

614 F. Supp. 1190, 1192 (D. Nev. 1985). The statute originally did not permit private rights of action at all. *Id.* at 1194. In 1987, the Nevada Legislature amended the UCPA to provide that "[i]n addition to any rights or remedies available to the Commission [of Insurance], *an insurer is liable to its insured* for any damages sustained by the *insured* as a result of the commission of any act set forth in subsection 1." NRS 686A.310(2) (emphasis added). An "insured" under the statute is "a person covered by a policy of health insurance issued in this state by an insurer." NRS 679B.530. Two years after the 1987 Amendment, the Legislature rejected another amendment that would have "expressly provide[d] for action by a third-party claimant for violation of the unfair claims settlement practices act by insurance companies." *Crystal Bay Gen. Imp. Dist. v. Aetna Cas. & Sur. Co.*, 713 F. Supp. 1371, 1377 (D. Nev. 1989). The Legislature has not since adopted any further changes to the limited UCPA private right of action allowing insureds to sue their own insurers. *Cf. Del Papa v. Board of Regents of Univ. & Cmty. College System of Nev.*, 114 Nev. 388, 396, 956 P.2d 770, 776 (1998) ("where the legislature has ample time to amend an administrative agency's reasonable interpretation of a statute, but fails to do so, such

acquiescence indicates the interpretation is consistent with legislative intent") (cleaned up).

This Court has repeatedly held that the UCPA "does not provide a private right of action to third-party claimants," *Fulbrook v. Allstate Ins. Co.*, Nos. 61567, 62199, 2015 WL 439598, at *4 (D. Nev. Jan. 30, 2015), and thus third parties lack standing to sue insurers under the UCPA even when their claims challenge insurer misconduct or violations of an insurance policy, *see Gunny v. Allstate Insurance Co.*, 108 Nev. 344, 830 P.2d 1335 (1992); *United First Ins. Co. v. McClelland*, 105 Nev. 504, 780 P.2d 193 (1989). In *Gunny*, for instance, the plaintiff was seriously injured by his father's boat. The plaintiff made a claim against his father's boat insurer, which failed to provide timely compensation for the injuries. The son sued his father's boat insurer alleging violations of its duties under the UCPA, but this Court rejected the claim, holding that the UCPA "creates no private right of action in favor of third-party claimants against an insurer." *Id.* at 346, 830 P.2d at 1336. To support that conclusion, the *Gunny* Court cited *Crystal Bay*, which recounted the UCPA's history in detail to explain why no general private right of action can be implied into the statute beyond

the narrow right of an insured to sue its insurer. 713 F. Supp. at 1376.

Federal district courts, too, have long recognized that the "law in Nevada is clear: third-party claimants may not bring claims against insurers . . . under NRS § 686A.310." *Talbot v. Sentinel Ins. Co., Ltd.*, 2012 WL 3995562, *3 (D. Nev. 2012); *see Burley v. National Union Fire Insurance Company of Pittsburg PA*, 2016 WL 4467892, *2 (D. Nev. 2016); *Wilson v. Bristol West Ins. Group*, 2009 WL 3105602, *2 (D. Nev. 2009); *Weast v. Travelers Cas. & Sur. Co.*, 7 F. Supp. 2d 1129, 1133 (D. Nev. 1998).

That long line of authority precludes any suit by TeamHealth against United under the UCPA. If injured tort claimants, or even the injured child of an insured, cannot sue under the UCPA even when the insured's acts cause them harm, there is no plausible basis upon which TeamHealth can sue under the statute. TeamHealth does not and could not contend that it qualifies as an "insured" under the UCPA—it obviously is not "a person covered by a policy of health insurance issued in this state by an insurer," NRS 679B.530—and it does not assert an assigned claim for benefits on behalf of members who *do* qualify as

insureds.[16] It accordingly cannot sue under the UCPA.

The Texas Supreme Court recently rejected a substantively identical UCPA claim asserted in litigation involving TeamHealth and United. *Texas Medicine Resources*, 659 S.W.3d 424. The only notable difference between the Texas UCPA and the Nevada UCPA—both are based on the same model statute—is that the Texas law permits an "insured *or beneficiary*" to bring suit. *Id.* at 437-38 (emphasis added). Applying that language, the Texas Supreme Court held that TeamHealth and other physician staffing companies could not sue United and other health plans under the Texas statute because the staffing companies were "neither insureds nor beneficiaries." *Id.* at 438. The same analysis applies here.

In the face of overwhelming precedent from this Court and others

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[16] Any such benefit claim would be completely preempted by ERISA § 502(a)(1)(B). *See infra* at V. Moreover, the UCPA claim that TeamHealth asserts—the failure to pay the full charges of the provider—differs qualitatively from the claim that a plan member would assert under the UCPA—the failure to pay the benefit required by the plan terms. *See Texas Medicine Resources*, 659 S.W.3d at 439 (distinguishing non-viable UCPA claim asserted by TeamHealth from viable UCPA claim available to plan member).

enforcing the UCPA's unambiguous limitations on suit, the district court here proffered no legitimate basis for allowing TeamHealth's UCPA claim to proceed even though TeamHealth is admittedly not an "insured." The court's principal theory was that the UCPA broadly states that a "*person* shall not engage" in unfair practices. NRS 686A.020 (emphasis added). Because United qualifies as a "person," the court reasoned, it must be subject to suit by TeamHealth under the UCPA. In the court's view, the statutory language authorizing suit by "insureds" does nothing more than "permissively" allow suits by insureds; the statute otherwise impliedly allows suit by *any* party who has suffered "legally redressable harm." (73App.18,098–100.)

That argument confuses the person *regulated* by the statute with the parties *who may sue* when the regulated persons violate the statute. Before the 1987 amendment, the statute did not include an express or implied private right of action at all. *See Tweet*, 614 F. Supp. at 1194. The entire point of the amendment was to authorize private suits by one narrow class of plaintiffs, *i.e.*, "insureds." NRS 686A.310(2). On the district court's reading, however, the amendment was meaningless because the UCPA *already* impliedly authorized private suits by

insureds and third parties like TeamHealth. Because this Court "avoid[s] statutory interpretation that renders language meaningless or superfluous," *Hobbs v. State*, 127 Nev. 234, 237, 251 P.3d 177, 179 (2011), the district court's reading must be rejected.

The district court's interpretation also inverts the proper approach to a private right of action. The district court assumed that any persons with legally redressable injuries may always bring suit under a statute unless the statute *prohibits* them from doing so. But the rule is the opposite: "[W]hen a statute does not expressly provide for a private cause of action, the absence of such a provision suggests that the Legislature did not intend for the statute to be enforced through a private cause of action." *Richardson Constr., Inc. v. Clark Cnty. Sch. Dis.*, 123 Nev. 61, 65,156 P.3d 21, 23 (2007). Accordingly, absent an "express" provision creating a private cause of action, this Court "will not read language into a statute granting a private cause of action for an independent tort." *Torres v. Nev. Direct Inc. Co.*, 131 Nev. 531, 542, 353 P.3d 1203, 1211 (2015). And while private rights of action sometimes can be implied when the Legislature's intent is unambiguous, the district court cited nothing that clearly reveals the

Legislature's intent to allow suit by private parties other than the "insureds" expressly authorized to sue. If anything, that express authorization impliedly *precludes* suit by other private parties, as recognized in the *Crystal Bay* decision cited in *Gunny*. *See Crystal Bay*, 713 F. Supp. at 1376.

Indeed, the court's reading of the UCPA cannot be reconciled with *Gunny*, or with *Fulbrook* and the many federal decisions similarly holding that third-party claimants lack standing to sue for violations of the UCPA. In *Gunny*, for example, the plaintiff was plainly aggrieved by the insurer's UCPA violations, which caused delay in payment for his injuries. This Court nevertheless held that he lacked standing because he did not qualify as an "insured." If the district court here were correct, the *Gunny* plaintiff did not *need* to be an "insured," since that provision is merely "permissive[]." This Court, however, held otherwise, denying standing precisely because the plaintiff was *not* an insured. TeamHealth lacks standing for the same reason.

According to the district court, *Gunny* and similar cases are distinguishable because the third-party claimants in such cases lacked a contractual relationship with the insurer and thus could not assert a

"legally redressable harm." But the same is true for TeamHealth—this dispute arose precisely *because* TeamHealth lacked an express contract with United (and TeamHealth failed as a matter of law to prove an implied-in-fact contract, as shown above, *supra* at II.A. And while a "legally redressable harm" is *necessary* for a plaintiff to assert any cause of action, it is not *sufficient* to assert a statutory claim—the statute itself must authorize a private right of action. *See Tweet*, 614 F. Supp. at 1194. The UCPA does not authorize such an action—as discussed above, the UCPA authorizes private suit only by an "insured," not by "any party with a contractual relationship with the insurer," and indeed not by *any* other private parties, as made clear by the *Crystal Bay* and *Tweet* decisions cited in *Gunny*, *see* 713 F. Supp. at 1376; 614 F. Supp. at 1194.

This Court did not hold otherwise in *Torres*, 131 Nev. at 542, 353 P.3d at 1211. According to the district court, the Court in *Torres* "expressly recognized the potential availability of claims asserted by third parties who are not insureds when standing can otherwise be established." (73App.18,098–99.) *Torres* said no such thing. The passage quoted by the district court states only that *Gunny* "intimated

in dicta . . . that a third-party who is a *specific intended beneficiary* of an insurance policy might have a sufficient relationship to support *a bad faith claim*." *Id.* (emphasis added). TeamHealth is not a "specific intended beneficiary" of an employee health plan, like an employee's dependent might be. Equally important, *Torres* and *Gunny* refer only to a specific intended beneficiary's standing to assert a *common-law bad faith claim*—neither decision remotely suggests that there is an implied cause of action *under the UCPA* for all private parties, which is the only question at issue here. And that question *is* answered by cases like *Gunny*, *Crystal Bay*, and *Tweet*, which all squarely hold that the UCPA creates no cause of action for any private party other than an insured.

No case holds or suggests otherwise. TeamHealth's UCPA claim never should have been submitted to the jury.

2. Three Defendants Are Not "Insurers" for All Disputed Claims Asserted By TeamHealth

TeamHealth's UCPA claim not only fails on the plaintiff-side of the "v.," it also fails on the defense-side as to three of the defendants. UHS and UMR, and UHIC for some disputed benefit claims, are not "insurers" under the UCPA, and thus cannot be liable under the

statute.

UHS and UMR did not provide insurance for any health plan. They instead only administered benefits for health plans that were self-funded or self-insured by the employers who sponsored them. UHIC likewise functioned solely as a third-party administrator for many, but not all, of the benefit claims for which TeamHealth was awarded damages. In a self-funded plan, the sponsor itself is fully responsible for maintaining the necessary financial reserves and for funding the actual benefit payments. *See Am.'s Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1324 (11th Cir. 2014) (self-insured employers "endure[] the financial risk associated with being responsible for paying health care charges incurred by its employees"). A self-insured plan sponsor, however, will typically "contract with third-party administrators ('TPAs') to perform certain administrative functions for the employer and each plan," which "might include processing claims, paying claims, and managing the everyday functioning of a plan." *Id*. The TPA "is merely a 'pass-through' who is not ultimately responsible" for funding claim payments made by the plan. *United States v. Baxter Int'l, Inc.*, 345 F.3d 866, 907 (11th Cir. 2003). The trial evidence confirmed these

limited roles for UHS and UMR and for UHIC for some of the disputed benefit claims.[17]

Entities acting as TPAs are not "insurers" subject to suit under the UCPA. Under Nevada law, an "insurer" is defined as "every person engaged as principal and as indemnitor, surety or contractor in the business of entering into contracts of insurance." NRS 679A.100. In *Albert H. Wohlers & Co. v. Bartgis,* 114 Nev. 1249, 1264, 969 P.2d 949, 960 (1998), this Court expressly held that a TPA is not an insurer for the purposes of NRS 686A.310: the UCPA applies only to "unfair practices in settling claims by an insurer, which [a TPA] is not." 114

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[17] *See* 32App.7,769 (some defendants perform TPA services); 32App.7,960–61 (TPAs pay benefit claims based on directives from self-insured clients because defendants only "administer the funds"); 34App.8,495–96 (UMR is TPA); 36App.8,853–54 ("UMR is the third-party administrator" and "UnitedHealthcare itself is a third-party administrator . . . [f]or self-employed groups"); 36App.8,953 (TPAs "do[] not incur the medical cost risk"); 36App.8,956 (UHIC is either TPA or insurer in different circumstances); 36App.8,961 (administrative services agreement is between "the employer group, with the third-party administrator to perform services on their behalf"); 39App.9,704 (UMR "is a third-party administrator … our clients are employer groups [who] wish to self-fund their benefit plan."); 39App.705–06 (UMR is TPA, and "the employer is actually the one that pays the claims. . . . So what UMR does is we administer the benefits [] that that employer group provides to us.").

Nev. at 1265. Even though the evidence there showed that the TPA "developed promotion material, issued policies, billed and collected premiums, paid and adjudicated claims," and "assisted" the plan's underwriter in developing the "limitation provision" at issue in the case, *id.* at 1263, the TPA did not qualify as an "insurer" because none of those acts involved entering into contracts of insurance. *See also Smith v. Blue Cross Blue Shield of South Carolina*, 2020 WL 1288650, at *7 (M.D. Fla. March 18, 2020) (TPAs are not "insurers" under Florida statutory definition identical to Nevada's statute). The same is true here: TeamHealth adduced no evidence establishing that any defendant entered into contracts of insurance while acting only in its TPA capacity. These defendants accordingly are not subject to suit under the UCPA.

3. TeamHealth Failed to Adduce Evidence Sufficient to Establish Any Violation of the UCPA

Even assuming that TeamHealth had standing to *allege* a viable UCPA claim against all defendants, it failed to *prove* that claim at trial.

To establish a UCPA violation, TeamHealth was required to prove that the United insurer-defendants failed "to effectuate prompt, fair

and equitable settlements of claims in which liability of the insurer has become reasonably clear." NRS 686A.310(1)(e). TeamHealth's evidence fell short in three respects: (1) United's alleged liability for TeamHealth's self-determined full billed charges was never "reasonably clear" before the jury's verdict; (2) United did not fail to "effectuate a prompt, equitable, and fair settlement" for its liability; and (3) TeamHealth's damages reflected only the substantive failure to pay a portion of the amount claimed, not a separate injury distinctly caused by improper benefit claims processing.

a. TeamHealth Did Not Prove That United's Liability Was "Reasonably Clear" Before Trial

An insurer may held liable under the UCPA only if it failed to promptly and fairly settle "claims" for which its "liability" was "reasonably clear." NRS 686A.310(1)(e). A UCPA plaintiff thus must prove that its claim for benefits "had become 'reasonably clear'" yet was not paid. *Tweet*, 614 F. Supp. at 1194. TeamHealth presented no such proof at trial.

As an initial matter, TeamHealth did not even *purport* to adduce evidence that United failed to promptly settle any reasonably clear

"claim" *filed by an insured*. The UCPA is focused solely on "the manner in which an insurer handles an insured's claim." *Patel v. Am. Nat'l Prop. & Cas. Co.*, 367 F. Supp. 3d 1186, 1193 (D. Nev. 2019). But nowhere did TeamHealth contend that United failed to determine the plan members' own benefit claims properly. To the contrary, TeamHealth expressly disclaimed any effort to establish liability on the ground that United violated obligations to its members under their ERISA-governed health plans. (21App.5,247 n.1 (plaintiffs "do not assert claims that are dependent on the existence of an assignment . . . from any [insured]"); 1App.111 (asserting that liability theory is "not derivative or dependent upon the terms of any particular patient's [plan] in any way"); 4App.763 n.7 (arguing that United's potential liability under insurance contracts is immaterial to TeamHealth liability theory). TeamHealth thus failed to show any defect in United's settlement of benefit "claims" as required for UCPA liability.

Even assuming the UCPA *also* imposed on United a duty to promptly and fairly meet TeamHealth's completely separate reimbursement demands on top of United's plan obligations to its members, TeamHealth still established no UCPA violation, because

United's liability to TeamHealth was not "reasonably clear" before trial. TeamHealth's trial theory was that United failed to allow payment of its full billed charges. Accordingly, to establish a UCPA claim on that basis, TeamHealth was required to prove that United's liability for those full billed charges was "reasonably clear." The jury, however, affirmatively *rejected* TeamHealth's claim for those full billed charges, finding United liable for only a fraction of those charges. That jury finding categorically forecloses any conclusion that United's liability for full billed charges was reasonably clear when United settled the disputed benefit claims during the period in dispute. That conclusion is likewise foreclosed by TeamHealth's own trial admission that United paid full billed charges for only about 7% of claims immediately before the liability period, and that TeamHealth overall receives full billed charges for an even smaller percentage of claims. *See supra* at I.A.2, II.A.1.

It is equally impossible to conclude that United's liability for the amount found by the jury was "reasonably clear." The jury's damages award did not correspond to the damages estimates identified by either party or their experts as an amount United should have allowed as

reasonable value for the disputed benefit claims. The figure was not "reasonably clear" before trial—in fact, it was nonexistent.

TeamHealth failed to establish a "reasonably clear" pre-trial liability in another way as well. The UCPA does not apply when an insurer withholds benefits demanded by an insured based on a good-faith disagreement over the insurer's total liability. *See Clifford v. Geico Cas. Co.*, 428 F. Supp. 3d 317, 325-26 (D. Nev. 2019) (good-faith "dispute over the value of claim" not actionable under NRS 686A.310). In many cases, the "reasonably clear" requirement is established when evidence shows that the insurer had concluded internally that a particular benefit claim should be paid, but then failed to pay that benefit promptly. No such evidence exists here. To the contrary, the undisputed evidence showed that United promptly allowed reimbursements for the amounts it believed were required under the applicable plan terms. (*See, e.g.*, 36App.8,760; 39App.9,558.) The disagreement here concerns *additional* payments that United indisputably believed were *not* required, or even *permitted*, under the terms of the applicable health plans.

Resolution of that disagreement required, among other things,

expert testimony on the reasonable value of the services at issue. And as courts have repeatedly held, the very fact that the jury required such technical and specialized evidence to determine reasonable value necessarily establishes that an insurer's liability to pay such value was not "reasonably clear." *See Lubritz c. AIG Claims, Inc.*, 2018 WL 7360623, at *7 (D. Nev. 2018) (disputed expert testimony precluded finding that "any amount above" what insurer "already paid" was "reasonably clear" liability); *Big-D Constr. Corp. v. Take It for Granite Too*, 917 F. Supp. 2d 1096, 1118-19 (D. Nev. 2013) ("genuine issues of material fact as to whether [insurer] is liable . . . for certain damage" cannot result in "reasonably clear" liability). And not only did the parties' experts disagree between them, but TeamHealth's own expert offered different accounts of United's liability during the trial, demonstrating that the liability was not reasonably clear even to him. *Compare* 42App.10,329 (measuring damages based on full billed charges) *with* 43App.10,599–60 (measuring damages based on average amount allowed by United to other non-network providers).

This lawsuit, in short, involves a genuine dispute over whether the payments that United allowed were less than the reasonable value

of the services at issue, and if so, how much more the health plans should have paid for those services. The additional amount owed, if any, was never "reasonably clear" before the verdict, as the verdict itself proved: the jury awarded TeamHealth only $2.65 million, as against TeamHealth's demand for more than $10 million in additional reimbursement. That fractional award conclusively establishes that United's liability for the verdict amount was not "reasonably clear" to anyone before trial, and especially not United.

b. TeamHealth Presented No Evidence That Defendants Failed to Negotiate Reimbursements in Good Faith

TeamHealth offered no evidence that United failed to negotiate its potential liability in good faith. *See Harter v. Gov't Emps. Ins. Co.*, 2020 WL 4586982, at *4 (D. Nev. June 11, 2020) (granting summary judgment where evidence showed defendant "negotiated in good faith"); *Matarazzo v. GEICO Cas. Co.*, 2020 WL 1517556, at *4 (D. Nev. Mar. 30, 2020) (granting summary judgment where insurer "promptly responded to plaintiff's requests and communications" and "had a basis for disputing plaintiff's demands for the full policy limit"); *Amini v. CSAA Gen. Ins. Co.*, 2016 WL 6573949, at *6 (D. Nev. Nov. 4, 2016)

(granting summary judgment where insurer "reasonably and promptly responded to claim communications and engaged in settlement negotiations"). As already discussed, the dispute here exists entirely because the parties could not reach agreement on contractually specified network rates. Those network negotiations are very different from claim-settlement negotiations between an insurer and its insured, but they are the closest analog available if one indulges TeamHealth's false premise that its reimbursement claims are equivalent under the UCPA to an insured's claim for plan benefits. If one does accept that premise, then TeamHealth's UCPA claim fails because it did not even try to establish that United breached a duty to negotiate reimbursements even after contract negotiations terminated unsuccessfully.

c. TeamHealth's Damages Evidence Was Limited to the Alleged Underpayment, Not Separate Damage From the Benefit Claims Process Itself

United is also entitled to judgment as a matter of law on the UCPA count because TeamHealth failed to establish damages distinct from United's alleged underpayment for emergency medicine services.

The UCPA distinguishes between damages caused by "claims

handling failures" and damages caused by "the denial of coverage itself." *Safety Mut. Cas. Corp. v. Clark Cty. Nev.*, 2012 WL 1432411, at *2 (D. Nev. Apr. 25, 2012); *see Sanders v. Church Mut. Ins. Co.*, 2013 WL 663022, at *3 (D. Nev. Feb. 21, 2013); *Yusko v. Horace Mann Servs. Corp.*, 2012 WL 458471, at *4 (D. Nev. 2012). As the Texas Supreme Court explained in applying the materially identical Texas statute, UCPA damages must be "separate and apart from those that would have resulted from a wrongful denial of the claim." *Provident Am. Ins. Co. v. Castaneda*, 988 S.W.2d 189, 199 (Tex. 1998). For example, when an insurer wrongly denies full payment, an insured can recover the full amount owed through a claim for breach of the insurance contract, and if the denial was in bad faith, the insured can obtain distinct relief under the UCPA for consequential monetary losses caused by the lack of timely payment. *See USF&G v. Peterson*, 91 Nev. 617, 619-20, 540 P.2d 1070, 1071 (1975) (adopting "the rule that allows recovery of consequential damages where there has been a showing of bad faith by the insurer").

In this case, however, TeamHealth abandoned its bad faith claim before trial. (22App.5,256–62; 107App.26,500.) It accordingly did not

even attempt to adduce concrete evidence of distinct, consequential monetary losses resulting from the alleged underpayments. To the contrary, its experts only calculated damages measured by the amount of alleged underpayments, and in closing TeamHealth sought damages only on that basis. As a result, its UCPA claim fails as a matter of law.

III.

THE PUNITIVE DAMAGES AWARD MUST BE REVERSED OR REDUCED

Even if the liability judgment on one or more counts is affirmed, the unjustified and grossly excessive $60 million punitive damages award cannot stand.

A. No Punitive Damages Award Is Permissible Under the Facts and Legal Claims in This Case

Nevada law prohibits punitive damages in a purely commercial dispute like this case, and neither the UCPA nor unjust enrichment claims permits punitive damages in any event.[18]

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[18] TeamHealth does not contend that its implied-in-fact contract claim supports punitive damage.

1. Nevada Law Prohibits Punitive Damages on These Facts

A plaintiff "is not automatically entitled to punitive damages" under Nevada law. *Bongiovi v. Sullivan*, 122 Nev. 556, 581, 138 P.3d 433, 450 (2006). Punitive damages are permissible only "when the plaintiff proves by clear and convincing evidence that the defendant is guilty of oppression, fraud or malice, express or implied." *Id.* (quotation omitted). The defendant's conduct must be more than wrongful or tortious—indeed, even "recklessness or gross negligence" does not suffice. *Countrywide*, 124 Nev. at 743, 192 P.3d at 254. This Court has not hesitated to reject punitive damages as a matter of law in cases that do not meet the high legal standard for such punishment. *See Winchell v. Schiff*, 124 Nev. 938, 948, 193 P.3d 946, 953 (2008); *Ins. Co. of the West v. Gibson Tile Co.*, 122 Nev. 455, 464, 134 P.3d 698, 703 (2006); *Great Am. Ins. Co. v. General Builders, Inc.*, 113 Nev. 346, 354-56, 934 P.2d 257, 263 (1997); *Chowdhry v. NLVH, Inc.*, 109 Nev. 478, 484, 851 P.2d 459, 463 (1993).

In particular, this Court has emphasized that punitive damages are inappropriate in commercial disputes between sophisticated actors.

In *General Builders*, the Court held that a district court erred in allowing punitive damages in an "ordinary breach of contract case" involving "experienced commercial entities" that "were never in inherently unequal bargaining positions," where the "only harm" suffered by the plaintiff was "easily compensated with money damages." 113 Nev. at 354-56, 934 P.2d at 263. All the same is true here. *See also Winchell*, 124 Nev. at 948, 193 P.3d hat 953 (rejecting punitive damages for business losses).

Similarly, both the U.S. Court of Appeals for the Ninth Circuit and federal district courts have rejected punitive damages under Nevada law in cases involving alleged wrongful denials of insurance claims, even when such denials impose hardship on the insured. *See Polymer Plastics Corp. v. Hartford Cas. Ins. Co.*, 389 Fed. Appx. 703, 707-08 (9th Cir. Nev. 2010); *Fernandez v. State Farm Mut. Auto. Ins. Co.*, 338 F. Supp. 3d 1193, 1202 (D. Nev. 2018); *Lubritz*, 2018 WL 7360623, at *8.

There is no evidence that United committed oppression or fraud or acted with implied malice, *i.e.*, conscious disregard for TeamHealth's known rights. This was, and remains, a good-faith commercial dispute

between large, highly sophisticated business entities, pure and simple. For its part, United indisputably remitted reimbursements in accordance with its plan obligations. TeamHealth sued United for more money only after terminating contract negotiations during which TeamHealth expressed a willingness to accept payment rates far below the full billed charges that it now says were legally mandatory all along. *See supra* Facts at A. But if they were, TeamHealth cannot explain why it was even discussing network contracts—it would be much better off if its clinicians simply provided all emergency medical services without a contract, because then TeamHealth could simply demand its full billed charges. The very existence of prior network contracts and negotiations shows that United did not willfully disregard any clearly established TeamHealth right to payment of whatever rates TeamHealth unilaterally demanded.

In the end, the record speaks for itself: United allowed reimbursements on average at amounts substantially greater than paid by Medicare for the same services and *much* closer to the reasonable value found by the jury than the wildly excessive full billed charges TeamHealth demanded. The jury verdict equated to 319% of Medicare,

see 49App.12,233; whereas United allowed reimbursements on average at 164% of Medicare, *see* 43App.10,708, and TeamHealth demanded billed charges that equated to 763% of Medicare, *see* 48App.11831. That record does not support any punishment for United at all, much less punishment in the amount of $60 million.

Ultimately, if merely seeking to reduce costs in a business relationship between a giant medical staffing company owned by the largest private equity firm in the world and a managed healthcare company were sufficiently reprehensible to award punitive damages, then "health plans would be liable for punitive damages in every case." *Long Beach Memorial Medical Center v. Kaiser Foundation Health Plan, Inc.*, 286 Cal. Rptr. 3d 419, 430 (Ct. App. 2021) (rejecting hospital's claim that Kaiser Permanente was deserving of punitive damages for intentionally underpaying the hospital "with the alleged bad motive of trying to save money and turn a profit"). This Court should not endorse that outcome.

2. Punitive Damages Cannot Be Awarded for Unprecedented UCPA Liability

As shown above, no Nevada case has ever recognized a claim under the UCPA by any party other than an insured suing its insurer. And many cases in Nevada—and in states with materially identical statutes—have affirmatively held that *only* "insureds" may sue under the statute. TeamHealth seeks the first appellate ruling anywhere extending a UCPA claim to include suits by third-parties seeking to enforce rights that allegedly exist *outside* an insurance relationship.

If the Court issues that ruling and allows United's unprecedented UCPA liability to stand, it should at least hold that such new liability cannot support punitive damages. This Court has long recognized that it is "unfair" to hold defendants liable for punitive damages "for conduct which they could not have known beforehand was actionable in this jurisdiction." *Hansen v. Harrah's*, 100 Nev. 60, 65, 675 P.2d 394, 397 (1984). Punitive damages accordingly are unavailable in a case where "the cause of action underlying any award of punitive damages was first adopted by this [C]ourt." *Mackintosh v. California Federal Sav. & Loan*

Ass'n, 113 Nev. 393, 406, 935 P.2d 1154, 1163 (1997). That rule precludes an award of punitive damages under the UCPA in this case.

3. Unjust Enrichment Is a Quasi-Contract Claim That Does Not Support Punitive Damages

TeamHealth belatedly added a claim for punitive damages to its unjust enrichment cause of action. But unjust enrichment is merely the implication of a contract at law—a "quasi-contract" is implied to avoid unjustly enriching a party who received a benefit at the expense of another, in the absence of any actual express or implied agreement between them. *See Certified Fire*, 128 Nev. at 380, 283 P.3d at 257 ("Where unjust enrichment is found, the law implies a quasi-contract which requires the defendant to pay to plaintiff the value of the benefit conferred.") (quoting *Lackner v. Glosser*, 892 A.2d 21, 34 (Pa. Super. Ct. 2006)).

In other words, unjust enrichment under these circumstances sounds in contract, not tort. And punitive damages cannot be awarded in an action for breach of an obligation arising from contract. Nevada law expressly limits an award of punitive damages to an action that is "for the breach of an obligation *not arising* from contract." NRS

42.005(1) (emphasis added). Accordingly, "[i]f the punitive damage award is not based upon a cause of action sounding in tort, the award must be stricken on appeal." *Sprouse v. Wentz*, 105 Nev. 597, 602, 781 P.2d 1136, 1139 (1989). In Nevada, the prohibition does not just apply to the cause of action *labeled* "breach of contract," but to any claim that *sounds* in contract, such as unjust enrichment/quasi-contract/contract implied-at-law. *See, e.g.*, *Road & Highway Builders v. N. Nev. Rebar*, 128 Nev. 384, 393, 284 P.3d 377, 383 (2012) (reversing award of punitive damages on breach of implied covenant of good faith and fair dealing claim that "sound[ed] in contract, and not tort"). Courts in many other jurisdictions have likewise rejected punitive damages for such claims.[19]

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[19] *See, e.g.*, *Priority Healthcare Corp. v. Chaudhuri*, 2008 WL 4459041 *5 (M.D. Fla. 2008); *Moench v. Notzon*, 2008 WL 668612 *5 n.3 (Tex. Ct. App. 2008); *U.S. East Telecommunications, Inc. v. U.S. West Information Sys., Inc.*, 1991 WL 64461 *4 (S.D.N.Y. 1991); *Edible Arrangements Int'l, Inc. v. Chinsammy*, 446 F. App'x 332, 334 (2d Cir. 2011); *Guobadia v. Irowa*, 103 F. Supp. 3d 325, 342 (E.D.N.Y. 2015); *Seagram v. David's Towing & Recovery, Inc.,* 62 F. Supp. 3d 467, 478 (E.D. Va. 2014); *Conner v. Decker*, 941 N.W.2d 355 (Iowa Ct. App. 2019); *Am. Safety Ins. Serv., Inc. v. Griggs*, 959 So. 2d 322, 332 (Fla. App. 2007); *Dewey v. Am. Stair Glide Corp.,* 557 S.W.2d 643, 650 (Mo. App. 1977).

As such decisions tacitly recognize, it would be patently illogical to permit punitive damages for breaching a quasi-contract implied at law, where the defendant's legal obligations were not clearly specified, while prohibiting punitive damages for breaching an express contract, where the defendant's obligations were clearly stated but ignored. Notably, Nevada law would unambiguously prohibit TeamHealth from obtaining punitive damages for violations of an express network contract, even if the violations were widespread and repeated. *Sprouse*, 105 Nev. at 602, 781 P.2d at 1139. It makes no sense to authorize punitive damages in a case where no such contract exists at all, and the legal obligations at issue were imposed only by operation of law and only *after* the fact.

B. The Due Process Clause Requires Reduction of the Punitive Damages Award

The Due Process Clause of the Fourteenth Amendment to the U.S. Constitution imposes distinct limitations on the size of punitive damages awards. Application of those limitations is reviewed de novo. *Bongiovi*, 122 Nev. at 583, 138 P.3d at 452. On the facts of this case, due process requires that the award be reduced to an amount below the $2.65 million compensatory damages award.

1. Due Process Allows No More Than a 1:1 Ratio of Punitive Damages to Compensatory Damages in Cases of Pure Economic Loss in a Commercial Dispute With a Nonvulnerable Plaintiff and No Fraud or Deceit

The "ratio between compensatory and punitive damages" is a "central feature" of the "due process analysis." *Exxon Shipping Co. v. Baker*, 554 U.S. 471, 507 (2008). Not only will "few awards exceeding a single-digit ratio between punitive and compensatory damages . . . satisfy due process," but when the compensatory damages award is "substantial, then a lesser ratio, perhaps only equal to compensatory damages, can reach the outermost limit of the due process guarantee." *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408, 425 (2003). A 1:1 limit is especially appropriate where, as here, only pure economic loss is involved and the conduct at issue is merely a business disagreement, not malicious acts intended to cause physical harm and the like. *See Baker*, 554 U.S.at 513 (endorsing 1:1 ratio as common-law limit in such cases).

This Court has held that a low ratio applies where, as here, the case involved only economic losses in a disputed commercial transaction where the plaintiff was not financially vulnerable. In *Exposure*

Graphics v. Rapid Mounting Display, 128 Nev. 895, 2012 WL 1080596 (2012), this Court rejected a punitive damages award equaling only 2.1 times compensatory damages, where the reprehensibility of the defendant's conduct was fairly limited given that the case stemmed from a business transaction. *Id.* at *2. As the Court explained, a ratio as high as 2.1:1 "should be limited to instances in which the injured party demonstrates a higher degree of reprehensibility than that which was present" in the case. *Id.* As shown in the next section, TeamHealth did not demonstrate *any* degree of reprehensibility. *See infra* at III.B.2.

This Court's decision in *Ace Truck & Equip. Rentals, Inc. v. Kahn*, 103 Nev. 503, 511, 746 P.2d 132, 137 (1987), *abrogated on other grounds by Bongiovi v. Sullivan*, 122 Nev. 556, 138 P.3d 433 (2006), is to similar effect. The plaintiffs there were awarded punitive damages for fraud relating to the sale of a business. They were not "vulnerable" victims, but were "business people of normal and expected wisdom and sophistication in making this transaction." *Id.* And while they suffered both economic harm and "considerable inconvenience and annoyance as a result of appellants' fraud," this Court observed that their experience

was "not high on the scale of severity of harm done when compared to the general run of malicious and oppressive acts which make up the bulk of punitive damage cases." *Id.* The plaintiffs' business remained "in operation" and "survived the defendants' misdeeds." *Id.* This Court accordingly reduced the punitive damages award to a roughly 1:1 ratio with compensatory damages. *Id.*; *see also Bongiovi*, 122 Nev. at 583 (upholding punitive damages award at 1:1 ratio as "not excessive because it is both reasonable and proportionate to the amount of harm to [plaintiff] Sullivan and to the compensatory damages award").

As shown in the next section, this case bears none of the hallmarks of reprehensibility that courts cite to justify punitive awards exceeding a 1:1 ratio.

2. The Lack of "Reprehensibility" Here Compels Reduction of the Punitive Damages Award to No More Than the Compensatory Damages Award

Reprehensibility of a defendant's conduct is "[p]erhaps the most important indicium of the reasonableness of a punitive damages award." *BMW of North America v. Gore*, 517 U.S. 559, 575 (1996). Even if conduct "is sufficiently reprehensible to give rise to tort liability," including "even a modest award of exemplary damages," it

does not follow that such conduct necessarily represents "the high degree of culpability that warrants a *substantial* punitive damages award." *Id.* 517 U.S. at 580 (emphasis added). To the contrary, "[i]t should be presumed a plaintiff has been made whole for his injuries by compensatory damages, so punitive damages should only be awarded if the defendant's culpability, after having paid compensatory damages, is so reprehensible as to warrant the imposition of further sanctions to achieve punishment or deterrence." *State Farm*, 538 U.S. at 419.

In *Gore*, the U.S. Supreme Court identified five factors that courts should consider in evaluating the reprehensibility of a defendant's conduct. 517 U.S. at 576-80. Each factor strongly supports reducing the award in this case to an amount lower than a 1:1 ratio with compensatory damages.

The first is whether the harm suffered by the plaintiff is "purely economic in nature." 517 U.S. at 576. Economic harms are considered less reprehensible than threats to the "health or safety of others." *Bains LLC v. Acro Prods. Co.*, 405 F.3d 764, 775 (9th Cir. 2005). This case involves purely economic loss incurred by a highly sophisticated commercial entity. TeamHealth is one of the largest medical-staffing

companies in the nation, with vast experience negotiating network contracts and pursuing non-network reimbursements. The sole issue in the case is whether TeamHealth was underpaid for the services at issue—a purely economic loss to TeamHealth shareholders and Blackstone, the international private equity firm that purchased TeamHealth in 2017. *See* https://www.teamhealth.com/news-and-resources/press-release/blackstone/.

The second reprehensibility factor is whether the defendant's "conduct evinced . . . indifference to or reckless disregard for the health and safety of others." 517 U.S. at 576. As just shown, this is a case of only economic loss. Even if this giant medical staffing company was underpaid by $2.65 million, there was no competent evidence whatsoever that the underpayment affected doctor compensation or the quality of medical care in Nevada. TeamHealth adduced no evidence regarding *any* healthcare provider's compensation, let alone evidence that any doctor's compensation was reduced or that any emergency room in Nevada was forced to close due to the alleged underpayments. In fact, TeamHealth *actively and successfully opposed* United's efforts to discover and present evidence concerning the effect of reimbursement

rates on the compensation of its affiliated doctors. *See supra* Facts at C.3–4.

The third reprehensibility factor is whether TeamHealth was "financially vulnerable." 517 U.S. at 576. Obviously not. TeamHealth is not, for example, a family living paycheck-to-paycheck or a senior on a fixed income—the proper subjects of this factor. *Cf. Lompe v. Sunridge Partners, LLC*, 818 F.3d 1041, 1066 (10th Cir. 2016) (low-income college student was financially vulnerable). Nor did TeamHealth show that it was teetering on a financial precipice, uniquely exposed to financial exploitation. To the contrary, TeamHealth portrayed itself at trial as a well-heeled business champion capable of standing up to a large healthcare payer. (*See* 38App.9,295 ("do you think that a mom and pop operation with four, or five, or six doctors has the resources to take on UnitedHealthcare?"); 48App.11,777–78; 48App.11,783.)

The fourth reprehensibility factor is whether United "repeatedly engaged in prohibited conduct." *Gore*, 517 U.S. at 576. It did not. United merely disputed the reimbursements demanded by TeamHealth—amounts grossly higher than the "reasonable value"

found by the jury. Indeed, the jury apparently agreed that United was *right* to dispute TeamHealth's demand for full charges. Even if United should have allowed *more*, as the jury also found, that difference merely reflects the parties' baseline commercial disagreement over the required reimbursement rates.

The final reprehensibility factor is whether United's conduct involved "deliberate false statements, acts of affirmative misconduct, or concealment." 517 U.S. at 579. TeamHealth's SAC did not even assert a fraud cause of action or an insurer bad faith claim. Again, the case involved solely a commercial dispute over reimbursement for non-network services rendered to third parties, and United's position in that dispute was much closer to the jury's ultimate resolution than were the outlandish demands asserted by TeamHealth. And United's reimbursement rates were not concealed in any way—they were made in the open, fully subject to review and challenge by such a sophisticated and well-resourced commercial entity as TeamHealth.

All five *Gore* reprehensibility factors thus support only modest punitive damages, if any, and certainly an amount below a 1:1 ratio. In concluding otherwise, the district court cited *In Re USA Commercial*

Mortg. Co., 2013 WL 3944184 (D. Nevada 2013), but if anything, *USA Commercial* shows why large punitive damages are *not* justified here. That case involved a massive, interstate ponzi-scheme in which insider managers and brokers fraudulently induced thousands of financially vulnerable persons across the nation to invest hundreds of millions of dollars in fractionalized "direct lender" beneficial interests in what were falsely represented to be fully-secured, short-term commercial real estate loans to independent borrowers and guarantors. *Id.* at *1. A jury awarded plaintiffs $52,565.02 in compensatory damages and $850,000 in punitive damages. *Id.* at *2. The court affirmed the punitive damages award in part because defendants' tortious conduct was despicable, reprehensible, repeated, infused with intentional malice, trickery, and deceit, inflicted on individuals who were extremely financially vulnerable, and even evidenced indifference to their health, safety, and financial circumstances, since plaintiffs effectively stole income the elderly victims were counting on to pay for shelter and medicine. *See id.* at *25, *27.

None of those factors exists here. TeamHealth is not a financially vulnerable senior citizen who lost income required to survive. United

did not conceal its reimbursement allowances or otherwise deceive TeamHealth about its allowances. It did not engage in any tortious acts, much less repeated acts of crime like the fraudster in *USA Commercial*. In short, *USA Commercial* both exemplifies the kind of case for which substantial punitive damages are justified and confirms that this is not such a case. If punitive damages are available to TeamHealth at all, the award should be reduced to an amount below the $2.65 million compensatory damages award.

C. The Punitive Damages Award Is Subject to a Statutory Cap Because TeamHealth Did Not Assert a Cause of Action for Bad Faith Denial of an Insurance Claim

Apart from federal constitutional limitations, punitive damages in Nevada are *also* subject to an express statutory cap that the district court erroneously refused to apply.

When compensatory damages are $100,000 or more, punitive damages cannot exceed "[t]hree times the amount of compensatory damages awarded to the plaintiff," subject to specified exceptions. NRS 42.005(1)(a). When compensatory damages are less than $100,000, the award is limited to $300,000. NRS 42.005(1)(b).

The jury here awarded a total of $2.65 million in compensatory

damages to TeamHealth and $60 million in punitive damages. The punitive damages award far exceeded the statutory cap, whether viewed in the aggregate or on a plaintiff-by-plaintiff basis. In the aggregate, of course, the award vastly exceeds the permitted 3:1 ratio. Matters are even worse at a more granular level. In the most egregious example, the jury awarded plaintiff Ruby Crest just $281.49 in compensatory damages, but $4 million in punitive damages—a preposterous ratio of 14,210:1. (*See* 49App.12,038; 49App.12,152.) Given that the compensatory damages awarded to Ruby Crest were below $100,000, the statute capped any punitive damages for that plaintiff at $300,000. If the statutory cap is properly applied to each TeamHealth plaintiff's award, the total punitive damages award would be reduced to approximately $10.57 million. (*See* 50App.12,346.)

The district court refused to apply the statutory cap because it held that the award fell within an exception for "an action brought against . . . [a]n insurer who acts in bad faith regarding its obligation to provide insurance coverage." NRS 42.005(2)(b). But the exception plainly does not apply here.

TeamHealth did not bring an action against United as its

"insurer" for breach of any "obligation"—in "bad faith" or otherwise—"to provide insurance coverage" to TeamHealth. Indeed, several defendants did not provide insurance to anyone, much less TeamHealth. *See supra* Facts at A, II.C.2. TeamHealth did not and could not allege that United provided an insurance policy to TeamHealth, nor did it contend that United breached an obligation to provide insurance coverage to TeamHealth. The only parties insured by United entities were some sponsors of insured plans and the plan members. And as part of its tactical pleading to avoid ERISA preemption, TeamHealth expressly and repeatedly *disclaimed* any effort to establish that any United entity breached an obligation to plan members under any insured plan. *See, e.g.*, 6App.1,472–7App.1,516; 4App.763 n.7; 39App.9,555–57; 46App.11,307.

TeamHealth also expressly abandoned its bad-faith claim before trial. The statutory exception for "[b]ad faith regarding [an insurer's] obligation to provide insurance coverage" refers to a term of art in insurance law, *i.e.*, an independent tort claim against an insurer for bad faith denial of timely benefits. "Bad faith involves an actual or implied awareness of the absence of a reasonable basis for denying benefits of

the policy." *American Excess Ins. Co. v. MGM Grand Hotels, Inc.*, 102 Nev. 601, 605, 729 P.2d 1352, 1355 (1986). "To establish a prima facie case of bad-faith refusal to pay an insurance claim, the plaintiff must establish that the insurer had no reasonable basis for disputing coverage, and that the insurer knew or recklessly disregarded the fact that there was no reasonable basis for disputing coverage." *Powers v. United Services Auto Ass'n*, 114 Nev. 690, 702-03, 962 P.2d 596, 604 (1998).

None of those elements were involved here: United is not an "insurer" of TeamHealth, it did not dispute "coverage" for any plan members, and it certainly did not do so knowing that any such denial lacked a reasonable basis. Indeed, TeamHealth has thus far avoided ERISA preemption by insisting that it seeks only to enforce obligations "independent" of United's obligations under any insured health plans. *See infra* at V.

The district court accordingly erred in invoking the insurer bad-faith exception to the statutory punitive damages cap. If the punitive damages award is not reversed in its entirety, or reduced to an amount below a 1:1 ratio in accordance with due process limitations, it must at

least be reduced to no more than $10.57 million under NRS 42.005(1)(a)-(b). (50App.12,346.)

IV.

THE DISTRICT COURT ERRED IN AWARDING PENALTY PREJUDGMENT INTEREST AND ATTORNEYS' FEES

TeamHealth's causes of action each asserted that United failed to allow its full billed charges, but TeamHealth affirmatively admitted that there were no delays in the payments that United did allow. (46App.11,346.) The district court nevertheless held that United violated Nevada's Prompt Pay Act ("PPA"),[20] awarding TeamHealth two remedies that the PPA authorizes for prevailing parties: (1) a penalty rate for prejudgment interest, resulting in $800,000 in prejudgment interest, and (2) attorneys' fees, in the amount of $12 million.[21]

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[20] The PPA is codified in various statutes, corresponding to the type of entity and/or health plan being regulated. NRS 683A.0879 (administrators); NRS 689A.410 (insurers and individual health insurance); NRS 689B.255 (insurers and group health insurance); NRS 695C.185 (health maintenance organization); NRS 689C.335 (formerly NRS 689C.485, carrier serving small employers). They are otherwise identical and use the same subsection numbers. For ease of reference, this brief cites the PPA simply as "PPA(#)."

[21] The order approving attorneys' fees makes passing reference to

The judgment on the PPA claim is wrong as a matter of law for multiple reasons. First, the PPA applies only to payments for coverage under health insurance policies or healthcare plans, and TeamHealth itself insisted that its reimbursement claims did not relate to either health insurance coverage or a health care plan. If they do, ERISA preempts them. Second, a PPA claim first must be filed before and resolved by the insurance commissioner, and TeamHealth did not exhaust that remedy. Third, the PPA does not apply because TeamHealth admittedly *did* receive prompt payment on all amounts allowed by United under the applicable health plans. Its only argument is about the *amount* allowed, which is not what the PPA regulates.

A. The PPA Either Does Not Apply or Is Preempted By ERISA

The PPA addresses only benefit claims that "relat[e] to health insurance coverage [or] a health care plan." PPA(1). From the very start—indeed to avoid dismissal of its case on the pleadings—TeamHealth insisted that it was "not seeking to recover against

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NRS 18.010(1), but the PPA was the only asserted basis for the fee award.

[United] for any claims arising under the[] [plans] with their insureds" and that its legal claims "have no connection to" the plans or coverage under them. (4App.763 n.7.) TeamHealth likewise avoided removal of the case by arguing that its causes of action were "not derivative or dependent upon the terms of any particular patient's [plan] in any way." 1.App.111; *see also* 21App.5,247 n.1 (plaintiffs "do not assert claims that are dependent on the existence of an assignment . . . from any [insured]"). By TeamHealth's own account, then, its causes of action do *not* "relate to" the plans or United's approval of member benefit claims made under them, as required for PPA liability. Because those statements were the principal basis for critical rulings in TeamHealth's favor—*i.e.*, avoiding both dismissal and removal—it is judicially estopped from now taking the "totally inconsistent" position that its case *does* relate to benefit claims under healthcare plans and health insurance policies. *S. Cal. Edison v. First Judicial Dist. Ct. of Nv.*, 127 Nev. 276, 285-86, 255 P.3d 231, 237 (2011).

Any such argument would fail in any event, because it would compel preemption of TeamHealth's entire case under ERISA, which "supersede[s] any and all State laws insofar as they may now or

hereafter relate to any employee benefit plan," 29 U.S.C. § 1144(a); *see infra* at V. At a minimum, "any determination of whether the Prompt Pay Act was complied with necessarily involves deciding whether the claim is covered by the plan—a classic instance of ERISA preemption." *Liberty Wellness Chiropractic v. Empire Healthchoice HMO, Inc.*, 2023 WL 1927828, at *7-8 (S.D.N.Y. Feb. 10, 2023); *see Norman Maurice Rowe, M.D., M.H.A., L.L.C. v. Oxford Health Ins. Co., Inc.*, 77 Misc. 3d 958, 962–63 (N.Y. Sup. Ct. 2022) ("Prompt Pay claims are also expressly pre-empted by ERISA.").

B. TeamHealth Failed to Exhaust Its Administrative Remedies

TeamHealth also failed to exhaust its mandatory pre-suit administrative PPA remedies, precluding any judicial resolution of its PPA claims.

The "exhaustion doctrine gives administrative agencies an opportunity to correct mistakes and conserve judicial resources, so its purpose is valuable; requiring exhaustion of administrative remedies often resolves disputes without the need for judicial involvement." *Allstate Ins. Co. v. Thorpe*, 123 Nev. 565, 571-72, 170 P.3d 989, 993-94

(2007). The failure to exhaust administrative remedies—especially those not just permitted, but mandated—"renders the controversy nonjusticiable." *Id*. at 571, 170 P.3d at 993.

That rule applies here and precludes judgment on the PPA claim. This Court held in *Thorpe* that the Insurance Commissioner "has exclusive jurisdiction to enforce [a] prompt-pay statute's provisions and that any person having a pecuniary interest in the statute's enforcement is restricted to seeking administrative relief." 123 Nev. at 571, 170 P.3d at 993. The exhaustion requirement arises from the Insurance Code—where the PPA appears—which established an administrative process that claimants must pursue before filing suit in court. NRS 679A.010. Absent an express provision granting a private right of action (and thereby conferring original jurisdiction on the courts), the Code grants the Insurance Commissioner "exclusive jurisdiction" by default. NRS 686A.015(1). In other words, "the insurance commissioner alone has authority to enforce the insurance code" in the first instance. *Joseph v. Hartford Fire Ins. Co.*, 2014 WL 2741063, at *2 (D. Nev. June 17, 2014). Because nothing in the PPA expressly confers original jurisdiction on courts to adjudicate PPA

violations, the Insurance Commissioner has exclusive original jurisdiction over PPA violations, as this Court held in *Thorpe*.

The Code empowers the Commissioner to exercise that jurisdiction by holding hearings for any purpose within the scope of the Insurance Code. *Thorpe*, 123 Nev. at 572, 170 P.3d at 994. The Code authorizes the Commissioner to "require" a regulated entity "to provide evidence which demonstrates that the [entity] has substantially complied with the [PPA's] requirements," PPA(7), and it empowers the Commissioner to make "determination[s]" regarding a regulated entity's "compliance" with the PPA, PPA(8). It is only after—and if—a party is "aggrieved" by the Commissioner's ruling that the party has a "right to seek judicial review" of the ruling, "in the manner provided by the Nevada Administrative Procedure Act.'" *Id*. (cleaned up). Absent a decision by the Commissioner on an administrative claim, then, there is nothing for a court to review, as *Thorpe* correctly held.

The district court, however, declined to follow *Thorpe* on the ground that, unlike the prompt-pay statute at issue there, the PPA includes a provision stating that the "court shall award costs and reasonable attorney's fees to the prevailing party in an action brought

pursuant to this section." PPA(5). According to the district court, that judicial remedies provision implicitly confers original jurisdiction on courts. It plainly does not. The provision on its face describes only the remedial authority of a court in an "action brought pursuant to this section." And as just shown, an action may be brought "pursuant to" the PPA only for review of a claim *first* filed with, and resolved by, the Insurance Commissioner. The judicial remedies provision simply grants the *reviewing* court authority to award costs and fees to the party that prevails on review; it does not *sub silento* override the entire administrative-claims structure and grant courts power to adjudicate cases for themselves in the first instance.

This point is further confirmed by *Thorpe*'s reliance on *City of Henderson v. Kilgore*, 122 Nev. 331, 131 P.3d 11 (2006). *See Thorpe*, 123 Nev. at 571 & n.14, 170 P.3d at 993 & n.14. The statute in *Henderson* contemplated both agency action and certain court-specific remedies, just like the PPA. 122 Nev. at 335-36, 131 P.3d at 14-15 (interpreting NRS 288.110(3)). This Court held that a claimant's failure to exhaust administrative remedies precluded application of the

statute's judicial remedies. The same analysis applies here, confirming that *Thorpe*'s exhaustion mandate applies to the PPA.

This Court's decision in *Neville v. Eighth Judicial District Court*, 133 Nev. 777, 406 P.3d 499 (2017), confirms the same point from the converse perspective. The Court in *Neville* recognized an implied private cause of action in a statute that also provided for administrative remedies, but the statute's language there shows why the PPA's attorneys' fees provision here does *not* implicitly create a private judicial cause of action. The statute in *Neville* provided for an attorneys' fees award when an employee has "cause to bring *suit*" and prevails "by *decision of the court* or *verdict of the jury*," stating further that fees may be awarded by the "court before which the case shall be *tried*." 133 Nev. at 781, 406 P.3d at 503 (quoting NRS 608.140; emphases added). The underscored references to "suit" and "verdict of the jury" and to a case that is "tried" make sense collectively only for *judicial* actions, where trials and verdicts occur. The judicial remedies provision of the PPA includes no such language. Rather, the PPA provision makes complete, coherent sense as simply authorizing a *reviewing* court to award fees to the party that prevails *on review*. The

provision cannot be reasonably read as silently overriding the requirement of initial review by the Commissioner.

C. The PPA Judgment Cannot Stand Because the Approved and Fully Payable Portions of the Disputed Benefit Claims Were Timely Paid

The PPA is solely focused on *timing*: an insurer has 30 days to approve a benefit claim and, if it does so, 30 days to pay the claim. PPA(1). The PPA also provides that the regulated entity "shall not pay only part of a claim that has been approved and is fully payable." PPA(4). In other words, the insurer must pay an approved claim in its full *approved amount*. The PPA on its face does not apply when the insurer approved *part* of a claim for payment and paid *that amount*. The remainder of the amount may be subject to dispute on its merits, but it is not subject to a PPA dispute about timing, because the statute solely "regulates *how quickly* an insurer must pay," not "*how much* an insurer must pay." *Em. Dep't Physicians P.C. v. United Healthcare, Inc.*, 507 F. Supp. 3d 814, 824-27 (E.D. Mich. 2020) (addressing similar statute) (emphasis in original)). A contrary reading would be absurd because, as demonstrated by the verdict here, not even TeamHealth correctly predicted the amount within the statutory 30 days; up through

trial, it was demanding payment to which it was not entitled.

The court in *Emergency Department* rejected a TeamHealth prompt-pay cause of action under a similar Michigan statute and similar circumstances. 507 F. Supp. 3d at 824-27. Like Nevada, even though the prompt-pay statute already existed, Michigan enacted a *new* statute (a "surprise medical billing" law) to "regulate *how much* an insurer must pay" for certain categories of health benefit claims. *Id.* at 825 (emphasis in original); *see supra* at n. 3 (explaining Nevada's Surprise Billing Act). In the court's view, the sequence of enactments confirmed that the preexisting prompt-pay act did not encompass substantive challenges to the *amount owed*, because if it did, the Legislature had no need to enact a new statute addressing the same subject. 507 F. Supp. 3d at 825.

The Nevada PPA's legislative history underscores the point. During hearings on the act, witnesses assured the Legislature that the PPA would *not* prohibit a regulated entity from approving and paying only the approved portion of a claim:

- "The language in the bill indicated when a portion of a claim was approved, that part should be paid," according to Nevada State Medical Association's representative. Hearing on S.B. 145 Before

the Assembly Comm. on Commerce and Labor, 70th Leg. Session (April 28, 1999) ("when a portion of a claim was approved that portion was owed," and that "the language required [the approved] portion to be paid" when only a portion of a claim was approved to be paid).

- Regarding "whether the wording [of the PPA] would allow for payment of an undisputed portion of a claim prior to resolution of the issues associated with the balance of the claim," a former member of the commissioner advisory committee answered "a company could pay the undisputed part of a claim and place a hold payment on the disputed portion of the claim until the disputed part had been resolved." Hearing on S.B. 145 Before the Assembly Comm. on Commerce and Labor, 70th Leg. Session (May 12, 1999).

That testimony confirms what the PPA's plain language already says: the statute does not apply when a regulated entity approves and timely pays part of a claim, but contests the remainder of the claim. United accordingly is entitled to judgment on the PPA claim.

V.

TEAMHEALTH'S LEGAL CLAIMS ARE ALL PREEMPTED BY ERISA

United submits that TeamHealth's entire case is preempted by ERISA, foreclosing any need for the analyses already discussed. United asserts this argument last only because this Court already considered the argument preliminarily on United's petition for interlocutory review and suggested that despite ERISA's broad preemptive force,

TeamHealth had "alleged" its "own implied-in-fact contract with United establishing a rate of payment, separate from any assignments from health plan members or right to benefits from United," and that the alleged contract—if proven—would establish "a relationship and claim not directly 'relating to' ERISA." Dkt. No. 81680, Order Denying Petition, Doc. No. 21-18915, filed July 1, 2021, at 3. Given that preliminary determination, United has principally addressed that alleged "separate" implied-in-fact contract on its own terms, along with other "independent" claims asserted by TeamHealth under Nevada law. But United respectfully submits that, properly analyzed, TeamHealth's causes of action are *not*, in fact, independent of the health plans that United insures or administers, and thus can only proceed as a claim for plan benefits under ERISA itself.

A. ERISA Preempts State-Law Claims That Relate to Employee Benefit Plans or Seek to Enforce Plan Rights and Obligations

"The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). With comprehensive regulation comes broad remedies and penalties. *Id.* (citing 29 U.S.C. § 1001(b)); *see* 29 U.S.C. §§ 1131-35.

Congress ensured uniform nationwide regulation of benefit plans in two ways. First, Congress made civil enforcement provisions set forth in ERISA § 502(a), 29 U.S.C. § 1132(a), "the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits." *Pilot Life*, 481 U.S. at 52. Accordingly, when a state-law cause of action "duplicates, supplements, or supplants the ERISA civil enforcement remedy," the claim is "completely preempted" and may proceed only as an ERISA claim and only in federal court. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004).

Second, when a state-law claim "relates to" an ERISA-governed plan, the claim is preempted and cannot proceed. 29 U.S.C. § 1144(a) (ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan"). A state law "relates to an ERISA plan" within the meaning of this provision "if it has a connection with or reference to such a plan." *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (quotation omitted). A state-law claim in turn has an impermissible "connection with" an ERISA plan when the claim seeks to govern "a central matter of plan administration" or "interferes

with nationally uniform plan administration," or when "acute, albeit indirect, economic effects of the state law force an ERISA plan to adopt a certain scheme of substantive coverage." *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 319–20 (2016) (quoting *Egelhoff*, 532 U.S. at 148). Alternatively, state law makes "reference to" an ERISA plan when it "acts immediately and exclusively upon" ERISA plans, or "where the existence of ERISA plans is essential to the law's operation." *Id.* (quoting *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997)). These principles apply not only to statutes, but also to state common-law claims that relate to ERISA-governed plans in the same way. *See Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 57 (1987); *Aetna Life Insurance Co. v. Bayona*, 223 F.3d 1030, 1034 (9th Cir. 2000).

Decisions of the U.S. Supreme Court addressing "relates to" preemption help delineate the rule's scope. In *Gobeille*, the Court found an impermissible connection with ERISA plans in a Vermont statute requiring health insurers, including ERISA plans, "to report detailed information about the administration of benefits," which was "a fundamental ERISA function." 577 U.S. at 325. In *Shaw v. Delta Air*

Lines, 463 U.S. 85 (1983), the Court held that a generally applicable anti-discrimination statute was preempted because it required ERISA plans to pay specific benefits not required under federal law. *Id.* at 106-09. By contrast, the Court found no preemption of a New York statute that imposed surcharges on hospital patients not covered by insurance because it only "indirectly" affected plans by changing the economics of their coverage decisions, but did not "bind plan administrators to any particular choice." *Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 659-60 (1995). Similarly, the Court found no preemption of an Arkansas statute requiring pharmacy benefit managers "to reimburse pharmacies at or above their acquisition costs" because it did "not require plans to provide any particular benefit to any particular beneficiary in any particular way." *Rutledge v. Pharm. Care Mgmt. Ass'n*, 141 S. Ct. 474, 482 (2020).

B. TeamHealth's Causes of Action "Relate To" ERISA-Governed Plans and Effectively Challenge United's Plan Administration Activities

Each of TeamHealth's four causes of action is preempted under ERISA §§ 514(a) and 502(a).

This Court has already held that UCPA claims are preempted

because they impose obligations on ERISA-governed plans:

> We add Nevada's voice to the growing body of case law holding state unfair insurance practice claims to be preempted by ERISA and conclude that Chapter 686A of the Nevada Insurance Code is preempted by ERISA when applied to a valid ERISA plan.

Villescas v. CNA Ins. Cos., 109 Nev. 1075, 1084, 864 P.2d 288, 294 (1993); *see Estate of Burgard v. Bank of Am.*, N.A., 2:15-CV-00833-RFB-PAL, 2017 WL 1273869, at *9 (D. Nev. Mar. 31, 2017) (reaffirming *Villescas* as applied to UCPA and bad faith claims); *Brandner v. UNUM Life Ins. Co. of Am.*, 152 F. Supp. 2d 1219, 1228 (D. Nev. 2001) (collecting cases).

The same logic applies to TeamHealth's PPA claims, which likewise would impose a payment obligation on ERISA governed benefit plans. If the PPA applies at all, it would only be because United had "approved" a benefit claim pursuant to the relevant ERISA plan. *E.g.*, NRS 689B.255(1). Accordingly, there "simply is no cause of action if there is no plan," and thus the cause of action is preempted. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990). Courts have held that a similar statute in New York—requiring prompt payment of benefit claims where the obligation to pay is "reasonably clear"—in

effect creates a cause of action "to recover for monies owed pursuant to [an ERISA plan]" and is therefore preempted. *Neurological Surgery, P.C. v. Siemens Corp.*, 2017 WL 6397737, at *5-6 (E.D.N.Y. Dec. 12, 2017) (collecting cases); *see Norman Maurice Rowe, M.D., M.H.A., L.L.C. v. Oxford Health Ins. Co., Inc.*, 77 Misc. 3d 958, 962-63 (N.Y. Sup. Ct. 2022). The Fifth Circuit likewise found that ERISA preempted the Texas PPA. *N. Cypress Med. Ctr. Operating Co., Ltd. v. Cigna Healthcare*, 781 F.3d 182, 201 (5th Cir. 2015). There is no basis for a different result in Nevada.

TeamHealth's implied-in-fact contract and unjust enrichment claims also are preempted. This Court preliminarily concluded otherwise as to the implied-in-fact contract claim, at least as alleged by TeamHealth, *see supra* Facts at C.2, but subsequent proceedings clearly revealed the extent to which all of TeamHealth's causes of action were intertwined with United's plan obligations and benefit-processing activities.

Common-law claims are preempted by ERISA not only when they "contradict written ERISA plan provisions," but also when they "would, as a practical matter, result in an amendment or modification of a

plan." *Wong v. Flynn-Kerper*, 999 F.3d 1205, 1207 (9th Cir. 2021); *see Blau v. Del Monte Corp.*, 748 F.2d 1348, 1356–57 (9th Cir. 1984), *abrogated on other grounds in Dytrt v. Mountain States Tel. & Tel. Co.*, 921 F.2d 889, 894 n.4 (9th Cir. 1990); *Lafferty v. Solar Turbines Int'l*, 666 F.2d 408, 409 (9th Cir. 1982); *Dependahl v. Falstaff Brewing Corp.*, 653 F.2d 1208, 1215-16 (8th Cir. 1981).[22] As TeamHealth argued the implied-in-fact contract and unjust enrichment claims at trial, those causes of action plainly sought to alter United's plan obligations and benefit-processing conduct both directly and in practical effect.

As shown above in the discussion of the legal claims on their merits, both required TeamHealth to establish that it conferred a benefit on United by "discharging" (fully or in part) its obligations to plan members. *See supra* at II.A–B; *see also Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co.*, 967 F.3d 218, 241-42 (3d Cir. 2020) (unjust enrichment claim requires proof that healthcare provider conferred

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[22] *Wong* involved a federal common-law estoppel claim, but its reasoning about the effect of the claim on plan terms shows why state-law claims with the same effect necessarily relate to the plan. The other cited cases all hold that ERISA § 514 preempts state common-law claims that would alter plan obligations.

benefit on health insurer by discharging its plan obligations). Those obligations, of course, exist only because of the plans and they are defined solely by the plans' terms. And if TeamHealth's conduct wholly or partially discharged United's plan obligations, then it necessarily either altered the plan terms specifying United's duties, or relieved United of its duty to perform under the plan. Either way, the direct connection between TeamHealth's legal claims and United's plan obligations is inescapable. *See Norman Maurice Rowe, M.D., M.H.A., L.L.C. v. Oxford Health Ins. Co., Inc.*, 77 Misc. 3d 958, 962 (N.Y. Sup. Ct. 2022) (holding that non-network provider's claims for breach of independent contract, unjust enrichment, and estoppel were preempted because "the only way to determine whether [the provider's] claims were administered properly is to review the terms of the governing ERISA Plan").

The interference with United's administrative duties is not just implicit; the clash between those duties and the final judgments entered below is quite explicit. For example, the plan documents prescribe certain specific duties with respect to non-network services, including instructing the administrator to exclusively use specific methodologies

for reimbursing out-of-network benefit claims (142App.35,264–143App.35,445; 37App.9,058–63, 9069–70), and in some instances, dictating a specific out-of-network reimbursement rate (40App.9,961–62.) For example, the Wal-Mart benefit plan required United to reimburse non-network claims at 125% of Medicare, yet the jury verdict would compel the plan to increase reimbursements to more than 300% of Medicare. 76App.18,914; 37App.9,044–50. The judgment thus flatly overrides the terms of the Wal-Mart plan and any other plan similarly requiring reimbursement at rates lower than the judgment compels. The judgment thereby contravenes such plans' efforts to control costs of non-network services—costs that are inevitably passed through to the plan's beneficiaries, either as direct charges for services or as reduced plan benefits.

The judgments obstruct the performance of other administrative duties as well. For example, HPN and SHL specifically structured their benefit claims processing systems to reimburse providers in accordance with plan requirements, not in accordance with providers' unilateral demands. (40App.9,967.) Compliance with the reimbursements required by the judgment would require these entities to reconfigure

their plan administrative systems, imposing undesired costs on sponsors and ultimately plan beneficiaries. (40App.9,960–62, 9,966–67, 9,969; 41App.10,018–19, 10,021–23.) The judgment's direct interference with plan administrative functions confirms the judgment's impermissible connection with ERISA plans.

Finally, that connection is sharply underscored by the unjustified and highly prejudicial spoliation instruction United suffered at trial. As discussed above, that instruction was based on United's failure to fully produce all the health plan documents for the thousands of plans put at issue in TeamHealth's benefit claims. *See supra* at I.B. It is impossible for TeamHealth to defend that instruction while simultaneously asserting that its legal claims had no connection with the very plan documents that provoked the instruction.

As tried by TeamHealth, in short, its causes of action were not solely about establishing its independent "right to payment" disconnected from the plans themselves, as TeamHealth has previously argued to avoid ERISA preemption. The trial was *all about* the health plans, including both the duties and restrictions they imposed on United. Trial thus confirmed that TeamHealth's causes of action had a

clear—and clearly impermissible—connection with the United-ERISA-governed plans. They are accordingly preempted.

C. ERISA's Insurance "Savings Clause" Does Not Save TeamHealth's Legal Claims From Preemption

TeamHealth cannot avoid preemption of its state-law claims by invoking ERISA's "saving clause," which provides that § 514(a)'s express "relates to" preemption clause does not apply to "any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(a). The savings clause itself is conditioned by a clawback "deemer" clause, which provides that an ERISA-governed employee benefit plan itself cannot be "deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts." *Id.* § 1144(b)(2)(B). Given the deemer clause, TeamHealth has no plausible argument that its state-law claims are saved from preemption as to self-funded plans for which United serves as a TPA. In that situation, the state-law claims act directly on the plan itself: they explicitly increase reimbursements the plan itself must make and they functionally alter the terms that govern United's administrative

operations.

TeamHealth's state-law claims involving insured plans are preempted as well. When a state-law claim "seeks remedies for the improper processing of a claim for benefits under an ERISA-regulated plan," the savings clause does not apply at all, because ERISA *separately* makes its remedies for improper claims-processing "exclusive" of all competing state remedies, even if they are otherwise laws that "regulate insurance." *Pilot Life*, 418 U.S. at 52; *see Davila*, 542 U.S. at 217-18 ("even a state law that can arguably be characterized as 'regulating insurance' will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme").

For the reasons already discussed, TeamHealth's state-law causes of action cannot be disentangled from the health plans that United insured and administered: they explicitly challenge the manner in which United administered benefits under the plan, and seek to challenge—and change—the manner in which United processes non-network benefits under those plans. Because TeamHealth's causes of action would impose liability for United's performance of claims-

processing and other administrative functions that "are central to, and an essential part of, the uniform system of plan administration contemplated by ERISA," *Gobeille*, 577 U.S. at 323, the claims "pose an obstacle to the purposes and objectives of Congress" and thus are not subject to the saving clause, *Davila*, 542 U.S. at 217 (quoting *Pilot Life*, 481 U.S. at 52).

VI.

TEAMHEALTH SHOULD BE ENJOINED FROM DISCLOSING UNITED'S CONFIDENTIAL INFORMATION

United previously filed a petition for a writ of mandamus challenging the district court's failure to enjoin TeamHealth from disclosing United's highly confidential information. That proceeding, Docket No. 85656, has been consolidated with this proceeding for briefing and argument by Order No. 23-9597. Pursuant to that Order, United hereby incorporates by reference pages 30-65 of its Mandamus Petition, which set forth the reasons the district court erred in declining to enjoin disclosure of the information at issue.

CONCLUSION

For the foregoing reasons, the judgment should be reversed. The case should be remanded for entry of judgment for United, or in the alternative for a new trial. TeamHealth also should be enjoined from publishing the confidential documents addressed in Docket 85656.

Dated this 18th day of April, 2023.

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CERTIFICATE OF COMPLIANCE

1. I certify that this brief complies with the formatting, typeface, and type-style requirements of NRAP 32(a)(4)–(6) because it was prepared in Microsoft Word 2010 with a proportionally spaced typeface in 14-point, double-spaced Century Schoolbook font.

2. I certify that this brief exceeds the type-volume limitations of NRAP 32(a)(7) because, except as exempted by NRAP 32(a)(7)(C), it contains 31,311 words.

3. I certify that I have read this brief, that it is not frivolous or interposed for any improper purpose, and that it complies with all applicable rules of appellate procedure, including NRAP 28(e). I understand that if it does not, I may be subject to sanctions.

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RULE 28(f) ADDENDUM OF STATE COURT DECISIONS

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Prepared by the Court

ATLANTIC ER PHYSICIANS, PA, *et al*	:	Superior Court of New Jersey
Plaintiff	:	Law Division- Gloucester County
v.	:	
	:	CIVIL ACTION
UNITEDHEALTH GROUP, INC.,	:	Docket No. GLO-L-1196-20 (CBLP)
UNITEDHEALTHCARE INS. CO., *et al*	:	
And MULTIPLAN, INC.	:	**Memorandum of Decision**
Defendants	:	

These motions to dismiss under R. 4:6-2(e), arise from an action filed by plaintiffs, “NJ Team Health”, who are emergency room physicians groups from all over the State who generally complain about out-of-network reimbursement rates from the defendants, who are health insurers and third-party administrators of employee health benefit plans.

More specifically, Team Health is a large emergency room staffing, billing and collections company that operates throughout the United States. They provide outsourced emergency medicine services on a national scale, and operate as many as 3,400 emergency medical facilities, employing approximately 19,000 people. Defendants are health insurers and third-party administrators who operate the largest health insurance carrier in the United States. These are primarily employee health benefit plans. Most healthcare providers enter into agreements (“network agreements”)

with health insurers and third-party administrators which specify how much the health plan will reimburse the provider for medical services rendered to their covered insureds. Healthcare services provided without any contractual agreement specifying a providers' reimbursement rates are "out-of-network", and the benefit amount is governed by the applicable heath benefit plan of which the patient is enrolled.

With regard to the instant action, until May 2020, Team Health plaintiffs allege their relationship with the defendant was controlled by a written contract in which they agreed to accept a certain negotiated amount for the health care services they provided to the defendants' insureds. It is alleged that around 2018, the United defendants unilaterally decided to substantially reduce reimbursement rates for plaintiffs' out-of-network services. In May 2020, United began implementing that plan against plaintiffs by terminating the express written agreements between the parties and thereafter began paying substantially less than what was previously agreed and substantially less than the reasonable value of the services plaintiffs provide. After May 2020, defendants contracted with defendant, Multiplan, Inc. to determine this out-of-network payment. Multiplan promotes itself as an unregulated cost management company that offers "cost control" through a program known as Data iSight. Multiplan claims the Data iSight program determines a reasonable reimbursement rate for health care services by applying a proprietary formula to the submitted claims. It is alleged that Multiplan receives a share of the fees an insurance company earns from adjudicating a health care provider's claim for less than the amount the provider charged.

This case involves 27,000 disputed claims for emergency services provided by plaintiffs to United members during the period from May 15, 2020, to December 31,

2021. As emergency medicine providers, the plaintiffs are required by law to treat and stabilize patients who present to the emergency room regardless of insurance coverage. The plaintiffs rely upon commercial insurance companies to pay a reasonable rate for the critical health care services provided. Plaintiffs allege that United and Multiplan conspired together to deny plaintiffs their billed amounts for medical services relying upon Multiplan's payment methodology. Plaintiffs contend that Multiplan's publicly stated claims process is based upon rational and accepted data is a fraud. Plaintiffs insist that United dictates the rates to be paid and uses Multiplan as a cover for this fraud. Plaintiffs contend that United and Multiplan reap huge profits at the expense of the plaintiffs. Plaintiff are suing to recover the reasonable value of their services over what was paid on these 27,000 claims. The plaintiffs' Second Amended Complaint sues the defendants alleging five separate causes of action- Count One- Breach of Implied-in Fact Contract; Count Two- Quantum Meruit; Count Three- Violation of New Jersey Health Claims Authorization, Processing and Payment Act ("HCPPA") (the first three counts are directed to defendants United, only); Counts Four and Five allege RICO violations and conspiracies as to both defendants. This similar litigation has been advanced in 6 or 7 other states to date.

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STANDARD OF REVIEW

Under R. 4:6-2(e), a motion to dismiss for failure to state a claim must be denied if, giving plaintiff the benefit of all the allegations asserted in the pleadings and all favorable inferences, a claim has been established. Grillo v. State, 469 N.J. Super. 267 (App. Div. 2021). The test for determining the adequacy of the pleading is whether a

cause of action is suggested by the facts. Motions to dismiss should be granted in only the rarest of instances. *See,* Printing Mart v. Sharp Elec. Corp., 116 N.J. 739 (1989).

ERISA PREEMPTION

This matter was originally filed on November 2, 2020, and defendants removed to the United States District Court, District of New Jersey. On February 17, 2021, plaintiffs filed a motion to remand this lawsuit from the District Court. On March 30, 2022, United States District Court Judge Renee Marie Bumb entered an Order that states in pertinent part, "unless and until there is clearly established precedent, if United Defendants argue for federal subject matter jurisdiction in the future based upon ERISA preemption, they must disclose to the court the caselaw that cuts against their legal arguments. United Defendants should lay out that federal district courts in New Jersey, Pennsylvania, Nevada, Arizona, Florida and perhaps elsewhere have denied their arguments for ERISA preemption." When pressed at oral argument, plaintiffs' counsel conceded that no court has found ERISA preemption in this matter.

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ERISA was passed by Congress in 1974 to address "mismanagement of funds accumulated to finance employee benefits. ERISA does not guarantee benefits. The statute seeks to make the benefits promised by an employer more secure by mandating certain oversight systems and other standard procedures. Gobeille v. Liberty Mut. Ins. Co., 136 S.Ct. 936, 946 (2016). ERISA was created to ensure employee benefit plans would be subject to a uniform nationwide regulatory scheme, and not a patchwork of inconsistent state regulations. To that end, ERISA includes "expansive pre-emption

provisions" to ensure that the regulation of employee benefit plans remain "exclusively a federal concern". Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004). There are two preemption types. Complete preemption under Section 1132(a), which is jurisdictional in nature. This preemption was rejected by Judge Bumb. The other form of preemption is conflict preemption under Section 514(a). this section expressly preempts state action and state law claims that "relate to" an ERISA plan. United Defendants argue that plaintiffs' claims relate to ERISA-governed health benefit plans and therefore must be dismissed with prejudice as conflict preempted.

A common law claim "relates to" an employee benefit plan governed by ERISA "if it has a connection with or reference to such a plan". Providence Health Plan v. McDowell, 385 F.3d 1168, 1172 (9th Cir. 2004). At this stage of the proceeding, the court finds that plaintiffs' state law claims relate solely to the rate of reimbursement, not the right of reimbursement. Each of the 27,000 claims at issue here have been paid by the defendants. Plaintiffs are not disputing the right to coverage under the plan rather they plead that the United defendants did not pay the reasonable value of the emergency services or they were underpaid for these services. Plaintiffs cite the U.S. Supreme Court case of Rutledge v. Pharm. Care Mgmt. Ass'n, 141 S.Ct. 474 (2020) as support for their position. As stated therein, "[C]rucially, not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan. That is especially so if a law merely affects costs." Id. at 480. Continuing, the Court says "ERISA does not preempt state rate regulations that merely increase costs..". At this stage, the court finds plaintiffs' arguments persuasive. As plaintiffs' state in their brief, they seek to hold United to its

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obligation to pay a reasonable value for the benefits United has already agreed to pay out. Plaintiff allegations do not implicate coverage determinations or plan administration requirements. Plaintiffs allege that they are entitled to the "reasonable value" of their services under applicable state law- not an ERISA plan. ERISA's goals of protecting participants and beneficiaries of employee benefits plans are not altered by plaintiffs claims.

Defendants request to dismiss for 514(a) preemption is denied.

DEFENDANTS CLAIM THAT PLAINTIFF CASE SHOULD BE DISMISSED BY THE ARBITRATION PROCESS ENACTED IN N.J.S. 26:2SS-1

In 2018, the New Jersey Legislature passed the "Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act (the "Act"). Defendants claim that plaintiffs must arbitrate any claims decision at issue in this case under the process outlined in Sections 9,10 and 11 of the Act. This argument is without merit. The Act's definitions under Section 3 specifically exclude self-funded plans unless the self-funded plan elects to be subject to the provisions of the Act. United defendants claim they are self-funded plans in their argument regarding preemption and have not provided any proof that they have opted-in to this statutory scheme. This basis alone precludes dismissal of plaintiffs' complaint.

COUNT ONE- BREACH OF IMPLIED-IN-FACT CONTRACT

United defendants seek dismissal of Count One of the Second Amended Complaint that alleges breach of an implied-in-fact contract. Plaintiffs' complaint alleges that prior to May 2020, the parties had a written contract for the reimbursement rates to be paid for out-of-network emergency health care services. They allege in paragraph 3 that in 2017 to 2018, "United concluded it could make more money by paying Plaintiffs and other emergency room doctors less, so United embarked on a scheme to do just that." In paragraph 28 through 31, it is alleged that United terminated the express written agreement in place to pursue greater profits by substantially reducing reimbursement rates it provided plaintiffs. The complaint says that United cut reimbursement rates to less than half what United had paid in the past pursuant to its previous contract. The plaintiffs now sue for recovery of the difference between what they bill versus what they were paid.

The essential feature of an implied-in-fact contract cause of action is that the asserted contractual obligation must have arisen from mutual agreement and intent to promise but where no written agreement is in place. However, the facts as pleaded decisively refute the existence of such agreement. To prevail on a breach of contract action, whether written or implied, a plaintiff must be able to prove all of the necessary terms of the contract. Here, the Second Amended Complaint could not be clearer that the parties were not in agreement as benefit amount the defendants would pay for the plaintiffs' services. Plaintiffs want the amount billed, as they contend it is a reasonable amount as to the value of their services. Defendants, however, paid a different amount- an amount they say is appropriate according to the Data iSight methodology. This

essential term- price is in no way an agreed upon term in this implied contract. Certainly, the court agrees that many of the other factors are in place, i.e. the agreement to provide out-of-network emergency services to the plan members and the expectation that the providers would be paid. But price is the element that does not exist in this arrangement. Plaintiffs specifically plead defendants terminated the contract in place prior to May 2020 because defendants did not want to pay the agreed upon rates. This undermines this cause of action.

Count One of plaintiffs' complaint is dismissed for failing to state a cause of action as plead.

COUNT TWO- QUANTUM MERUIT

In order to recover on a claim for the quasi-contractual theory of quantum meruit, a plaintiff must establish four elements: (1) the performance of services in good faith; (2) the acceptance of services by the person to whom they are rendered; (3) an expectation of compensation therefore; and (4) the reasonable value of the services. Sean Wood LLC v. Hegarty Group, 422 N.J. Super. 500, 513 (App. Div. 2011). "Quasi-contractual recovery on the basis of quantum meruit rests on the equitable principle that a person shall not be allowed to enrich himself unjustly at the expense of another" Id. at 512.

In order for plaintiffs to sufficiently plead this cause of action, it must demonstrate that the services they performed in good faith conferred a benefit not only on the patients they served (who are not defendants) but rather on the insurers of the patients. The complaint alleges in paragraph 59 that "[B]oth United and United's Members benefited from the services Plaintiff provided. For example, United used and enjoyed the benefit of Plaintiff's services because Plaintiffs help United discharge its

legal and contractual obligation to its insureds to provide them with emergency care". At this stage of the proceedings, this argument is persuasive. The insurer defendants received a benefit by paying the plaintiffs a rate of reimbursement significantly less than a reasonable rate. They were able to pocket the difference in profits while simultaneously discharging its contractual obligation to pay for out-of-network emergency care for its members. Though the benefit conferred is not direct, there is arguably a benefit conferred to the defendants.

COUNT THREE- VIOLATION OF NEW JERSEY HEALTH CLAIMS AUTORIZATION, PROCESSING AND PAYMENT ACT ("HCAPPA")

Team Health plaintiffs allege in Count Three that the defendants failed "to timely pay the full amounts due to plaintiffs for their out-of-network emergency claims", in violation of HCAPPA, N.J.S. 17B:26-9.1. This statute permits the provider from recovering 12% interest on any unpaid claims. The parties go back and forth on whether the statute confers a private right of action by a medical provider against an insured. At this point, the court does not have to reach this answer. This statutory penalty for failing to pay a valid insurance claim promptly is only applicable if plaintiff is successful in this litigation compelling payment from the defendants. The court will revisit this issue upon a successful recovery by plaintiff.

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COUNTS FOUR AND FIVE- VIOLATIONS OF NJ-RICO (as to both sets of defendants)

In Counts Four and Five of the Second Amended Complaint, plaintiffs allege that the defendants committed acts of theft under N.J.S. 2C:20-3(a) and (b), 2C:20-4(a)-(c) and 2C:20-8(a) by a pattern of racketeering activity in violation of N.J.S. 2C:41-1.

Basically, the plaintiffs state that United and Multiplan engaged in a conspiracy to divert millions of dollars away from the plaintiffs by falsely and fraudulently hiding behind Data iSight methodology, which in fact was a deceitful ploy to pay reimbursement rates set by United rather than reasonable value.

To state a claim for violation of New Jersey's RICO law (N.J.S. 2C:41-1, et seq.), a plaintiff must allege (1) the existence of an enterprise; (2) that the enterprise engaged in activities that affected trade or commerce; (3) that the defendants were employed by or associated with the enterprise; (4) that the defendants participated in the conduct of the affairs of the enterprise; (5) that the defendants participated through a pattern of racketeering activity; and (6) that the plaintiff was injured as a result of the activity. Marina Dist. Dev. Co. v. Ivey, 216 F. Supp. 3d 426, 436 (N.J. Dist. Ct. 2016). A defendant in a racketeering conspiracy need not itself commit or agree to commit predicate acts. Smith v. Berg, 247 F.3d 532, 537 (3d Cir. 2001). Rather, "all that is necessary for such a conspiracy is that the conspirators share a common purpose." Id. Thus, if defendants agree to a plan wherein some conspirators will commit crimes and others will provide support, "the supporters are as guilty as the perpetrators." Salinas v. United States, 522 U.S. 52, 64, 118 S. Ct. 469, 139 L. Ed. 2d 352 (1997). Each defendant must "agree to commission of two or more racketeering acts," United States v. Phillips, 874 F.2d 123, 127 n.4 (3d Cir. 1989), and each defendant must "adopt the goal of furthering or facilitating the criminal endeavor," Smith, 247 F.3d at 537.

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Defendants first argue that plaintiff's pleading is deficient in that it does not comply with the heightened pleading standard required by R. 4:5-8. This rule requires "[I]n all allegations of misrepresentation, fraud, …. Particulars of the wrong, with dates and items *if necessary*, shall be stated *insofar as practicable.* (emphasis supplied). Here, the complaint satisfies the Rule by placing defendants on notice of the alleged wrongs. Specifically, the complaint states that between May 2020 and December 2021, United Healthcare defendants conspired with Multiplan defendant to unilaterally set the rate of reimbursement for the plaintiffs. This rate was set by United but asserts fraudulently that the reimbursement rate was determined by Data iSight at a geographically competitive rate. The fraud/conspiracy began just before the May 2020 change. The plaintiff alleges damages calculated at the amount billed by plaintiff minus the amount paid by defendants. This pleading is sufficient as to R. 4:5-8.

The more interesting argument raised by both defendants is that plaintiffs fail to allege that the defendants' racketeering conduct was the proximate cause of their damages. See, Maio v. Aetna Inc., 221 F.3d 472, 483 holding that plaintiff must "make two related but analytically distinct threshold showings…(1) that the plaintiff suffered an injury to business or property; and (2) that the plaintiff's injury was proximately caused by the defendants' [RICO] violation. The defendants argue that plaintiffs are required to treat all patients who arrive at hospitals for emergency care, and even if the defendants shared their payment methodology, nothing would change, i.e. the plaintiffs would receive the same amount. This court finds this unpersuasive as the argument ignores the alleged fraud as alleged. Plaintiffs say that the Data iSight rate is merely a cover for

United's reimbursement rate that it unilaterally set. The plaintiffs allege that United and Multiplan conspired to set an artificially low rate to reap huge profits disguising its conspiracy by pretending the rate was set by Data iSight. Their damages would be the difference between they amount they billed and the amount they received. As alleged, the plaintiff's damages are the proximate cause of the RICO conspiracy. They may has performed the same services as required by law, but they would have received significantly more money for doing so, if not defrauded by the defendants.

The court requests the defendants prepare an Order consistent with this opinion.

DATED: August 23, 2022

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JAMES R. SWIFT, JSC

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IN THE CIRCUIT COURT FOR THE
THIRTEENTH JUDICIAL CIRCUIT IN AND
FOR HILLSBOROUGH COUNTY, FLORIDA

GULF-TO-BAY ANESTHESIOLOGY
ASSOCIATES, LLC,

Plaintiff, Case No.: 20-CA-008606

v.

UNITED HEALTHCARE OF FLORIDA,
INC., UNITEDHEALTHCARE
INSURANCE CO., UMR, INC., and
MULTIPLAN, INC.,

Defendants.
_____/

ORDER GRANTING DEFENDANTS' MOTION TO DISMISS COUNT III OF PLAINTIFF'S THIRD AMENDED COMPLAINT AND SUPPORTING MEMORANDUM OF LAW

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THIS CAUSE came before the Court for hearing on July 20, 2022, upon the Defendants' UnitedHealthcare of Florida, Inc., UnitedHealthcare Insurance Company, and UMR, Inc.'s (together, the "United Defendants") Motion to Dismiss Count III of Plaintiff's Third Amended Complaint and Supporting Memorandum of Law (the "Motion to Dismiss"). The Court having considered the Motion to Dismiss, the Plaintiff's Response in Opposition to Defendants' Motion to Dismiss Count III of Plaintiff's Third Amended Complaint ("Opposition"), and having reviewed the file and the papers submitted, and having heard the argument of counsel, and being otherwise fully advised, hereby **ORDERS** and **ADJUDGES**:

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1. Plaintiff's claim for breach of contract implied-in-fact in Count III of Plaintiff's Third Amended Complaint fails to state a cause of action for the reasons set forth by the Court at the July 20, 2022 hearing, including this Court's finding that there is an absence of factual allegations of mutual assent.

2. This Court also finds that Plaintiff has been granted leave to amend multiple times and has had multiple opportunities to plead a claim for breach of contract implied-in-fact and has been unable to plead a viable cause of action. The Court further finds that Plaintiff will not be able to cure the pleading deficiencies and that dismissal with prejudice is appropriate.

3. Accordingly, the Motion to Dismiss is **GRANTED** and Count III of Plaintiff's Third Amended Complaint is dismissed **with prejudice.**

4. The Plaintiff shall file a fourth amended complaint that removes Plaintiff's claim for breach of contract implied-in-fact (previously pled in Count III of Plaintiff's Third Amended Complaint) on or before August 17, 2022. Defendants shall then file an answer to Plaintiff's Fourth Amended Complaint on or before September 16, 2022.

DONE AND ORDERED in Chambers in Tampa, Hillsborough County, Florida, on _____ 2022.

Electronically Conformed 8/11/2022
Darren D. Farfante

DIVISION L PRESIDING JUDGE
The Honorable Darren D. Farfante
Circuit Court Judge

Copies furnished to: Counsel of Record

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