CASE NO. 85525; *combined with* CASE NO. 85656

IN THE SUPREME COURT OF NEVADA

UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTHCARE SERVICES, INC. D/B/A UNITEDHEALTHCARE; UMR, INC. D/B/A UNITED MEDICAL RESOURCES; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; AND HEALTH PLAN OF NEVADA, INC.,

Appellants/Petitioners,

vs.

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; AND CRUM STEFANKO AND JONES, LTD., D/B/A RUBY CREST EMERGENCY MEDICINE.

Respondents/Real Parties in Interest.

Appeal from the Eighth Judicial District Court, Clark County
District Court Case No. A-19-792978
Hon. Nancy L. Allf, District Judge

RESPONDENTS' ANSWERING BRIEF

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NRAP 26.1 DISCLOSURE

Pursuant to Nevada Rule of Appellate Procedure 26.1, Respondents/Real Parties in Interest submit this Disclosure Statement:

The undersigned counsel of record certifies that the following are persons and entities as described in Nevada Rule of Appellate Procedure 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.

1. Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada-Mandavia, P.C., and Crum, Stefanko & Jones, Ltd. d/b/a Ruby Crest Emergency Physicians are the Respondents/Real Parties in Interest in this proceeding. None of the Respondents/Real Parties in Interest is owned by a parent company and none has 10% or more of its stock owned by a publicly held corporation.

2. Respondents/Real Parties in Interest have been represented by attorneys from the following law firms: Bailey Kennedy, LLP; Lash Goldberg LLP; Ahmad, Zavitsanos & Mensing PLLC; McDonald Carano LLP; Fennemore Craig, P.C.

DATED this 28th day of August, 2023.

BAILEY❖KENNEDY

By: */s/ Dennis L. Kennedy*
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2. Whether the district court erred in denying United's motion for judgment as a matter of law on the Health Care Providers'[2] implied-in-fact contract claim because the evidence presented does not support a finding that the parties agreed that United would pay the Health Care Providers' full billed charges;

3. Whether the district court erred in denying United's motion for judgment as a matter of law on the Health Care Providers' unjust enrichment claim because the evidence showed that: (a) there was no inequity when United deliberately underpaid the Health Care Providers because the Health Care Providers

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[1] Appellants/Petitioners United Healthcare Insurance Company ("UHIC"), United Healthcare Services, Inc. d/b/a UnitedHealthcare ("UHC Services"), UMR, Inc. d/b/a United Medical Resources ("UMR"), Sierra Health and Life Insurance Company, Inc. ("Sierra"), and Health Plan of Nevada, Inc. ("HPN") are collectively referred to herein as "United."

[2] Respondents/Real Parties in Interest Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada-Mandavia, P.C., and Crum, Stefanko & Jones, Ltd. d/b/a Ruby Crest Emergency Physicians are collectively referred to herein as the "Health Care Providers."

could have submitted balance bills to United's members, and (b) any benefit resulting from the Health Care Providers' provision of emergency medical care to United's members was conferred upon the members themselves, rather than upon United;

4. Whether the district court erred in denying United's motion for judgment as a matter of law on the Health Care Providers' Unfair Claims Practices Act ("UCPA") claim because (a) that statute does not create a private right of action for third-party medical providers, (b) that statute does not create a cause of action against third-party administrators ("TPAs") of self-funded health plans, and (c) the evidence presented at trial was insufficient to support a verdict in favor of the Health Care Providers;

5. Whether the jury's punitive damages award should be reversed because (a) the evidence presented at trial was insufficient to support a finding that United had engaged in conduct involving oppression, fraud, and/or malice, or (b) as a matter of law, punitive damages are unavailable under the Health Care Providers' UCPA and unjust enrichment claims;

6. Whether the jury's punitive damages award should be reduced because (a) the amount of punitive damages awarded does not comport with due process, or (b) the district court erred in holding that an exception to Nevada's statutory cap on punitive damages applies here;

7. Whether the district court erred in holding that the Health Care Providers' claims are not preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. 1001 *et seq.*, with respect to underlying reimbursement claims under self-funded health plans;

8. Whether the district court erred in awarding attorneys' fees and interest under the Prompt Pay Act ("PPA") provisions governing health insurance policies because (a) the Health Care Providers have argued previously that their claims do not "relate to" health plans and are therefore estopped from contending that their claims do relate to health plans, (b) the Health Care Providers were required to exhaust administrative remedies and did not do so, and (c) United promptly paid the amounts that it allowed on the underlying claims; and

9. Whether the district court erred in holding that the principle of public access to court records supersedes any interest United may have in concealing from public view portions of the trial record and therefore denying United's request to order that evidence permanently sealed.

INTRODUCTION

Emergency medical providers play an essential role in our nation's healthcare infrastructure. They are the front-line treatment providers for patients from all walks of life, suffering the full spectrum of emergent medical conditions. These include heart attacks and strokes, traumatic injuries, infectious diseases, and numerous other threats to life and limb. In recognition of emergency medical providers' critical importance—and to ensure that all members of society have access to treatment in the face of medical emergencies—the U.S. Congress and most state legislatures have enacted statutes requiring emergency medical providers to render care to all patients who present in hospital emergency departments, regardless of the patients' insurance status or ability to pay. This public policy and these laws have obvious salutary effects, insofar as they ensure that nobody is denied lifesaving treatment simply because of financial circumstances.

Yet, despite their beneficial value, the public policy and laws obligating emergency medical providers to treat all presenting patients cause certain externalities. Notably, they put those providers at a distinct disadvantage in their negotiations with commercial health insurers over rates of reimbursement. With non-emergency medical specialties, if a provider is "non-participating" or "out-of-network" with a given insurer—*i.e.*, the provider and insurer fail to agree on contract terms and reimbursement rates—the provider can decline to provide treatment to the

insurer's members. Should the insurer's network become too narrow, the dearth of available providers can jeopardize the insurer's regulatory compliance and damage its business, as dissatisfied members switch to different insurers. This incentivizes insurers to offer reasonable rates that providers will accept, to ensure an adequate range of providers in their networks for their members. And providers are likewise incentivized to accept reasonable offers to stay in network, as the steerage of insurers' members to in-network providers is essential to providers' ability to maintain an adequate base of patients.

This equilibrium does not exist with emergency care. Because emergency medical providers are required by law to treat all patients regardless of insurance status, they cannot turn away patients holding out-of-network insurance. And because insurers understand that their members necessarily will be treated by out-of-network emergency medical providers, they have little incentive to offer reasonable rates that would bring those providers in network. Instead, the profit-maximizing approach for insurers is to keep emergency medical providers out of network unless those providers agree to extraordinarily low rates. When treatment is provided on an out-of-network basis, the insurers can simply pay the claims after the fact at low rates that they unilaterally determine, and the providers are left with few options. Unfortunately, if insurers are too aggressive in pressing this advantage, their behavior not only harms the providers themselves, it ultimately threatens the

economic viability of emergency medicine (with obvious, deleterious fallout for society at large).

This imbalance forms the backdrop for this dispute. Appellants/Petitioners are affiliates of UnitedHealth Group Inc. UnitedHealth Group Inc. and its affiliated entities are the nation's largest insurance company, with a market capitalization of more than $500 billion. United underwrites health insurance sold to groups and individuals and also serves as an administrator for self-funded, employer-sponsored health plans. The Health Care Providers are medical practices operating out of hospital emergency departments in Nevada. They are affiliated with a company commonly referred to as "TeamHealth," a practice management organization with over 400 affiliated physician corporations that provide emergency medical services throughout the United States. The Health Care Providers do not participate in United's network. Yet, despite their out-of-network status, they have treated—and continue to treat—United's members,[3] as those individuals present at emergency departments staffed by the Health Care Providers. This dispute concerns the egregiously low rates of reimbursements that United paid to the Health Care Providers for out-of-network emergency medical services provided between July 1, 2017 and January 31, 2020.

[3] United's members are individuals holding health insurance underwritten and/or administered by United.

As demonstrated at trial, it was no accident that United reimbursed the Health Care Providers' claims at amounts well below the reasonable value of the services rendered. Rather, the underpayments were the product of United's strategic nationwide scheme to enrich itself at the expense of emergency medical providers. Per that scheme, United systematically cut its payments for out-of-network emergency claims to amounts that it knew to be well below the industry-standard reimbursement amounts, while siphoning off a percentage of the money that its self-funded health plan clients had earmarked for the payment of those claims and retaining the funds for itself. United's scheme has been wildly successful, generating billions of dollars in additional profits. But those profits have come at the expense of hardworking emergency medical providers throughout the United States, as well as the countless members of the public who rely on those providers to deliver lifesaving care at a moment's notice. In fact, the destructive effects of United's rate-slashing initiative became evident in May 2023, when Envision Healthcare Corporation—TeamHealth's most prominent competitor—filed for bankruptcy, citing United's ruthlessness as a key driver of its deteriorated financial condition.[4]

The trial evidence further demonstrated that United's campaign against

[4] *See In re Envision Healthcare Corp.*, No. 23-90342, at Dkt. 2 ¶ 6 (S.D. Tex. Bankr. May 15, 2023).

providers is multifaceted and has involved habitual, intentional dishonesty. For instance, United employed the services of a contractual counterparty—Multiplan, Inc. ("Multiplan")—which purported to calculate the out-of-network reimbursement amounts through a proprietary pricing engine called "Data iSight." This allowed United to represent that its rates had been computed by a neutral third party, based on objective market data. In reality, Data iSight was a sham. The trial evidence showed that United secretly had dictated the rates to Multiplan, which then rigged Data iSight to "calculate" the rates that United had pre-determined it would pay.

Simultaneously, United embarked upon an aggressive public relations and lobbying campaign, seeking to turn public opinion against emergency medical providers and ultimately secure legislation favorably regulating out-of-network reimbursement rates. The linchpin of that campaign was a study by an academic at Yale University named Zack Cooper, entitled *Surprise! Out-of-Network Billing for Emergency Care in the United States* ("Yale Study"). Mr. Cooper and his colleagues purported to conclude that out-of-network medical providers have driven inflation in emergency medical spending by charging unreasonable amounts and then deliberately going out of network to pressure insurers into paying the unreasonable charges, and they specifically named TeamHealth and its affiliates as notable offenders. The Yale Study was highly influential, and it was cited repeatedly by Members of Congress during debates over the recently enacted No Surprises Act,

Pub. L. No. 116-260, 134 Stat. 1182, Division BB, and by the administrative agencies crafting that law's implementing regulations. But documents produced in this matter's discovery process—and later presented at trial—revealed that United was secretly responsible for the Yale Study. United colluded with Mr. Cooper to perform the Yale Study, maintained a consistent dialogue with him, and exercised editorial control over the final product. But United made a calculated decision and concerted effort to conceal its involvement from the public, so that the Yale Study could masquerade as the unbiased work of a neutral academic.

Confronted with this record of deliberate, malicious conduct, the jury decided to punish United by awarding $60,000,000 in punitive damages. That number, while seemingly large in absolute terms, is a pittance for United, representing approximately 0.01% of its current market capitalization. That award was entirely reasonable, was legally supported, and should be left undisturbed. Moreover, and as explained in detail below, United's other various arguments for reversal are without merit. First, United is not entitled to a new trial because the district court's evidentiary rulings were reasonable under the circumstances and well within its broad discretion, as was the rebuttable presumption instruction pertaining to United's serious and repeated willful discovery violations and willful suppression of evidence. Second, United is not entitled to judgment as a matter of law because the claims that the Health Care Providers presented and proved at trial were fully

supported, both legally and factually. This Court should affirm the judgment below.

STATEMENT OF THE CASE

This proceeding is United's appeal from a judgment entered upon a jury verdict rendered in favor of the Health Care Providers following a trial in the Eighth Judicial District Court, presided over by the Honorable Nancy L. Allf. The dispute concerns the proper rates of reimbursement that United was required to pay for out-of-network emergency medical services provided to United's members. United has always understood its obligation to pay emergency medical providers for medically necessary care provided to its members, even where the providers are out of network. (32 AA[5] 7987:11-23; 39 AA 9557:17-19.) Historically, United paid out-of-network professional emergency claims at "reasonable and customary" rates, using the 80th percentile of an independent charge database called "FAIR Health." (4 RA 507, 517; 12 RA 2036; 37 AA 9030:21-31:9.) As United was well aware, this was the longstanding standard practice in the industry. (4 RA 507.) Nonetheless, beginning in 2017, United abandoned this well-established payment standard and implemented

[5] "AA" refers to United's appendix filed in connection with its appeal (Case No. 85525). "PA" refers to United's appendix filed in connection with its mandamus petition (Case No. 85656). "RA" refers to the Health Care Providers' appendix filed in connection with this Answering Brief. Pursuant to NRAP 30(a), the parties attempted but could not reach an agreement concerning a possible joint appendix. For citation purposes, the number preceding AA, RA, or PA refers to the applicable volume. The number(s) succeeding AA, RA, or PA refers to the page number(s), and, if applicable, the line number(s).

a concerted plan to slash the reimbursements paid to emergency medical providers. (5 RA 772, 776; 31 AA 7747:14-17, 7750:6-11; 32 AA 7753:21-54:12, 7923:24-25:1.) United had no reason for doing this, other than to garner more profits for itself. (32 AA 7752:24-53:1, 7923:24-25:1; 31 AA 7747:18-48:3; 13 RA 2366; 2 RA 297-98.) The Health Care Providers refused to accept these artificially low payments and sued United to vindicate their rights under Nevada law.

The Health Care Providers filed this action on April 15, 2019, in the Eighth Judicial District Court, asserting claims for (1) breach of implied-in-fact contract; (2) tortious breach of the implied covenant of good faith and fair dealing; (3) unjust enrichment; (4) violation of the UCPA, NRS 686A.020 and 686A.310; (5) violation of the PPA; and (6) violation of the Consumer Fraud and Deceptive Trade Practices Act. (1 AA 1-17.) On May 14, 2019, United removed the action to the United States District Court for the District of Nevada, contending that the Health Care Providers' state law claims were completely preempted by ERISA § 502(a). (1 AA 42-100.) The Health Care Providers timely moved to remand. (1 AA 100-22.) The federal court granted the motion to remand, finding that the Health Care Providers' claims were not completely preempted and therefore that there was no federal jurisdiction. (3 AA 519-24.)

The case was remanded to the Eighth Judicial District Court on February 20, 2020. (3 AA 519-24.) Thereafter, United moved for dismissal based upon ERISA

preemption and failure to state a claim. (5 AA 1027-172.) The district court denied the motion. United then petitioned this Court for interlocutory review of its ERISA defenses, as well as several other dismissal arguments that the district court had rejected. (1 RA 32-106.) The Court denied United's petition. (1 RA 239-43.)

The case proceeded to trial on four causes of action: (1) breach of implied-in-fact contract; (2) unjust enrichment; (3) violations of the UCPA; and (4) violations of the PPA. (21 AA 5246-22 AA 5264.) The trial's liability phase lasted for thirteen days. In that time, eighteen witnesses testified, and 247 documents were admitted into evidence. After hearing the testimony and reviewing the evidence, the jury awarded the Health Care Providers a total of $2.65 million in compensatory damages. (29 AA 123035-46.) After a later punitive damages phase involving the presentation of additional evidence, the jury awarded $60 million in punitive damages on the UCPA and unjust enrichment claims. (49 AA 12150-52.) The district court also assessed a special interest penalty under the PPA, for a total final judgment of $63,429,873.96. (53 AA 13171-78.) Separately, the district court awarded the Health Care Providers attorneys' fees of approximately $12 million under the PPA and more than $800,000 in costs pursuant to NRS 18.110. (73 AA 18010.) From voir dire through the end of the punitive damages phase, the trial lasted over six weeks. Following trial, the district court denied United's motions (1) for a new trial, (2) for renewed judgment as a matter of law, (3) for remittitur and to

alter or amend the judgment, and (4) to limit punitive damages. United's appeal followed.

This Answering Brief also responds to United's mandamus petition challenging the district court's partial denial of its motion to seal large portions of the trial record. United's mandamus petition was Case No. 85656. The Court consolidated that action with United's appeal in Order No. 23-09597.

STATEMENT OF FACTS

A. The Parties

The Health Care Providers are professional emergency medical groups operating out of hospital emergency departments in Clark, Elko, and Churchill Counties, Nevada. (21 AA 5250-22 AA 5251.) They provide around-the-clock emergency medical services to these communities. Hospital emergency departments are obligated by both federal and Nevada law to render stabilizing medical treatment to all presenting patients, regardless of the patients' insurance status or ability to pay. *See* Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd; NRS 439B.410. The Health Care Providers fulfill this role for the hospitals whose emergency departments they staff. In so doing, the Health Care Providers render emergency medical care to all presenting patients, including patients with insurance coverage issued, administered, and/or underwritten by United. (5 PA 1190:6-24; 32 AA 7987:11-23; 40 AA 9871:23-73:5.)

United issues, administers, and/or underwrites health coverage, including coverage for medically necessary emergency care. (21 AA 5248-49.) When acting as an underwriter, United collects insurance premiums, administers benefits, and pays healthcare claims. (21 AA 5248-49; 98 AA 024293.) When acting as a TPA, United establishes a network of participating providers for its self-funded health plan clients, processes claims, and collects fees, including a fee per month per member ("PMPM"). (31 AA 7745.)

B. The Unique Relationship Between the Health Care Providers and United

It is standard practice in the managed care industry for medical providers to negotiate with health insurance companies to become participating providers in the insurers "networks." Those express "in-network" agreements come with a number of substantial benefits for the medical providers, including, *inter alia*, patient steerage, patient volume, prompt payment, rate certainty, and administrative dispute resolution procedures. In exchange for these contractual benefits, in-network providers discount their billed charges and accept these discounted, agreed rates as payment in full. When medical providers do not have express, in-network agreements, they are considered "out-of-network," or "non-participating." Such providers do not receive any of the contractual benefits featured in the in-network relationship.

As a general rule, medical providers can decline to treat patients holding out-

of-network insurance, and insurers can decline payment to out-of-network providers. (32 AA 7987:11-23.) Emergency medical providers, like the Health Care Providers, are the exception to this rule. (32 AA 7987:11-23.) As noted above, emergency medical providers are obligated by law to provide stabilizing care to all presenting patients. Correspondingly, health insurers like United are obligated by law to cover and pay for medically necessary emergency care, regardless of a provider's network status. 42 U.S.C. §18022(b)(1)(B). (39 AA 9589:13-91:3.) United at all times has understood these legal duties, understood that the Health Care Providers will provide emergency medical services to United's members irrespective of network status, and understood that the Health Care Providers expect payment for those emergency medical services. (5 PA 1190:6-24; 32 AA 7987:11-23; 46 AA 11345:12-14; 40 AA 9871:23-73:5.) In these circumstances, United is obligated by state law to pay the Health Care Providers at reasonable rates for the services they provide.

During the relevant period of July 1, 2017 to January 31, 2020 ("Dispute Period"), the Health Care Providers were out of network with United. Accordingly, this lawsuit exclusively involves out-of-network claims. (46 AA 11416:23-17:10.)

C. The Health Care Providers' Disputed Claims

Prior to the Dispute Period, United adjudicated certain out-of-network claims at reasonable, acceptable rates. (12 RA 2036; 2 RA 295, 358; 4 RA 507, 517.) United paid the Health Care providers at rates equaling the Health Care Providers'

billed charges, or at rates pursuant to "wrap/rental agreements." (34 AA 8378:12-16; 2 RA 285-86; 4 RA 517.) A wrap/rental agreement is an agreement between a provider and a third party, whereby the provider agrees to accept a modest discount off its billed charges as payment in full. (32 AA 7770:24-72:25.) This creates a "rental network" that the third party then markets to insurers like United, to access when the insurers' members receive out-of-network care. (32 AA 7770:24-72:25.) Prior to the Dispute Period, United processed and paid 97% of the Health Care Providers' out-of-network claims at rates ranging from 90% to 100% of billed charges, which the Health Care Providers accepted as payment in full. (2 RA 358.)

In contrast, in the Dispute Period, the Health Care Providers *disputed* claims that United paid at rates well below acceptable levels. (22 AA 5253-5254 ¶ 44.) Importantly, for each disputed claim, United determined that the claim was for a covered emergency service and was fully payable. (46 AA 11416:23-17:4 (disputed claims are commercial claims adjudicated as covered services and payable, not denied).) The only dispute in this case was over the rates of reimbursement. (46 AA 11416:23-17:4.)

D. The Historic Rates for Out-of-Network Emergency Services: Reasonable and Customary Billed Charges

The evidence at trial proved that United had slashed its rates of payment pursuant to a calculated scheme to reap profits at the expense of emergency medical providers. (5 RA 772, 776; 2 PA 459:14-17; 2 PA 462:6-11, 465:21-66:12; 32 AA

7923:24-25:1.) For many years prior to the rollout of this scheme, United had recognized an obligation to pay reasonable rates to emergency clinicians who did not participate in its network. (4 RA 507, 517; 12 RA 2036.) As shown in its internal documents, United knew that industry standard practice was to calculate "reasonable and customary" rates using a database maintained by the independent nonprofit FAIR Health, Inc. (4 RA 507, 517.) Using this "traditional" approach, United reimbursed claims for out-of-network emergency services at rates equaling the providers' billed charges, if those charges did not exceed the 80th percentile of charges in the FAIR Health database. (4 RA 505, 517.) Prior to the Dispute Period, United used this FAIR Health benchmark to determine reimbursements for out-of-network services. (4 RA 517; 32 AA 7910:24-11:14; 37 AA 9030:21-31:9.) United indeed subscribed to data published by FAIR Health. (32 AA 7909:7-9.)

United also maintained a website entitled "Information on Payment of Out-of-Network Services," where it publicized to its members that United would utilize the FAIR Health database for payment of claims at "the reasonable and customary amount," "the "usual, customary, and reasonable amount," the "prevailing rate," or "other similar terms that base payment on what other healthcare professionals in a geographic area charge for their services." (12 RA 2036; 32 AA 7902:4-04:15.) United further explained on its publicly available website that it frequently used the 80th percentile of the FAIR Health Benchmark Databases to calculate how much to

pay for out-of-network professional medical services. (12 RA 2038.) Throughout this period, United enjoyed industry-leading margins. (5 RA 724.)

E. United's Campaign to Slash Out-of-Network Payments for Emergency Services

United at all times was aware that reductions in its reimbursement amounts would hurt emergency medical providers and would increase financial burdens on its members (who would become subject to balance bills). (13 RA 2366.) Yet it nonetheless began a campaign to abolish the industry-standard reimbursement approach and "get clients off R&C [reasonable and customary]/FAIR Health." (12 RA 2049; 32 AA 7923:18-25:1.) In so doing, United implemented alternative reimbursement methodologies that resulted in dramatically reduced reimbursement amounts. (32 AA 7753:21-54:12; 34 AA 8492:4-22.) Further, it misappropriated funds that had been earmarked for the payment of out-of-network emergency claims in the form of "shared savings fees." (32 AA 7923:18-25:1.)

The scheme worked as follows: where United was acting as a TPA for its self-funded health plan clients, it would reimburse emergency medical claims at exceedingly low rates. United would then designate the difference between the medical providers' billed charges and the amounts that United had paid on the claims as "savings," and it would retain a portion of the "savings" as fees for itself. (37 AA 9003:14-19.) Because the fees generally were calculated as a percentage—often [redacted]—of the "savings" on a given claim, the amount of money United could

generate from this scheme bore an inverse relationship with the amounts that United would pay in reimbursements to emergency medical providers. (34 AA 8492:4-22; 39 AA 9711:5-12; 3 RA 433.)

To deflect the blowback that it knew would be generated by this brazen money-grab, United sought to create a false impression that its lowered reimbursement rates were reasonable. It did this in two primary ways: (1) by contracting with MultiPlan for use of Multiplan's Data iSight product; and (2) through a coordinated media / public relations campaign to villainize emergency medical providers, including the Health Care Providers.

1. United's Collusion with MultiPlan/Data iSight

United contracted with a third party—MultiPlan—which operates a pricing engine called Data iSight (euphemistically referred to within United as "Outlier Cost Management" or "OCM"). (36 AA 8817:7-18; 37 AA 9020:10-17; 4 RA 540.) United promoted Data iSight as an objective and geographically adjusted tool for determining fair reimbursement rates, based on market data. (36 AA 8817:7-18; 37 AA 9020:10-17; 4 RA 540.) But internal United documents that the Health Care Providers obtained in discovery demonstrated that Data iSight was a sham. In fact, the rates that Data iSight purported to "calculate" were secretly dictated to Multiplan by United. (4 RA 535-36; 11 RA 1985; 39 AA 9536:21-40:21; 37 AA 9012:9-11.) When United first deployed Data iSight, the rate of payment that it chose was [redacted]

of the applicable Medicare fee-for-service rate. (4 RA 535-36; 11 RA 1985; 39 AA 9536:21-40:21; 37 AA 9012:9-11.) United later instructed MultiPlan to set the rates even lower—at [redacted] of Medicare. (4 RA 535-36; 11 RA 1985; 39 AA 9536:21-40:21; 37 AA 9012:9-11.)

United's ultimate aim was to reduce the reimbursement amounts even further over time. (33 AA 8075:11-16.) Multiplan was a willing participant in this plot because it received a shared savings fee of [redacted], which was calculated in the same manner as United's [redacted] fee: [redacted]. (32 AA 7973:4-14; 34 AA 8494:1-3.) In other words, Multiplan—like United—had a financial incentive to price claims as low as possible. (32 AA 7973:4-14.)

United's shared savings program was extraordinarily profitable. (32 AA 7763:19-23.) When asked on cross-examination what United did to earn its enormous fees, a United executive responded only that: "[w]e have to send claims over," "[w]e have security requirements," "[w]e have to answer the phone." (34 AA 8493:23-94:13.) United's financial results reflect this success. The 2019 results for its West Region describe Nevada as one of two "outperforming markets," with skyrocketing margins following implementation of OCM. (13 RA 2238; 12 RA 2125.) Those results are particularly notable, given the absence of any discernible work that United performed to generate its shared savings fees. (31 AA 7747:18-48:3; 32 AA 7752:24-53:13; 34 AA 8493:23-94:13.)

After the switch to shared savings/OCM, United's payments to the Health Care Providers declined each year. (42 AA 10349:23-50:7.) For the claims disputed at trial, United paid an average of [redacted] per claim, which reflected a $10,399,341 discount off the Health Care Providers' billed charges. (13 RA 2363; 42 AA 10352:8-16.) As a result, United unilaterally paid only [redacted] of the Health Care Providers' charges, despite these charges largely mirroring the 80th percentile of the FAIR Health benchmark. (40 AA 9903:5-14; 42 AA 10427:4-10.) Evidence at trial showed that United's calculation of rates for claims was devoid of rhyme or reason, including ***United's admission*** that it used "random calculated amounts." (41 AA 10033:24-35:1, 10065:20-66:1; 4 RA 540.)

This scheme enriched United at the expense of both the Health Care Providers and United's own members. United acknowledged internally that its "migration to high reduction programs" resulted in "less member protection." (13 RA 2366.) Translation: United understood that its underpayments would result in its members receiving "balance bills" from medical providers. In other words, by implementing its scheme to enrich itself through the generation of shared savings fees, United knowingly exposed its members to balance billing. (2 PA 459-66.)

2. United's Media Campaign to Villainize the Health Care Providers

To further facilitate its wrongful scheme, United launched a concerted, multifaceted public relations and lobbying campaign. (2 PA 473:21-74:12; 121 PA

30080.) That campaign targeted emergency medical providers generally, and TeamHealth-affiliated practices in particular. The cornerstone of United's campaign was its collusion with Mr. Cooper, who wrote a series of articles and papers regarding out-of-network reimbursements, culminating with the Yale Study. (2 RA 291, 519-25; 5 RA 796-98.) Those articles were critical of emergency medical practices, generally accusing them of engaging in predatory pricing and balance billing. (4 RA 519-25.) Mr. Cooper did not disclose, however, that he had worked hand-in-glove with United, both in preparing his publications and in orchestrating the subsequent media blitz. Notably, United made the decision to identify TeamHealth by name in the Yale Study and made a calculated decision to conceal its own involvement from the public. (5 RA 755.) For instance, in a May 19, 2016 internal email, United communications employee Brenda Perez stated that "our support of [Mr. Cooper] is expected to remain 'behind-the-scenes,'" and that "we'll have to look into the possibility of further distancing ourselves from the [Yale Study] and the messaging." (2 RA 290; 4 RA 538-39.) In a March 9, 2017 internal email, Sam Ho—United's Executive Vice President and Chief Medical Officer—stated: "I agree with identification of [TeamHealth and Envision], and also reaffirm that [United] should not be identified as the data source." (5 RA 755.) And in an April 13, 2017 email to United executive Theodore Prospect, Mr. Cooper stated: "We have taken steps to make sure [United] is not named." (5 RA 797; 2 RA 292; 4 RA 520-

22.)

United used the publicity it had ginned up to further rationalize its underpayments as the appropriate response to a supposedly serious problem: egregious billing by emergency medical providers and rising costs for out-of-network services. (4 RA 497-502, 554-55.) However, the evidence presented at trial revealed that these concerns were fabricated. According to United's own internal documents, emergency medical providers' average billed charges had *declined* each year from 2016 to 2019. (32 AA 7888:2-90:19; 12 RA 2056.) And the Health Care Providers' billed charges had increased only minimally in that period. (42 AA 10362:8-24.) In addition, the trial evidence showed that the Health Care Providers' billed charges were far lower than those of Sound Physicians, an emergency medical practice owned by United. (45 AA 11192:7-99:8.) Moreover, the trial evidence showed that the Health Care Providers had an internal policy against balance billing. (40 AA 9885:15-87:16, 9889:24-90:24.)

F. United's Extended Pattern of Discovery Abuses

United's conduct throughout this matter's discovery process was unyieldingly abusive. On the one hand, United sought numerous categories of irrelevant evidence. The district court appropriately sustained the Health Care Providers' objections to many of United's requests, so that discovery could remain focused on relevant data: *i.e.*, data showing the reasonable rates for comparable out-of-network

emergency services under commercial health plans. (37 AA 9165, 9167.) Several of these exclusions form the basis for United's motion for a new trial and are addressed and disposed of *infra*.

On the other hand, United willfully disregarded its *own* discovery obligations. In response, the district court entered five separate orders ("Discovery Orders") compelling United to participate meaningfully in discovery and to produce relevant evidence. The district court repeatedly admonished United for its malfeasance and threatened to impose sanctions should United's behavior fail to improve. Below, the Health Care Providers summarize the relevant history.

1. December 9, 2019: The Health Care Providers Serve Initial Discovery Requests

On December 9, 2019, the Health Care Providers served their initial Requests for Production and Interrogatories (the "Initial Discovery Requests"). (1 RA 1-17.) In the Initial Discovery Requests, the Health Care Providers requested several categories of documents targeted to United's strategy, decision-making, and basis for implementing and calculating the dramatically reduced reimbursement rates. For instance:

- RFP No. 6 requested all Documents and/or Communications relating to United's decision to reduce payment for any Claim;
- RFP No. 7 sought all Documents and/or Communications supporting or relating to United's contention or belief that it is entitled to pay or allow less than the full billed charges for any Claim;

- RFP No. 18 covered all Documents and/or Communications regarding the rationale, basis, or justification for the reduced rates for emergency services proposed to the Health Care Providers by United in or around 2017 to Present;
- RFP No. 32 requested all Documents and/or Communications regarding United's goals, thoughts, discussions, considerations, and/or strategy regarding reimbursement rates and/or fee schedules for non-participating Emergency Medicine Groups and/or any hospitals or other providers of Emergency Department Services from January 1, 2016, through the present.

United responded to the Initial Discovery Requests but refused to produce documents. (1 RA 8-9, 11, 13.)

2. The Five Discovery Orders

As a result of United's obstinacy, the district court entered five separate Discovery Orders.

First Order Dated September 28, 2020

In the first of two orders entered on September 28, 2020, the district court denied United's motion for immediate entry of an ESI protocol and required United to participate meaningfully in discovery in the interim. (1 RA 115.)

Second Order Dated September 28, 2020

The district court's second September 28, 2020 order compelled United to produce documents responsive to the Initial Discovery Requests, including RFP Nos. 3-7, 11-13, 15-20, 24, 37, 39-40, and 42. (9 AA 2184-95.) The district court overruled United's objections, including its arguments on burdensomeness, as follows:

> The Court has also considered United's argument that the method of production of the Administrative Records[6] would not be proportional to the needs of the case. United's proposal to employ statistical sampling methodology, require the parties to employ experts to attempt to match each party's claims data, and/or only require the parties to produce documents related to a smaller set of the at-issue claims does not sufficiently address the discovery needed for the Health Care Providers to prosecute this case.

(9 AA 2192 ¶ 18.)[7]

Order Dated October 27, 2020

The district court's October 27, 2020 order compelled United to produce additional documents responsive to the Initial Discovery Requests, including: documents related to United's decision-making and strategy in connection with its out-of-network reimbursement rates (RFP Nos. 6, 7, 18, 32); documents and communications about the at-issue claims (RFP Nos. 3, 17); and documents relating to United's affirmative defenses (RFP No. 45). (11 AA 2684-95.) The district court

[6] United defined the term "administrative record" to include explanation of benefits forms, provider remittance advices, appeal documents, correspondence, and plan documents in effect at the time of service. (9 AA 2190-91 ¶ 11.)

[7] The Health Care Providers also offered to narrow the universe documents to be produced through a "claim matching" process, so that production of certain documents (explanations of benefits, provider remittance advices, etc.) could be excused to the extent the business records of the parties matched. (9 AA 2184-95.) However, because the Health Care Providers do not have copies of plan documents, United was required to produce those.

also made specific findings regarding United's noncompliance and issued a stern warning to United, foreshadowing an adverse inference instruction:

> The Court finds that United has not participated in discovery with sufficient effort and has not taken a rational approach to its discovery obligations. ***In the event that United does not meet the deadlines of the Court, the Court will have no choice but to make negative inferences.***

(11 AA 2690 ¶¶ 9-10 (emphasis added).)

Order Dated November 9, 2020

The district court's November 9, 2020 order set production deadlines. This was necessary because United had at that point produced a mere 50 claim files. The order required United to "produce a minimum of 2,000 claims files per month" and made additional findings regarding United's ongoing pattern of noncompliance. (12 AA 2779:22-26.)

Order Dated January 20, 2021

The district court's January 20, 2021 order denied United's motion for clarification of the October 27, 2020 order[8] and once again required United to make productions responsive to the Initial Discovery Requests. (1 RA 231-38.)

3. United's Noncompliance with the District Court's Discovery Orders

Following the district court's January 20, 2021 order, United *still* refused to

[8] 1 RA 165.

make meaningful productions. With no other recourse to compel United's compliance, the Health Care Providers filed a Renewed Motion for Sanctions ("Renewed Motion for Sanctions") on March 8, 2021. In that motion, the Health Care Providers requested that the district court issue the ultimate sanction of striking United's Answer and Affirmative Defenses as punishment for its ongoing pattern of misconduct.[9] (16 AA 3863-83.) The Health Care Providers detailed United's ongoing noncompliance with the prior Discovery Orders, including, notably, its refusal to produce documents responsive to the Initial Discovery Requests. By that time, United had produced a mere 97,901 *pages* of documents, the vast majority of which were a small portion of the "administrative records" that United had been ordered to produce in full on September 28, 2020. (16 AA 3863-83.)

On April 9, 2021, with less than one week before the April 15, 2021 document production cutoff, the district court convened a hearing on the Renewed Motion for Sanctions. United represented to the court that it had "substantially complied" with the Discovery Orders. (17 AA 4029:11-14.) However, when the district court asked United's counsel to quantify the percentage of its supposed "substantial compliance," counsel hedged: "[W]e are doing our absolute best to get there. And my hope is that we will." (17 AA 4037:14-22.) When the district court repeated the

[9] The Renewed Motion for Sanctions alternatively sought less-extreme forms of relief. (16 AA 3863-83.)

question, counsel still did not provide a definitive answer. (17 AA 4037:25-38:23.)

Despite its April 9, 2021 protestation to the district court that it had "substantially complied" with the Discovery Orders, on April 15, 2021—the final day for document productions under the scheduling order—United made a production that was more than ***five times as large*** as its total volume of documents produced to that date. The production was so voluminous that it took the Health Care Providers ***four days*** merely to download, unzip, and load the documents into a review platform. (2 RA 252.) To further put things in perspective: on April 9th, the bates-range of United's existing production stood at DEF100331. (2 RA 252.) At the end of the day on April 15th, the bates-range stood at DEF528969, plus additional documents bates-labeled UNITED-DEF0000001-0004749, yielding a total of ***at least 433,387 pages*** produced after the hearing on April 9, 2021. (2 RA 252.) Even that understates things, because many of the documents turned over in the April 15th production were PowerPoint presentations and Excel spreadsheets that were given only a single bates-number, but that actually consisted of numerous pages.

That United produced the overwhelming majority of its documents in a single document dump on the final day—rather than make timely rolling productions throughout the discovery period—proved enormously problematic for the Health Care Providers' counsel. That is because counsel had to scramble to review the

hundreds of thousands of pages under extraordinary time pressure, in order to be prepared for depositions that were beginning immediately after document discovery closed. (18 AA 4397.) Moreover, even despite the eleventh-hour production, United still failed to turn over vast swaths of the materials that the district court had ordered it to produce, including—notably—the full set of plan documents. (48 AA 11884:11-13.)

The Health Care Providers were further hamstrung by United's flagrant abuse of confidentiality designations. United designated a staggering ***63% of its production*** as Highly Confidential – Attorney's Eyes Only ("AEO"). (1 AA 227:1-5; 12 AA 2988-89.) As a result, the Health Care Providers' counsel were unable to share the documents with their clients, which was needed so that their clients could explain to counsel the documents' contents and significance. Of course, the vast majority of the documents tagged AEO were ***not*** "highly confidential" under any remotely reasonable construction of that phrase. In fact, many were not confidential at all. Notable examples included, *inter alia*, a copy of the final, published version of the Yale Study (which is readily available to the public on the internet) and a document merely containing inspirational quotes from legendary football coach Vince Lombardi. (125 AA 30967; 50 AA 12327:9-18.)

4. The District Court's August 3, 2021 Sanctions Order

On August 3, 2021—in response to United's pattern of bad faith conduct

throughout the discovery process and noncompliance with numerous prior orders—the district court issued a sanctions order (the "August 3, 2021 Order"). (18 AA 4383-402.) First, the district court acknowledged United's representation on April 9th that it purportedly had "substantially complied" with the court's Discovery Orders and already had produced a "massive amount" of relevant documents. (18 AA 4391 ¶ 14.) The district court found, however, that United's document production was deficient and "that United [was] not in compliance with the Court's September 28, 2020, October 27, 2020, November 9, 2020, and January 20, 2021 orders because United has failed to produce and provide critical information and documents compelled by those Orders."[10] (18 AA 4391-92 ¶¶ 16, 18.)

Accordingly, the district court issued the following findings of fact and conclusions of law that would ultimately lead to a rebuttable presumption instruction at trial:

- "United has shown a consistent pattern and practice of delay and obstruction in this case." (18 AA 4393 ¶ 21.)
- "United's failure to comply with the Orders of [the] Court has resulted in needless waste of time and resources." (18 AA 4393 ¶ 22.)

[10] The inadequacy of United's production was not the only wrongful conduct addressed in the August 3, 2021 Order. For instance, United had not produced a privilege log, despite admitting that it had withheld or redacted approximately 500 documents on privilege grounds. (18 AA 4393 ¶ 17.) The district court aptly described this omission as "shocking." (18 AA 4393 ¶ 17.)

- "The Court is also very concerned with the fact that the [Health Care Providers] have taken depositions without all of the documents being produced." (18 AA 4394 ¶ 23.)

- "Prejudice from the unreasonable delay in failing to comply with a court order will be presumed" as a matter of law. (18 AA 4395 ¶ 28 (citing *Foster v. Dingwall*, 126 Nev. 56, 65-66, 227 P.3d 1042, 1048-49 (2010).)

- "United's unquantifiable substantial compliance with the Court's September 28, October 27, November 8, and January 20 Orders and the rules of discovery in [Nevada] warrants sanctions and relief to the Health Care Providers." (18 AA 4395 ¶ 30.)

- "With respect to the first *Young* factor, the Court finds United's conduct to be willful. In evaluating the degree of United's willfulness, the Court finds that there has been a pattern of noncompliance by United. By omission, there has been an effort by United to keep the Health Care Providers from discovering information and having access to witnesses. United's willfulness lies with the United defendants and not its attorneys." (18 AA 4395 ¶ 31.)

Although the district court determined sanctions were appropriate, it declined to level the most severe sanctions sought by the Health Care Providers: striking United's Answer and Affirmative Defenses. Instead, the district court exercised its discretion and issued a measured, restrained sanction:

> In connection with RFP Nos. 5, 6, 7, 9, 10, 11, 12, 13, 15, 16, 18, 21, 27, 28, 30, 31, 32, 34 and Interrogatory Nos. 2, 3 and 10, anything not produced by United by 5:00 p.m. Pacific time on April 15, 2021 will result in a negative inference which may be asked of witnesses at the time of trial or at any hearing and will be included in jury instructions stating that the jury should infer that the information would be harmful to United's position.

(18 AA 4396.)

STATEMENT OF FACTS DIRECTED TO CASE NO. 85656[11]

A. The Stipulated Confidentiality and Protective Order

On June 24, 2020, the district court entered a Stipulated Confidentiality and Protective Order (the "Protective Order") to govern the discovery process. (1 PA 1-24.) The Protective Order allowed the parties to designate any document or electronically stored information produced in discovery as "Confidential Information" by marking it either "Confidential" or AEO.[12] However, the Protective Order required the parties to exercise restraint and care in designating materials for protection. (1 PA 5 ¶ 2, 9 ¶ 8.) The parties agreed that entering into the Protective Order would not operate as an admission by any party that any particular document, testimony, or information designated as Confidential or AEO did in fact contain or reflect that party's trade secrets or proprietary, confidential, or competitively sensitive business, commercial, financial, or personal information. (1 PA 16 ¶ 24.) Further, the designating party bore the burden of showing why information was

[11] In Order No. 23-09597, the Court consolidated United's mandamus petition (Case No. 85656) with its appeal (Case No. 85525). Because the mandamus petition implicates certain facts and procedural history that are relevant only to the issues raised therein, the Health Care Providers include a separate statement of facts directed to the mandamus petition.

[12] Per the Protective Order, the AEO designation was reserved for trade secrets and other "highly competitive or commercially sensitive proprietary and non-public information that would significantly harm business advantages of" the producing party. (1 PA 5-6 ¶ 2.)

entitled to confidential treatment. (1 PA 9-10 ¶ 9.)

The Protective Order contemplated reduced protections as trial approached. For example, ¶¶ 12(g) and 19 allowed witnesses expected to testify at trial to access AEO information in advance of their testimony. (1 PA 11-12 ¶¶ 11 and 12, 15 ¶ 19.) In addition, the Parties were not precluded from disclosing or offering into evidence information designated as Confidential or AEO. (1 PA 15-16 ¶ 20.) Nor did the Protective Order require the courtroom to be sealed if any such information was going to be presented. (1 PA 15-16 ¶ 20.)

B. United Abuses the Protective Order and Over-Designates Documents as AEO

Throughout the discovery process, United made a mockery of the Protective Order's requirement that parties exercise restraint in designating materials as "Confidential" or "AEO." (1 PA 9 ¶ 8.) Notably, United produced over 61,000 documents, of which it designated ***38,430 (63%)*** as "AEO." (1 PA 227:1-5; 12 PA 2988-89.) Virtually none of the documents came close to warranting this highest level of protection. (1 PA 231:18-24; 12 PA 2988-89.)

United's gross over-designation of documents as AEO resulted in enormous expenditures of money and time litigating confidentiality issues. (12 PA 2988-89.) By United's own admission, the parties engaged in multiple rounds of motion practice over the confidentiality designations. (12 PA 2989; 1 PA 231:18-24.) Both the special discovery master and the district court recognized on numerous occasions

that United had abused the process. (12 PA 2989; 1 PA 227:11-20, 231:18-24.)

C. Public Access to the Trial and Agreed Protocol for Confidential Exhibits

There was significant public interest in the trial. (2 PA 339:16-17, 444:24-25; 4 PA 803:1-2; 11 PA 2743:22-24; 12 PA 2800:20-21, 2987-2988, 31 PA 7408:12-7409:10, 7444:17-7445:9.) As a result, the district court granted two media requests. (1 PA 52-68.) On October 28, 2021, after those requests already had been granted, United filed an Objection to the Media Requests. (1 PA 69-83.) Despite numerous hearings in the case already having been held in public and broadcast over the internet, United sought to close the courtroom. (1 PA 69-83.)

On November 1, 2021—during a break from jury selection—the district court held a hearing on United's Objection to the Media Requests. (1 PA 218:13-40:11.) In the hearing, United clarified that it was not seeking a "dark" trial or to prevent publication of materials designated Confidential. (1 PA 218:19-19:4, 234:17-19.) Rather, United maintained that it was seeking only to prevent disclosure of exhibits designated AEO. (1 PA 218:21-19:4, 234:15-19.)

After hearing argument from all parties, the district court stated:

> I can't really totally rule on everything now because I don't know what's going to be offered. But I suggest we take it up on a piecemeal basis. I can tell you right now that I will not seal anything that's admitted. It's not going to happen. I'd be inclined [on] attorney's eyes only to close the room and have a redacted transcript, but it's going to have to be taken up on a case-by-case basis . . . I won't allow you to

> interrupt the presentation of the case, but I am going to look at protecting your rights as to AEO things, if necessary.

(1 PA 236:3-9, 237:17-22, 239:10-13, 239:23-25.)

The court then instructed the parties to confer on a protocol for the presentation of AEO exhibits, and it assured United that appropriate measures would be taken. (1 PA 239:10-13, 239: 23-25, 240:10.)

On November 3, 2021, following the parties' conferral, United informed the district court that it had identified a mere 19 exhibits containing AEO information on the Health Care Providers' exhibit list (the "19 AEO Exhibits").[13] United represented that these documents could be entered into evidence with certain portions redacted. (2 PA 493:22-94:15.) The court responded that it would not allow exhibits admitted into evidence or considered by the jury to be redacted. (2 PA 497:19-22.) Rather, if the evidence admitted contained AEO information, the district court would clear the courtroom and allow the transcript to be redacted after trial. (2 PA 497:19-25.) United confirmed that this would resolve its concerns. (2 PA 498:1-2.) Ultimately, the parties agreed on a protocol whereby United would propose redactions to portions of the 19 AEO Exhibits and the Health Care Providers would neither show those portions virtually nor read them aloud (without waiver of

[13] The 19 AEO Exhibits were: PX1, PX8, PX10, PX29, PX71, PX75, PX77, PX127, PX147, PX148, PX149, PX171, PX208, PX230, PX231, PX319, PX346, PX351, and PX507. (30 PA 7179 n.7; 31 PA 7439:2-9.)

any ultimate objections on sealing). (12 PA 2997; 30 PA 7179.)

The trial was conducted in accordance with the parties' agreement. (12 PA 299; 30 PA 7179.) Throughout the proceedings, numerous documents that had been marked confidential during the discovery process—but were not among the 19 AEO Exhibits—were admitted into evidence and discussed in open court without objection from United.[14] This occurred with media present in the courtroom and the trial livestreamed over the internet. Indeed, United itself introduced its own confidential documents without seeking protection. (*E.g.*, 5 PA 1192:9-18; 5 PA 1200:25-1216, 1220; 6 PA 1271:4-72:2; 5 PA 1053:20-54:8.)[15]

D. United's Motion to Seal

On December 5, 2021, United filed a Motion to Seal Certain Confidential Trial Exhibits ("Motion to Seal") that massively expanded the universe of documents over which it sought protection. (17 PA 3883-977.) Specifically, United

[14] *E.g.*, 34 AA 8361:1-5, 8384:25-86:24; 34 AA 8494:20-98:22; 3 PA 730:7-735:25; 4 PA 804:19-813:16; 5 PA 1040:25-1045:2.

[15] During the trial, TeamHealth posted on a public website several exhibits that had been admitted into evidence and discussed on the record. (5 PA 1017:2-6; 7 PA 1723:6-8.) These did *not* include any of the 19 AEO Exhibits or exhibits that otherwise were the subject of specific confidentiality objections. (7 PA 1724:19-25:3.) Indeed, the contents of these documents had been the subject of extensive testimony from one of United's executives, all of which was publicly broadcast. (12 PA 2996-97.) Nonetheless, United raised an objection to the website and the district court instructed TeamHealth to take the documents down, which it did. (5 PA 1068:9-18; 7 PA 1723:8, 1724:19-25:3; 12 PA 2997-98.)

requested that the district court permanently seal 124 exhibits.[16] (17 PA 3906-30, 4019-43; 31 PA 7439:25-40:4.) Curiously, of the original 19 AEO Exhibits, seven were not included in the set.[17] (17 PA 3906-30; 4019-43; 31 PA 7439:10-15.) In responding to the Motion to Seal, the Health Care Providers consented to certain proposed redactions but opposed the majority. (12 PA 2985-13 PA 3003.)

The district court carefully considered the Motion to Seal. Remarkably, it held ***four separate post-trial hearings***, wherein it individually considered each and every exhibit that United sought to seal. Those hearings and the court's holdings are summarized below:

1. January 12, 2022 Hearing

The first hearing took place on January 12, 2022. (31 PA 7403-98.) After considering Exhibits A and B to United's Motion to Seal (listing the proposed redactions and the reasons for them), considering witness declarations and the parties' briefing, and hearing oral argument, the district court made a preliminary ruling from the bench. It found "that the insurance industry is highly regulated. It is very competitive. The business models are almost identical. And, the defendant is a publicly-traded company." (31 PA 7493:17-20.) The district court further found

[16] On December 8, 2021, United filed a Supplement to Defendants' Motion to Seal Certain Confidential Trial Exhibits, requesting that two additional exhibits be sealed. (17 PA 3978-95.)

[17] PX29, PX125, PX171, PX208, PX346, PX351, and PX507.

that "[t]he strategies here for any business is to provide value for its customers and success for its shareholders" and that insurance companies "know a lot more about each other" and "[t]hey learn those metrics" from each other and the business models and metrics are identical. (31 PA 7493:21-25.) The district court then acknowledged the governing legal standard:

> [I]n Nevada, the Supreme Court rule is the least restrictive means. And I have to make findings in order to seal or redact things. And I can only do it for personal information, medical records, trade secrets, or when it's justified – which gives me some discretion.

(31 PA 7494:2-6.)

After weighing the evidence in light of that standard, the district court denied the Motion to Seal "in the most part," including:

> [W]ith regard to reimbursement rates; allowed amounts; the summit for Western Region; [Plaintiffs'] Exhibits 329, 378, 380; the chart of summary of claims in dispute; Plaintiffs' 175, 236. It will be denied with regard to anything that was publicly disclosed, which includes anything used in opening or closing or used at trial; [Plaintiffs' Exhibit] 256; Defendants' [Exhibit] 5507, [Plaintiffs' Exhibit] 218. It will be denied with regard to claim files, except personal information. It's denied with regard to amounts of billed or reimbursement. And it'll be denied with regard[to Plaintiffs'] Exhibit 473.

(31 PA 7494:15-95:1.)

The district court did however grant the Motion to Seal "in a few areas," including "the M&A targets, because I believe that was proprietary," "the Atlanta analysis," and "individual medical data." (31 PA 7494:7-14.) Finally, the court determined that the public interest in open access to court records outweighed

United's interest in protecting its information. (31 PA 7496:5-23.)

2. February 10, 2022 Hearing

The parties conferred and reached agreement on the application of the district court's ruling to the majority of United's proposed redactions. The court then held a February 10, 2022 hearing to address the redactions that remained in dispute.[18] (31 PA 7564-67; 32 PA 7568-74, 7629:4-95:16.) At that second hearing, the district court addressed each proposed redaction, one by one. It found that United's plans to expand into new geographic areas constituted trade secret information that should be redacted. (32 PA 7654:23-55:2.) Similarly, it found that certain sensitive financial information should be redacted. (32 PA 7665:1-4, 7672:4-7.) Because the court was unable to get through the full set of disputed redactions, it set another hearing for the following week. (32 PA 7694:11-14.)

3. February 16, 2022 Hearing

At the February 16, 2022 hearing, the district court addressed each page of certain documents containing proposed redactions, heard arguments from the parties, and issued a ruling after properly weighing the evidence. (32 PA 7707:25-86:20.) The district court once again was unable to get through the full set of disputed documents, so it set another hearing for the following day. (32 PA 7785:13-

[18] At this hearing, the district court heard argument on United's request for an evidentiary hearing on the Motion to Seal. (32 PA 7580:10-85:16.) The district court denied the request, finding it unnecessary. (32 PA 7585:13-16.)

86:25.)

4. February 17, 2022 Hearing

On February 17, 2022, the district court held its fourth hearing on the Motion to Seal. (53 AA 13144:22-46:21; 53 AA 13154:16-57:10.) At United's request, the court did not hear argument on specific redactions. Instead, it directed the parties to work together to resolve any outstanding issues in accordance with the previous rulings. (32 PA 7790-91; 53 AA 13154:16-57:10.) The court further directed the parties to submit an index describing any unresolved disputes, along with brief statements of the parties' respective positions, by March 4, 2022. (32 PA 7790-91; 53 AA 13154:16-57:10.) Consistent with that instruction, the parties submitted a March 4, 2022 Joint Status Report and Table Identifying the Redactions to Trial Exhibits That Remain in Dispute ("Joint Status Report"). (32 PA 7790-817; 33 PA 7818-24.)

5. The District Court's Written Order on the Motion to Seal

After four lengthy hearings and a careful review of all filings related to the Motion to Seal, the district court entered its Order Granting In Part and Denying In Part Defendants' Motion to Seal Certain Confidential Trial Exhibits ("Order on Motion to Seal"). (15 PA 3663-16 PA 3806.) Attached to that written order was an appendix ("Appendix A") containing a document-by-document and page-by-page breakdown of the court's ruling. (15 PA 3663-16 PA 3806.) Per the Order and

Appendix A, the Motion to Seal was denied with respect to multiple categories of information. (15 PA 3663-16 PA 3806.) However, consistent with its prior rulings, the court granted the Motion with respect to certain highly sensitive information. (15 PA 3663-16 PA 3806.)

The district court stayed execution of the Order on the Motion to Seal for thirty days, so that United could seek any appellate remedies it wished to pursue.

6. The District Court's Order Unsealing Trial Transcripts

On October 5, 2022, the district court held a status conference regarding the trial transcripts. (33 PA 7825-31.) Afterwards, and in light of the fact that no party had moved to seal any portion of those transcripts, the court ordered them immediately unsealed. (13 PA 3169-76.) After entry of that order, United moved to redact ten numerical figures appearing on five pages of the transcripts. (13 PA 3151-61.) United could not explain why it had not raised this issue at any time prior. (33 PA 7830:14-31:5.) The district court ultimately denied the motion, finding that the numerical figures were not entitled to protection under the prior Order on Motion to Seal. (15 PA 3653-54.)

SUMMARY OF THE ARGUMENT

I. To prevail on a motion for a new trial, a party must show that irregularities in the trial materially affected its substantial rights. United has not come close to satisfying that exacting standard. The district court's exclusion of in-

network reimbursement data and Medicare reimbursement data were entirely appropriate in a case exclusively involving reimbursement claims that were out-of-network (*i.e.*, not in-network) and commercial (*i.e.*, not Medicare). Moreover, the district court's exclusion of cost data was appropriate, because cost data has no bearing on the question at issue here: the reasonable value of the medical services rendered. That value is determined by market prices, not the cost of providing the services. Finally, the district court's rebuttable persumption instruction was an appropriate, measured response to United's pattern of intentional misconduct and self-serving noncompliance throughout the discovery process. At a minimum, the district court did not abuse its discretion in entering the various discovery orders.

II. United is not entitled to judgment as a matter of law on any of the claims asserted and proven at trial:

- With respect to the implied-in-fact contract claim, United argues that there was no contract because the parties never agreed on a price term. That position fails because, under longstanding Nevada law, formation of a valid implied contract does not require agreement on a price term. Rather, where parties agree that one will perform services in exchange for payment from the other but fail to agree on price, *quantum meruit* serves as a gap-filler to require reimbursement at reasonable market rates. That is precisely what the Health

Care Providers sought in this case: reimbursement from United at reasonable market rates.

- With respect to the unjust enrichment claim, this Court has long held that the Restatement (Third) of Restitution and Unjust Enrichment is authoritative on questions of unjust enrichment in Nevada. Here, the Restatement is squarely on point, and it unambiguously provides that a medical provider who renders out-of-network care to an insured patient is entitled to reimbursement at reasonable rates from the patient's insurer.
- With respect to the Health Care Providers' claim under the UCPA, the text of that statute, its legislative history, contextual clues, and basic canons of statutory construction make clear that third-party medical providers may assert claims against their patients' insurers, and that TPAs of self-funded health plans are considered insurers. Moreover, the Health Care Providers presented substantial evidence to support every element of their UCPA claim.

III. This Court should not overturn or reduce the jury's punitive damages award. The Health Care Providers presented an enormous volume of evidence demonstrating conduct by United that involved oppression, fraud, and malice. That conduct was in service of United's carefully considered, premeditated plot to enrich itself at the expense of emergency medical providers, by taking advantage of the providers' obligation to provide care to all presenting patients. As part of that plot,

United deliberately paid reimbursements at rates it knew to be substantially below reasonable value, while lying about how its rates were calculated, siphoning off money its self-funded health plan clients had earmarked for the payment of claims, and retaining those funds for itself. Moreover, the punitive damages award—while large in absolute terms—was a *de minimis* amount of money for United and does not infringe upon United's due process rights. Finally, the district court correctly held that an exception to the statutory punitive damages cap applies here.

IV. The Court should not hold that the Health Care Providers' claims are preempted by ERISA. First, this Court already definitively resolved that issue when it denied United's writ petition seeking dismissal of the Health Care Providers' claims based on ERISA preemption. United has presented no reason for the Court to revisit that ruling. Moreover, that prior ruling was absolutely correct on the merits and fully in line with a broad judicial consensus that legal claims asserted by medical providers against TPAs of self-funded health plans challenging rates of reimbursement are not preempted by ERISA.

V. The district court did not err in awarding attorneys' fees and interest to the Health Care Providers under the statutory PPA provisions governing health insurance. First, there is no inconsistency between Health Care Providers' arguments that their claims do not "relate to" ERISA plans and therefore are not preempted and also that the PPA applies. In the context of ERISA preemption, the

phrase "relate to" has a very specific, limited application that does not comport with common usage. Thus, a claim can relate to health plans for purposes of the PPA and still not be preempted by ERISA. Second, the text of the PPA indicates that the Legislature intended to create a private right of action under that statute. Third, United violated the PPA by withholding payment of portions of fully payable claims.

VI. Finally, the district court's order denying in part United's Motion to Seal was fully consistent with the strong public policy favoring open access to court records, and United has offered no meritorious reason for this Court to reverse that decision. In any event, United waived any potential right to have its materials sealed by failing to object at trial when those materials were introduced and discussed by counsel and witnesses in open court (in a public proceeding that was livestreamed over the internet).

STANDARD OF REVIEW

This Court reviews a district court's order denying a motion for new trial under an abuse of discretion standard. *Gunderson v. D.R. Horton, Inc.*, 130 Nev. 67, 74, 319 P.3d 606, 611 (2014). In applying that standard, the Court "will give deference to the district court's factual findings and application of the [legal] standards to the facts." *Id.* The Court will not disturb the district court's decision "absent palpable abuse." *Nelson v. Heer*, 123 Nev. 217, 223, 163 P.3d 420, 424-25

(2007). A district court's denial of a motion for judgment as a matter of law is reviewed *de novo*. *Wyeth v. Rowatt*, 126 Nev. 446, 460, 244 P.3d 765, 775 (2010).

ARGUMENT

I. THE DISTRICT COURT DID NOT ABUSE ITS DISCRETION IN DENYING UNITED'S MOTION FOR A NEW TRIAL

United appeals the district court's denial of its motion for a new trial pursuant to NRCP 59(a)(1). (United Br.[19] at 44.) That Rule provides that a district court may grant a new trial in response to certain enumerated "causes or grounds materially affecting the substantial rights of the moving party." To prevail on a motion under Rule 59(a)(1), the moving party must demonstrate: (1) that one of the "causes or grounds" applies,[20] and (2) that such cause or ground "materially affect[ed]" the moving party's "substantial rights." *See Pizarro-Ortega v. Cervantes-Lopez*, 133 Nev. 261, 266, 396 P.3d 783, 788 (2017) ("[E]ven when one of NRCP 59(a)'s new-trial grounds has been established, the established ground must have materially

[19] Citations herein to "United Br." refer to United's Opening Brief in its appeal (Case No. 85525) dated April 18, 2023. Citations to "Pet'n" refer to United's mandamus petition (Case No. 85656) dated November 15, 2022.

[20] The specific enumerated "causes or grounds" upon which United relies are: "irregularity in the proceedings . . . 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), and "error in law occurring at the trial and objected to by the party making the motion," NRCP 59(a)(1)(G). (United Br. at 44-45.)

affected the substantial rights of the aggrieved party to warrant a new trial." (brackets and quotation marks omitted)). Given this standard and the record below, the district court did not abuse its discretion in denying United's motion for a new trial.[21]

A. The District Court's Evidentiary Rulings Were Well Within Its Broad Discretion and Any Potential Error Was Harmless

United seeks a new trial based upon purportedly erroneous evidentiary rulings. (United Br. at 45.) One of the key disputed factual questions in this case is whether the rates that United paid to the Health Care Providers for out-of-network emergency medical services provided to its commercially insured members reflected the reasonable value of the services. (*See infra* Parts II.A, II.B.) United takes issue with a series of discovery orders—later converted into *limine* rulings—that precluded discovery and presentation of certain categories of evidence that United contends would have been probative on the issue of reasonable value. (United Br. at 54-55.) These categories include, *inter alia*, evidence showing non-analogous in-

[21] United takes an unwarranted potshot at the district court, accusing it of having made "one-sided" discovery and evidentiary rulings. (United Br. at 25.) That is not fair, and it is not true. Rather, the district court went out of its way—expending considerable time and enormous effort—to issue rulings that were evenhanded and well-reasoned and to impose sensible guardrails on an otherwise unwieldy process. Its efforts were commendable and deserving of praise. To the extent the court's exclusions lend themselves to an appearance of one-sidedness, that is merely a reflection of how much irrelevant, prejudicial evidence United sought to introduce. In any event, numerous rulings went in favor of United and against the Health Care Providers. (*E.g.*, 33 AA 8154-65.)

network rates and Medicare rates, evidence of the parties' prior contracting history, and evidence of the Health Care Providers' costs to deliver emergency medical services. (United Br. at 54-55.) United contends it was denied a fair trial because, without this supposedly critical evidence, "[t]he jurors . . . were forced to assess reasonable value based mainly on the *least* probative indicator: [the Health Care Providers'] own billed charges themselves. . . ." (United Br. at 54 (emphasis in original).)

United's request for a new trial is unfounded. Even assuming *arguendo* that certain evidentiary rulings were incorrect (and they were not)—United cannot show that such errors materially affected its substantial rights, for several reasons. *See Gallardo-Recendez v. Ely*, No. 78077, 2020 WL 5888031, at *1 (Nev. Oct. 1, 2020) (unpublished disposition) (affirming denial of motion for new trial where Rule 59(a) ground warranting new trial was established but errors had not materially affected substantial rights of moving party). First, United mischaracterizes the trial record. Notwithstanding United's protestations, the jury was *not* forced to assess reasonable value based mainly on the Health Care Providers' billed charges. Rather, the record included substantial evidence of other rates paid and accepted in the relevant Nevada markets. Notably, this evidence included data showing rates for out-of-network commercial claims, *i.e.* the claims most comparable to the disputed claims at issue. (8 PA 1792:13-22, 1866:17-22, 1923:5-23; 13 RA 2397.)

Second, United's substantial rights were not materially affected because, while the Health Care Providers *argued* that their billed charges reflected the reasonable value of the disputed claims, the jury ultimately rejected that position. The Health Care Providers sought $10.4 million in compensatory damages, reflecting the difference between their full billed charges and the amounts United had paid on the disputed claims. Despite that request, the jury awarded only $2,650,512 in compensatory damages. Thus, even if the evidentiary submissions pertinent to the calculation of reasonable value had in fact been limited primarily to the Health Care Providers' billed charges (and they were not), any attendant error was harmless.[22]

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[22] In any event, United talks out of both sides of its mouth when it complains that the Health Care Providers' billed charges are the "least probative indicator" of reasonable value. As detailed above, United for years earned substantial shared savings fees from its self-funded health plan clients, which it [redacted] (37 AA 9003:14-19; 34 AA 8488:15-18.) If United were correct that billed charges do not bear upon reasonable value and that there is no obligation for a plan to pay billed charges for covered out-of-network services, then any purported "savings" were illusory. If that were true, then United has extracted enormous fees from its plan clients with no reasonable basis for doing so (possibly in violation of its fiduciary duties). *See Hi-Lex Controls, Inc. v. Blue Cross Blue Shield of Mich.*, 751 F.3d 740, 742 (6th Cir. 2014) (affirming trial court judgment that TPA of self-funded health plan had engaged in prohibited self-dealing and had violated fiduciary obligations to plan by "inflating hospital claims with hidden surcharges in order to retain additional administrative compensation").

The district court's denial of United's motion for a new trial should be affirmed for the additional reason that United cannot establish any of the grounds set forth in Rule 59(a)(1). The supposed trial errors that United has identified amount to nothing more than run-of-the-mill evidentiary rulings pertaining to relevance and probative value versus the potential to cause prejudice and/or jury confusion. Given the parameters of this dispute, the district court's evidentiary determinations were well-founded. At a minimum, they fall comfortably within that court's broad discretion over evidentiary matters and provide no basis for this Court to take the extraordinary step of ordering a new trial.[23] *See LVMPD v. Yeghiazarian*, 129 Nev. 760, 764-65, 312 P.3d 503, 507 (2013) ("We review a district court's decision to exclude evidence for an abuse of discretion. The district court's exercise of discretion will not be disturbed absent a showing of palpable abuse." (citations and quotation marks omitted)); *M.C. Multi-Family Dev., L.L.C. v. Crestdale Assocs., Ltd.*, 124 Nev. 901, 913, 193 P.3d 536, 544 (2008) (same).

The specific evidentiary issues that serve as the basis for United's appeal are addressed in detail below.

[23] The district court's attention to focusing the evidentiary presentations upon relevant information was particularly apt given the trial's lengthy scope. Even with the court's *limine* rulings in place, the trial lasted for weeks. Had the districted court not precluded the introduction of irrelevant evidence, the trial easily could have lasted many additional weeks.

1. The district court's exclusion of in-network reimbursement amounts was not erroneous.

The district court excluded evidence of the Health Care Providers' contracted reimbursement rates with other insurers, *i.e.*, their in-network reimbursement amounts. United believes this ruling was erroneous and warrants a new trial. (United Br. at 58-60.) United is wrong.

The district court's exclusion of evidence regarding the Health Care Providers' in-network rates was well-founded. The disputed claims at issue in this case are exclusively out-of-network, and out-of-network claims are qualitatively different from in-network claims and command different market rates. That is because medical providers receive certain bundled benefits from insurers for being in-network. These benefits can include, *inter alia*, steerage of the insurers' members to the in-network providers, certainty of reimbursement amounts, prompt payment of claims, the availability of administrative appeals procedures etc. In exchange for these valuable benefits, in-network providers offer discounted rates to insurers. Conversely, where a provider is out-of-network and does not enjoy the in-network benefits, the in-network discount is unwarranted.

Numerous courts have recognized that this exchange—in-network benefits for discounted reimbursement rates—forms the basis of the "managed care bargain." For instance, the United States Court of Appeals for the Tenth Circuit explained in *Geddes v. United Staffing Alliance Employee Medical Plan* that "interpreting a

customary charge in the medical market as synonymous with the discounted rate negotiated by a health plan with its preferred providers is a ***significant deviation from industry custom***." 469 F.3d 919, 930 (10th Cir. 2006) (quotation marks omitted and emphasis added). Further:

> [T]he in-network provider fee is by definition *not* the usual fee charged by physicians in any given market. The whole purpose of assembling a network of preferred health providers is to allow the insurer to cover its beneficiaries' expenses on a negotiated schedule ***below the prevailing market rate***."

Id. (bold and italicized emphasis added; italicized emphasis in original).

Along those lines, the United States Court of Appeals for the Eleventh Circuit has observed that "[g]iven what is usual and customary in the managed care industry, we cannot imagine that even a poorly represented entity would promise to discount its fees in return for nothing." *HCA Health Servs. of Ga., Inc. v. Emp'rs Health Ins. Co.*, 240 F.3d 982, 999 n.33 (11th Cir. 2001), *implied overruling on other grounds recognized by Doyle v. Liberty Life Assurance Co. of Bos.*, 542 F.3d 1352, 1359 (11th Cir. 2008).[24]

[24] *See also Heartland Surgical Specialty Hosp., LLC v. Midwest Div., Inc.*, 527 F. Supp. 2d 1257, 1265 (D. Kan. 2007) ("In healthcare, the premise of selective contracting is to deliver volume to a healthcare provider in exchange for better reimbursement rates from the MCO."); *Crutcher v. Multiplan, Inc.*, 2020 WL 4495710, at *1 (W.D. Mo. Aug. 4, 2020) (discussing managed care tradeoff between rate and volume); *Christie Clinic, P.C. v. Multiplan, Inc.*, 2008 WL 4615435, *1-2 (C.D. Ill. Oct. 15, 2008) (discussing relationship between steerage to in-network providers and rates); *Methodist Health Servs. Corp. v. OSF Healthcare Sys.*, 2016

Given the well-recognized distinction between in-network and out-of-network reimbursement claims and their attendant market reimbursement rates, the district court reasonably determined that calculating out-of-network reimbursement amounts by looking to in-network rate data would involve an apples-to-oranges comparison. Thus, in-network reimbursement data was of limited probative value, and allowing the jury to hear evidence regarding that data likely would have resulted in prejudice and/or jury confusion. (37 AA 9165, 9167.) That determination was entirely appropriate. At a minimum, it was well within the bounds of the district court's broad discretion over questions of admissibility. *See Sheehan & Sheehan v. Nelson Malley & Co.*, 121 Nev. 481, 492, 117 P.3d 219, 226 (2005) ("[T]he trial court is vested with broad discretion in determining the admissibility of evidence.").

2. The district court's exclusion of evidence of prior contracting history was not erroneous.

United contends that the district court erred by excluding evidence of the parties' prior contracting history for two reasons: (1) evidence of the parties' prior in-network rates would be relevant to the reasonable value calculation, and (2) evidence showing that the parties later attempted but failed to reach agreement on

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WL 5817176, *2 (C.D. Ill. Sept. 30, 2016) (discussing relationship between price and volume in broad and narrow networks).

new in-network rates would be relevant to the question of whether the parties formed an implied-in-fact contract. (United Br. at 60-62.) Neither position has merit.

First, the parties' prior in-network rates have minimal probative value for the reasons set forth above. Second, United mischaracterizes the implied-in-fact contract claim. As explained more fully in Part II.A, *infra*, the Health Care Providers do not contend that the parties ever agreed upon a price term. Rather, the parties agreed that the Health Care Providers would treat United's members and submit claims in a form preferred by United, and that United in turn would pay for the claims. Absent an agreed-upon price term, *quantum meruit* serves as a gap-filler. Thus, evidence of the contract negotiations has minimal probative value, and the district court's exclusion of that evidence was well within its broad discretion.

3. The district court's exclusion of evidence and argument pertaining to Medicare rates was not erroneous.

United takes issue with the district court's exclusion of certain evidence and argument pertaining to Medicare reimbursement rates. Once again, the district court's ruling in this regard was well within its broad discretion and provides no basis for this Court to order a new trial.

The district court's *limine* instruction was measured and limited. The court excluded:

> Any evidence, argument or testimony that Medicare or non-commercial reimbursements rates are the reasonable rate, that providers accept it

> most of the time, or arguing reasonableness based on a percentage of Medicare or non-commercial reimbursement rates . . . .

(37 AA 9166:23-26.)

In short—and as United concedes—the court did *not* prevent United from offering evidence of Medicare rates. It merely prevented United from arguing that Medicare rates—or some derivative thereof—are reasonable. That makes perfect sense, because the disputed claims in this case are out-of-network commercial claims, and Medicare is not a commercial insurance program. As United itself admits, reasonable value in a commercial transaction is measured by market prices—*i.e.*, the prices that willing market participants operating at arm's length would charge and accept. (United Br. at 47-48, 60.) Medicare rates, in contrast, are established by government fiat, with no room for negotiation. Thus, Medicare rates have no bearing on the question at issue: what is the reasonable value of the medical services that the Health Care Providers delivered to United's commercially insured members?

The district court's *limine* instruction was not only reasonable in light of the fact that Medicare rates have minimal, if any, probative value, it was entirely necessary to ensure a fair trial. That is because, in the absence of the court's instruction, United would have been free to argue that Medicare rates necessarily reflect reasonable value. That argument likely would have been persuasive to the jury, given that Medicare is the largest payor in the country and its rates enjoy the

imprimatur of the federal government. But, as explained, Medicare rates inherently *do not* reflect reasonable value, because those rates are set by government mandate rather than market forces. Allowing United to argue that Medicare rates are reasonable would have led to substantial prejudice and jury confusion. The district court appropriately excluded such evidence and argument.

Moreover, United now misrepresents the scope of the district court's instruction. It complains that the court prevented its expert from explaining "how Medicare establishes its reimbursement rates and how those rates inform the reasonable value of [the Health Care Providers'] services." (United Br. at 64.) But, on its face, the court's instruction did not preclude evidence regarding how Medicare rates are determined. (37 AA 9166:14-21.) This was confirmed on the record at trial, when the parties agreed that the court's *limine* instruction regarding Medicare would *only* prevent United from offering testimony: (1) that Medicare is the largest payor in the country—suggesting that its rates are necessarily the usual rates received by providers, and (2) testimony that Medicare itself is an appropriate rate. (35 AA 8569:9-70:8.) And the court's instruction did not prevent United from explaining how it calculated the rates it paid; it merely prevented United from arguing that certain rates are reasonable *because* they are Medicare rates (or

Medicare plus a small premium).[25] Ultimately, the district court recognized (correctly) that Medicare rates inherently do not represent reasonable value in a commercial transaction, and—in order to prevent prejudice and jury confusion—it prevented United from offering testimony and argument suggesting that those rates do represent reasonable value. That instruction was wholly appropriate and *certainly* within the court's broad discretion.

Finally, United contends that the district court's *limine* instruction wrongly prevented witness Leslie Hare from explaining that one of the Defendants had calculated the reimbursement amounts it paid to the Health Care Providers according to the federal "greatest of three" ("GoT") rule, because one prong of the GoT analysis is the applicable Medicare fee-for-service rate.[26] (United Br. at 66-67.) Once again, that is wrong. The court's instruction merely prevented Ms. Hare from

[25] United actually elicited the sort of testimony it now contends was precluded by the district court's *limine* instruction. The Health Care Providers did not object. (4 PA 952:3-6.)

[26] GoT is an Affordable Care Act regulation that requires a commercial health insurer reimbursing an out-of-network emergency medical provider to pay, at a minimum, the greater of: (1) the insurer's median in-network rate for the service provided; (2) the amount calculated using the relevant health plan's formula for calculating out-of-network reimbursements (if any); and (3) the applicable Medicare fee-for-service rate. 45 C.F.R. § 147.138(b)(3)(i).

testifying that Medicare rates are reasonable, not from explaining how United calculated the amounts it paid.[27]

In any event, while the court did *not* prevent Ms. Hare from discussing GoT, such an instruction—had the court given one—would have been entirely reasonable. That is because even if United could demonstrate that it complied with GoT, that would not satisfy its obligations under Nevada law. As the federal Departments of Labor, Treasury, and Health & Human Services have explained in published guidance, "[u]nder the GOT regulation, ***the three prongs work together to establish a floor*** on the payment amount for out-of-network emergency services, and ***each state generally retains authority to set higher amounts for health insurance issued within the state***." 83 Fed. Reg. 19431-01, 19435 (May 3, 2018) (emphasis added). In other words, while GoT sets a federally mandated floor for out-of-network emergency reimbursement amounts, the regulation permits the States to establish higher floors. As such, because the Health Care Providers have asserted an entitlement to additional reimbursement under Nevada law, the relevant question

[27] The testimony that United highlights (United Br. at 67) does not suggest otherwise. It shows that the Health Care Providers' counsel asked Ms. Hare on cross-examination to answer "yes or no" as to whether the relevant health plan has a requirement for "usual and customary" reimbursement amounts written into its plan documents. (40 AA 9972:5-25.) Counsel's statement that the witness should "keep within the scope" referenced a separate GoT prong: "median par[ticipating],"—*i.e.*, median in-network reimbursement amount—that was the subject of a different *limine* instruction. (40 AA 9971:10-17.)

here is not what federal law has to say about the calculation of out-of-network rates, but what is required under Nevada law. Allowing United's witnesses to testify that United complied with its reimbursement obligations under state law by adhering to a federal regulation that in fact sets a lower reimbursement threshold than required under state law would pose an obvious risk of prejudice and jury confusion.

4. The district court's exclusion of cost evidence was not erroneous.

United contends that the district court's exclusion of evidence showing the Health Care Providers' costs incurred in delivering medical services warrants a new trial. (United Br. at 68-74.) That is wrong; cost data has minimal, if any, probative value with respect to the core question at issue: what is the reasonable value of the medical services that the Health Care Providers delivered to United's insureds? (*See* 12 RA 2036 (showing that United's determination of reasonable rates are based on what comparable providers in a geographic area *charge* for their services).)

United principally argues that this Court's decision in *Certified Fire Protection, Inc. v. Precision Construction, Inc.*, 128 Nev. 371, 283 P.3d 250 (2012), establishes that there are "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." (United Br. at 69-70.) That is wrong. The portion of *Certified Fire* that United considers significant is a footnote citing to § 49

of the Restatement (Third) of Restitution and Unjust Enrichment.[28] (United Br. at 70 (citing *Certified Fire*, 128 Nev. at 381 n.3, 283 P.3d at 257 n.3).) That Restatement provision directs that there are several alternative measures of enrichment from the receipt of nonreturnable benefits. One of them is "the market value of the benefit." Another is "the cost to the claimant of conferring the benefit." RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 49(3) (2011). Critically—and as United neglects to mention—the provision further directs that "[i]f the measures of enrichment available in a particular case yield different results, the choice between them is governed by the rules of §§ 50-52." *Id.* Section 50, in turn, provides that "[e]mergency medical treatment . . . will be valued for restitution purposes as if [it] had been validly requested. See § 20, Illustration 8." RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 50 cmt. e (2011). And § 20, Illustration 8 directs that a physician who provides emergency medical care is entitled to restitution "in the amount of his reasonable and customary charge." RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 20 cmt. c, illus. 8 (2011). Further, comment c of § 20 provides that the appropriate measure of value for emergency medical services rendered is "market value." In short, per the Restatement, the Health Care Providers' damages are measured by

[28] The Restatement is authoritative in Nevada. (*See infra* Part II.B.)

market value—*i.e.*, usual and customary rates—rather than costs.[29] Because the Restatement is authoritative in Nevada, cost evidence is irrelevant, and the district court did not err in excluding it.[30]

B. The District Court's Rebuttable Presumption Instruction Was Entirely Justified and Appropriate

United complains that the district court's delivery of a rebuttable presumption instruction as a sanction for United's discovery infractions resulted in prejudice, and it seeks a new trial on this alternative basis. (United Br. at 76-81.) That position

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[29] United cites several cases in which courts addressing payer/provider reimbursement disputes involving TeamHealth-affiliated plaintiffs have allowed discovery of cost evidence. (United Br. at 71.) There are other such disputes in which the courts have precluded cost discovery. (*See* 28(f) Addendum.) In fact, in the dispute between United and TeamHealth-affiliated providers in New York that United highlights on page 71 of its brief, the federal magistrate judge assigned to the case initially precluded cost discovery. *Emergency Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.*, 2023 WL 2447263, at *1 (S.D.N.Y. Mar. 10, 2023). The district judge later reversed that decision. The fact that experienced jurists have gone both ways on this issue demonstrates, at minimum, that the district court did not abuse its discretion to such a degree that a new trial is warranted.

[30] United's gripe that it was precluded from addressing the Health Care Providers' corporate structure (United Br. at 74-75) is unfounded. Indeed, United's counsel acknowledged on the record:

> I just wanted to say, Your Honor, that I understand that you're -- what your preliminary ruling was on corporate structure, but we've obviously gone through this whole trial and we've talked about the fact that TeamHealth owns Fremont, that Blackstone owns TeamHealth, and we got into that . . . .

(74 AA 18392, 18406.)

should be wholly rejected. The instruction was not an abuse of the district court's discretion. Rather, it was an appropriate, measured response to United's shocking pattern of discovery malfeasance. If anything, the district court was too lenient.

A district court has broad discretion to impose discovery sanctions and settle jury instructions. *See* NRCP 37(b); *MDB Trucking, LLC v. Versa Prod. Co., Inc.*, 136 Nev. 626, 631, 475 P.3d 397, 403 (2020) (citation omitted); *Bass-Davis v. Davis*, 122 Nev. 442, 447-48, 134 P.3d 103, 106 (2006). "If the district court, in rendering its discretionary ruling on whether to give an adverse inference instruction, has examined the relevant facts, applied a proper standard of law, and, utilizing a demonstratively rational process, reached a conclusion that a reasonable judge could reach, affirmance is appropriate." *Bass-Davis*, 122 Nev. at 447-48, 134 P.3d at 106 (citation and quotations omitted).

NRCP 37(b)(1) provides a non-exhaustive menu of sanctions available to the district court where a party "fails to obey an order to provide or permit discovery." In determining an appropriate sanction, the district court should consider several nonexclusive factors that look primarily to the willfulness or culpability of the offending party, the prejudice to the non-offending party caused by the loss or destruction of evidence, and the feasibility and fairness of alternative, less severe sanctions. *See, e.g.*, *Young v. Johnny Ribeiro Bldg., Inc.*, 106 Nev. 88, 93, 787 P.2d 777, 780 (1990); *see also MDB Trucking*, 136 Nev. at 631-32, 475 P.3d at 403-04

(quotations omitted). If the district court determines that the offending party willfully suppressed evidence, a rebuttable presumption arises under NRS 47.250(3) that the evidence was materially adverse to that party.[31] *MDB Trucking*, 136 Nev. at 635, 475 P.3d at 405. Nevada courts define "willful" discovery misconduct as "an intent to harm one's party opponent" by failing to produce material evidence in accordance with the district court's orders. *MDB Trucking*, 136 Nev. at 632, 475 P.3d at 404.

Here, the district court appropriately recognized that United had engaged in a pattern of discovery abuses. (*See supra* Statement of Facts, Part F.) Moreover, the sanction that the district court ultimately decided to impose—a measured rebuttable presumption instruction—"was among the most restrained in its arsenal." *Higgs v. Costa Crociere S.P.A. Co.*, 969 F.3d 1295, 1306 (11th Cir. 2020). As recounted above, the Health Care Providers served initial discovery in December 2019. (1 RA 1-17.) The requested materials included the plan documents, which state the relevant terms of United's members' health plans. (1 RA 8-9, 11.) Through seventeen months of discovery, United persistently refused to produce these documents in full, despite ***five separate court orders*** compelling it to do so. United's shenanigans extended even further, including, *inter alia*: (1) producing the vast majority of its

[31] Prejudice will also be presumed from unreasonable delay in compliance with discovery obligations. *See Foster*, 126 Nev. at 65-66, 227 P.3d at 1048-49.

documents on the final day of the document discovery period, rather than rolling productions throughout, (2) failure to produce a privilege log, despite having withheld hundreds of documents on privilege grounds, and (3) flagrant abuse of confidentiality designations. (*See supra* Statement of Facts, Part F.) All of these actions made it substantially more difficult for the Health Care Providers' counsel to prepare for witness depositions and trial. Indeed, United's primary defense at trial was that the rates it had paid were calculated according to the terms of its members' plans. (6 PA 1264:18-20; 38 AA 9410:3-10.) But the very documents that the Health Care Providers would need in order to test that assertion were the ones United failed to produce (despite having been ordered to do so multiple times).[32]

In its August 3, 2021 Order, the district court recounted the record of United's discovery violations and refusal to comply with court orders. (18 AA 4383-402.) As a sanction, the district court opted to deliver a measured instruction informing the jury of its findings that "Defendants had failed to comply with certain orders requiring responses to discovery" and that "Defendants' conduct was willful." (48 AA 11755:19-56:20.) The instruction directed the jury, should it find "that the Defendants have not rebutted evidence introduced by Plaintiff that relevant evidence

[32] In fact, the (incomplete) set of plan documents United *did* produce served to undermine its defense, because many of them contained terms requiring reimbursement at reasonable rates. (*See, e.g.*, 6 RA 884.)

was suppressed" by United, "to presume that the evidence was adverse to [United]." (48 AA 11972.) Given the record, this was well within the bounds of the district court's discretion, and in fact reflected an extraordinary degree of restraint. A new trial is not warranted on this basis.[33]

II. UNITED IS NOT ENTITLED TO JUDGMENT AS A MATTER OF LAW

United seeks judgment as a matter of law on all claims presented at trial. (United Br. at 81.) Nevada Rule of Civil Procedure 50(a) provides that where "a party has been fully heard on an issue during a jury trial," the trial court may grant judgment as a matter of law "if it finds that a reasonable jury would not have a legally sufficient evidentiary basis to find for the party on that issue." In applying that standard, "the district court must view the evidence and all inferences in favor of the nonmoving party." *Nelson*, 123 Nev. at 222, 163 P.3d at 424. If the nonmoving party "presented sufficient evidence such that the jury could grant relief to that

[33] United whines that the district court "erroneously instructed the jury that United had 'willfully' 'destroyed' documents essential to the case . . . ." (United Br. at 76.) It did not. Rather, the court informed the jury of its finding that United had "failed to comply with certain orders requiring responses to discovery." (48 AA 11972.) The reference in Jury Instruction 15 to "destroying evidence" was boilerplate from a pattern jury instruction, which the district court modified to make clear precisely what it had found. In any event, whether United willfully *destroyed* evidence or willfully *suppressed* evidence is immaterial. The bottom line is that United failed to produce discoverable information in its possession, custody, and control, despite multiple court orders compelling it to do so. The district court was absolutely entitled to inform the jury of such.

party," the trial court must deny the motion. *Id.* at 222-23, 163 P.3d at 424. This Court applies the same standard on appellate review. *Id.* at 223, 163 P.3d at 424.

Here, the evidentiary record created at trial was massive, consisting of 14 days of witness testimony and nearly 250 trial exhibits. After considering the voluminous record, the jury returned a verdict for the Health Care Providers and against all Defendants on all claims asserted. That verdict was supported by the evidence, was consistent with the law, and should be left undisturbed.

A. The Judgment Against United on the Health Care Providers' Implied Contract Claim Should Be Affirmed

Under Nevada law, an implied-in-fact contract exists where the conduct of the parties demonstrates that they (1) intended to contract; (2) exchanged bargained-for promises; and (3) the terms of the bargain are sufficiently clear. *See Certified Fire*, 128 Nev. at 379-80, 283 P.3d at 256. "[W]hether a contract exists is [a question] of fact, requiring this court to defer to the district court's findings unless they are clearly erroneous or not based on substantial evidence." *Id.* at 378, 283 P.3d at 255 (alterations in original). Here, there was extensive record support for each of the three elements, and the jury appropriately returned a verdict for the Health Care Providers on their implied-in-fact contract claim.

United seeks judgment as a matter of law on the implied contract claim for two related reasons. First, it contends that "[the Health Care Providers] identified no conduct by United in any way manifesting its agreement to allow payment of [the

Health Care Providers'] full billed charges." (United Br. at 83.) Second, United argues that the Health Care Providers "provided no consideration for United's alleged promise to pay full billed charges." (United Br. at 83-84.) Neither position has merit.

In addressing the implied contract claim, United attacks a strawman. That is because the claim actually asserted was not that the parties had formed an agreement *for United to pay full billed charges*; it was that the parties had agreed that the Health Care Providers would treat United's members and submit claims in a form requested by United, and that United, in turn, would pay the Health Care Providers. This basic truth is evident in Jury Instruction 25, which explained that:

> Plaintiffs claim that they entered into an implied contract with Defendants. The Plaintiffs contend that they agreed to provide emergency care to patients covered by health care plans that Defendants issued or administered, submit claims in the manner required by the Defendants and not balance bill the patients. Plaintiffs contend that in exchange Defendants agreed to reimburse Plaintiffs for the reasonable value of Plaintiffs' services.

(48 AA 11982.)

It is further evident in the verdict form, which made no mention of the Health Care Providers' billed charges. Rather, that form merely asked the jury to decide: (1) whether United had formed an implied contract with the Health Care Providers; (2) if so, whether United had "fail[ed] to comply" with the terms of that contract;

and (3) if so, "what amount of money . . . should be awarded," absent reference to a specific price term. (49 AA 12035, 12039-40.)

Notably, a claim that parties formed an implied agreement for one party to perform services and the other to pay for those services—but without a definitive price term—is fully consistent with Nevada law. As this Court explained in *Certified Fire*:

> To find a contract implied-in-fact, the fact-finder must conclude that the parties intended to contract and promises were exchanged, the general obligations for which must be sufficiently clear. ***It is at that point that a party may invoke quantum meruit as a gap-filler to supply the absent term***. Where such a contract exists, then, quantum meruit ensures the laborer receives the reasonable value, usually market price, for his services.

128 Nev. at 379-80, 283 P.3d at 256 (emphasis added and citations omitted).

That is precisely what happened here. The jury simply found that the parties had formed an implied contract. While that contract lacked a definitive price term,[34]

[34] United maintains that 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" precludes a finding that the parties entered into a contract. (United Br. at 89.) That position misstates the law. Formation of an implied contract does *not* require that the parties agree on a price term. Rather, absent evidence of an agreement on price, the law imposes a requirement to pay reasonable value. *Certified Fire*, 128 Nev. at 379-80, 283 P.3d at 256; *see also Sierra Dev. Co. v. Chartwell Advisory Grp., Ltd.*, 325 F. Supp. 3d 1102, 1107 (D. Nev. 2018) ("quantum meruit may be employed as a gap-filler to supply absent terms"); *Mielke v. Standard Metals Processing, Inc.*, 2015 WL 1886709, at *5 (D. Nev. Apr. 24, 2015) (same); *Risinger v. SOC LLC*, 936 F. Supp. 2d 1235, 1247 (D. Nev. 2013).

the law supplies a gap-filler requiring reimbursement at rates equaling the reasonable value of the services. And although the Health Care Providers argued at trial that their billed charges equaled the reasonable value of the services, that is *not* a contention that the parties specifically agreed to reimbursement at the Health Care Providers' full billed charges. Rather, there was an obligation imposed by law for United to pay the reasonable value of the services rendered, and that in turn triggered a factual dispute over what that reasonable value happened to be.[35] The jury then resolved the factual dispute by calculating reasonable value based on the evidence presented. Given the amount of damages awarded, the jury apparently determined reasonable value to be less than the Health Care Providers' full billed charges, although nearly double what United had paid. (49 AA 12035-46; 13 RA 2252-65.)

Moreover, the jury's finding that the parties formed an implied contract was amply supported by the trial record. As noted, the elements of contract formation are: (1) an intention to contract; (2) exchange of promises; and (3) sufficiently clear terms. *Certified Fire*, 128 Nev. at 379-80, 283 P.3d at 256. Each of those elements enjoys sufficient evidentiary support here. There was evidence that the parties intended to contract in the form of testimony from United executives that United understood that the Health Care Providers had provided valuable services to

[35] Indeed, United's representatives acknowledged in their testimony that United had an obligation to pay reasonable value. (39 AA 9557:17-19, 9589:13-91:3.)

United's members and that United was obligated to reimburse the Health Care Providers for those services. (39 AA 9557:17-19, 9589:13-91:3; 32 AA 7987:11-23; 5 PA 1190:6-24; 46 AA 11345:12-14; 40 AA 9871:23-73:5.) There was further evidence that in exchange for United's promise to reimburse the Health Care Providers, the Health Care Providers promised to treat United's members and to submit their claims in a form preferred by United.[36] (46 AA 11387:1-89:25; 8 PA 1971:8-14; 32 AA 7987:11-23.) Reviewing the evidence in the light most favorable to the Health Care Providers and drawing all inferences in their favor, *Nelson*, 123 Nev. at 222, 163 P.3d at 424, that is more than enough to support the jury's verdict. In fact, a Nevada federal district court addressing a dispute over reimbursement amounts for emergency medical claims recently held that allegations very similar to those proven in this case were sufficient to support an implied contract claim. *Prime Healthcare Servs. – Reno, LLC v. Hometown Health Providers Ins. Co., Inc.*, 2022 WL 1692525, at *7-8 (D. Nev. May 26, 2022). This Court should affirm the district

[36] United argues that there was no consideration for the implied contract because the Health Care Providers had a pre-existing statutory duty to treat its members. (United Br. at 91-92.) "[C]onsideration may be any benefit conferred or any detriment suffered . . . and the law will not enter into an inquiry as to its adequacy." *Nyberg v. Kirby*, 65 Nev. 42, 51, 188 P.2d 1006, 1010 (1948). Here, evidence that the Health Care Providers agreed to submit claims in a form preferred by United in exchange for United's agreement to pay reimbursements is valid consideration.

court's judgment on the Health Care Providers' implied contract claim for the same reasons.[37]

B. The Judgment Against United on the Health Care Providers' Unjust Enrichment Claim Should Be Affirmed

As this Court has explained, "[u]njust enrichment exists when the plaintiff confers a benefit on the defendant, the defendant appreciates such benefit, and there

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[37] United notes several disputes between itself and other TeamHealth-affiliated emergency medical providers where courts have rejected the plaintiffs' implied contract claims, and it urges this Court to follow suit. (United Br. at 89-90.) The Court should decline that invitation. The cases cited are inapposite, as they are all pleading-stage decisions finding that the plaintiffs had not adequately alleged implied contract claims. *See, e.g.*, *ACS Primary Care Physicians Sw., P.A. v. UnitedHealthcare Ins. Co.*, 514 F. Supp. 3d 927, 933-34 (S.D. Tex. 2021), *rev'd on other grounds*, 60 F.4th 899 (dismissing implied contract claim because "[p]laintiffs' allegations are wholly conclusory and bereft of facts that demonstrate a meeting of the minds"). Here, in contrast, not only have the Health Care Providers *stated* their claim, they *proved* their claim to a jury at trial. Moreover, United's cases were decided under the laws of other jurisdictions, which often differ meaningfully from Nevada law. *See, e.g.*, *Emergency Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.*, 2021 WL 4437166, at *12 (S.D.N.Y. Sept. 28, 2021) (dismissing implied contract claim in part because plaintiffs "[did] not plead a necessary meeting of the minds as to the price of services, which under New York law is an essential contract term.").

In any event, United neglects to mention that numerous courts have ruled in favor of provider-plaintiffs on this issue in analogous disputes. *See, e.g.*, *InPhyNet S. Broward, LLC v. AvMed, Inc.*, 2020 WL 5231563 at *2-3 (Fla. Cir. Ct. Aug. 31, 2020) (denying an insurer's motion to dismiss in relevant part because a healthcare provider sufficiently stated a cause of action for breach of contract implied-in-fact regarding insufficient reimbursements for out-of-network emergency services); *Fla. Emergency Physicians Kang & Assocs. v. Cap. Health Plan, Inc.*, 2020 WL 13823028, at *1 (Fla. Cir. Ct. June 4, 2020) (same).

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." *Certified Fire*, 128 Nev. at 381, 283 P.3d at 257 (quotation marks omitted). A "benefit" can include "services beneficial to or at the request of the other, denotes any form of advantage, and is not confined to retention of money or property." *Id.* at 382, 283 P.3d at 257 (quotation marks omitted). "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. In other words, the defendant makes restitution to the plaintiff in *quantum meruit*." *Id.* at 380-81, 283 P.3d at 257. And q*uantum meruit* is "restitution for the market value of goods or services."[38] *Id.* at 380, 283 P.3d at 256.

According to United, the Court should grant judgment as a matter of law on the Health Care Providers' unjust enrichment claim because: (1) the circumstances present no inequity because the Health Care Providers could have submitted balance bills to United's members for the amounts of United's underpayments, and (2) any benefit arising from the Health Care Providers' provision of valuable medical services was conferred upon United's members, not United itself. Those positions should be rejected.

[38] As explained above, *quantum meruit* also supplies the price term for the Health Care Providers' implied contract claim.

With respect to the law of unjust enrichment, this Court has declared that "Nevada jurisprudence relies on the First and Third Restatements of Restitution and Unjust Enrichment for guidance." *Korte Constr. Co. v. State ex rel. Bd. of Regents of Nev. Sys. of Higher Educ.*, 137 Nev. 378, 381, 492 P.3d 540, 543-44 (2021); *see also Certified Fire*, 128 Nev. at 379-82, 283 P.3d at 256-57 (citing Restatement as authoritative expression of law of unjust enrichment); *Nautilus Ins. Co. v. Access Med., LLC*, 137 Nev. 96, 101-12, 482 P.3d 683, 688-96 (2021) (same). Here, the Restatement (Third) of Restitution and Unjust Enrichment is directly on point and supplies the answer to the specific question at issue. Section 20 provides that "[t]he claim for emergency medical services rendered in the absence of contract is one of restitution's paradigms . . . . An emergency that threatens life or health offers the ultimate justification for conferring a benefit in the absence of contract, if need be, asserting a claim for payment only after services have been rendered." RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 20 cmt. a (2011). Critically, this principle applies to an unjust enrichment claim against an insurer: "The claim described in this section may be asserted against the recipient of services, a successor, or a representative . . . based on the theory that the claimant, by obtaining needed services for the benefit of a third person, has in so doing discharged a duty of the defendant." *Id.*

Section 22 of the Restatement describes the exact situation presented here. It provides that "[a] person who performs another's duty to a third person or to the public is entitled to restitution from the other as necessary to prevent unjust enrichment, if the circumstances justify the decision to intervene without request." *Id.* § 22(1). It specifies that such "unrequested intervention may be justified" whenever "the claimant . . . perform[s] another's duty to furnish necessaries to a third person to avoid imminent harm to the interests of the third person." *Id.* § 22(2)(b). The Restatement then offers this illustration:

> Hospital provides emergency services to patients enrolled with Managed Care Organization, at rates established under a contract designating Hospital a "preferred provider." The contract expires and is not renewed after the parties fail to reach agreement about price. Hospital continues to provide services to MCO's patients nevertheless. MCO tenders payment for these services at the "preferred" rate fixed by the prior agreement; Hospital demands compensation at the higher, "standard" rate invoiced to uninsured patients. The court finds that there is no contract, express or implied, to fix the price of Hospital's services on either basis. ***Hospital's right to payment from MCO rests on a claim in restitution under § 22(2)(b); MCO's unjust enrichment is measured by the reasonable value of the services rendered by Hospital***.

Id. at cmt. g, illus. 10 (emphasis added).

The Restatement's clear example fits precisely within the parameters of this case: an out-of-network emergency medical provider (the Health Care Providers) seeking payment from an insurance company (United) for the reasonable value of the emergency services provided to the insurance company's members. Consistent

with the Restatement, a Nevada federal district court recently upheld an emergency medical provider's unjust enrichment claim against a health insurer in perfectly analogous circumstances. *Prime Healthcare*, 2022 WL 1692525, at *8 (recognizing that "[b]y rendering medically necessary services to the insured members, it is plausible that [provider] conferred a benefit to [insurer], because [insurer] would not have to compensate another provider for the same services."). Courts in other jurisdictions agree. *See, e.g.*, *Emergency Physician Servs. of N.Y.*, 2021 WL 4437166, at *12 (recognizing that "where, as here, a hospital is required by law to treat patients in an emergency room, an insurance company is unjustly enriched if it fails to pay the hospital in full for the costs incurred in rendering the necessary treatment to the insurer's enrollees").[39] In addressing this issue, the court in *El Paso*

[39] *See also HCA Health Servs. of Va., Inc. v. CoreSource, Inc.*, 2020 WL 4036197, at *6 (E.D. Va. July 17, 2020) ("The defendants' argument that the Hospital conferred a benefit on the [patient], not CoreSource, misses the mark. Indeed, courts have held that healthcare providers may recover under an unjust enrichment theory of liability against entities responsible for reimbursing those providers."); *Baptist Hosp. of Miami, Inc. v. Medica Healthcare Plans, Inc.*, 385 F. Supp. 3d 1289, 1293 (S.D. Fla. 2019) (plaintiff provider sufficiently alleged benefit conferred where it pled that the "Hospitals conferred a direct benefit on Medica by providing valuable medical services to members of Medica's healthcare plans"); *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc.*, 832 A.2d 501, 507 (Pa. Super. Ct. 2003); *Aetna Life Ins. Co. v. Huntingdon Valley Surgery Ctr.*, 2015 WL 1954287, at *10 (E.D. Pa. Apr. 30, 2015); *River Park Hosp., Inc. v. BlueCross BlueShield of Tenn., Inc.*, 173 S.W.3d 43, 59-60 (Tenn. Ct. App. 2002); *Appalachian Reg'l Healthcare v. Coventry Health & Life Ins. Co.*, 2013 WL 1314154 (E.D. Ky. Mar. 28, 2013); *Surgery Ctr. of Viera, LLC v. UnitedHealthcare, Inc.*, 465 F. Supp. 3d 1211, 1224 (M.D. Fla. 2020); *Nat'l Labs., LLC v. United Healthcare Grp., Inc.*, 2018 WL 11260511, at *4

Healthcare System, Ltd. v. Molina Healthcare of New Mexico, Inc. explained that:

> While it is true that the immediate beneficiaries of the medical services were the patients, and not [the payer], [payer] *did* receive the benefit of having its obligations to its plan members . . . discharged. . . . Indeed, [payer's] very reason for existence is to ensure that such services are provided to plan members; seeing this core obligation fulfilled is hardly incidental.

683 F. Supp. 2d 454, 461 (W.D. Tex. 2010).

Similarly, the court in *South Broward Hospital District v. ELAP Services, LLC* observed:

> As a matter of law, a healthcare provider can state a claim for unjust enrichment where it alleges that it would be inequitable for healthcare insurers to be allowed to collect premiums from their members and subscribers in return for agreeing to properly reimburse providers that render covered medical services without paying the value thereof to the provider.

2020 WL 7074645, at *7 (S.D. Fla. Dec. 3, 2020).

And while United has identified certain opposing decisions (United Br. at 95-97), the Restatement view—and more analytically sound view—recognizes that in discharging an insurer's contractual obligation to provide for its members' care by providing valuable medical services to those members, an emergency medical provider confers a benefit upon the insurer, and it would be inequitable for the insurer to retain that benefit without paying fair value. Because Nevada law treats

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(S.D. Fla. Apr. 4, 2018); *N.Y.C. Health & Hosps. Corp. v. WellCare of N.Y., Inc.*, 937 N.Y.S.2d 540, 546 (Sup. Ct. 2011); *Merkle v. Health Options, Inc.*, 940 So. 2d 1190, 1199 (Fla. Dist. Ct. App. 2006).

the Restatement as authoritative, this Court should affirm the district court's denial of United's motion for judgment as a matter of law on the Health Care Providers' unjust enrichment claim.[40]

C. The Judgment Against United on the Health Care Providers' UCPA Claim Should Be Affirmed

The UCPA provides, *inter alia*, that "[a] person shall not engage in this state in any practice which is defined in . . . NRS 686A.310 . . . to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance." NRS 686A.020. Section 686A.310(1), in turn, enumerates a series of "unfair

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[40] United separately argues that the Health Care Providers cannot recover on both their implied contract and unjust enrichment claims, because the law prohibits recovery in unjust enrichment where the parties' relationship is governed by a contract. (United Br. at 94-95.) The Health Care Providers agree with that general proposition of law, and the implied contract claim and unjust enrichment claim were pled in the alternative. Nonetheless, the principle that a party may not simultaneously recover under both a contract and unjust enrichment has no application here. As this Court has explained, *quantum meruit* serves two separate roles: (1) to supply the missing price term where parties formed an implied-in-fact contract but did not agree upon price; and (2) to dictate the measure of restitution where parties have not formed a contract but the elements of unjust enrichment are otherwise satisfied. *Certified Fire*, 128 Nev. at 379-82, 283 P.3d at 256-57.

Here, as noted, the Health Care Providers relied upon *quantum meruit* both to supply the price term for their implied contract and also to measure restitution in the event there was no valid contract. The implied contract and unjust enrichment claims therefore sought identical damages: the difference between the reasonable value of the services provided to United's members and the amounts United actually paid. (48 AA 11957, 11979, 11982.) The jury in fact awarded identical damages on the two claims. (49 AA 12035-46.) And there was no double recovery, because the Health Care Providers collected that amount only once.

practices," one of which is "[f]ailing to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear." NRS 686A.310(1)(e). Subpart (2) of § 686A.310 contains an express private right of action. It directs that "[i]n addition to any rights or remedies available to the [Insurance] Commissioner, an insurer is liable to its insured for any damages sustained by the insured as a result of the commission of any act set forth in subsection 1 as an unfair practice."

United seeks judgment as a matter of law on the Health Care Providers' UCPA claim for three reasons. It contends that: (1) standing to assert a UCPA claim is limited to insureds, as opposed to third party medical providers who render care to insureds; (2) a UCPA claim may be asserted only against an insurer, and that several of the United Defendants are not insurers; and (3) the Health Care Providers did not adduce evidence sufficient to prove their UCPA claim. Each of those positions is without merit.

1. The Health Care Providers have standing to assert a UCPA claim under the circumstances presented.

United argues that the Health Care Providers do not have standing to assert a UCPA claim, because standing is limited exclusively to insureds. Its position rests largely upon this Court's decision in *Gunny v. Allstate Insurance Co.*, 108 Nev. 344, 830 P.2d 1335 (1992) (per curiam). *Gunny* involved a claim under a liability insurance policy. The plaintiff had been injured in an accident on his father's boat.

Id. at 345, 830 P.2d at 1335. Rather than sue his father, he filed a claim directly against his father's insurer. *Id.* at 345, 830 P.2d at 1335. When the insurer did not pay the claim in the appropriate time period, the plaintiff sued the insurer, asserting claims for common law bad faith and violation of § 686A.310. *Id.* at 345, 830 P.2d at 1335. On appeal, this Court held that the plaintiff "ha[d] no private right of action as a third-party claimant under NRS 686A.310." *Id.* at 346, 830 P.2d at 1336.

The Court's holding in *Gunny* was perfectly reasonable under the circumstances. Because the plaintiff was not a policyholder, the proper course of action would have been to bring a personal injury claim against the tortfeasor (his father). That claim would have triggered the insurer's duties under the policy to defend and indemnify its insured. If the insurer then had unreasonably delayed in providing coverage, the insured (*i.e.*, the father) could have asserted bad faith and/or UCPA claims against the insurer. That is because, in that instance, the insured father would have been the party injured by the insurer's conduct.

The circumstances here are markedly different from those presented in *Gunny*. This case involves health insurance, not liability insurance. And this case involves emergency services and care, which the Health Care Providers are obligated to provide and for which United is obligated to pay. Unlike the insured in *Gunny*, who was a total stranger to the insurance agreement, the Health Care Providers have a direct relationship with United. (*See supra* Argument, Parts II.A, II.B.) The Health

Care Providers billed United directly for the services provided, and United—recognizing its obligation to pay for these covered emergency medical services—reimbursed the Health Care Providers directly (albeit at unreasonably low rates). It has always been the case—and obvious to United—that the parties who would be injured by its unfair claims handling practices are the medical providers who render care to its members and subsequently submit claims for reimbursement to United. Indeed, if the Health Care Providers were strangers to the insurance relationship, United would not have paid the claims that they submitted. Further, here—as distinguished from *Gunny*—the Plaintiffs had an implied-in-fact contract with the insurer.

"The leading rule of statutory construction is to ascertain the intent of the legislature in enacting the statute." *Dezzani v. Kern & Assocs., Ltd.*, 134 Nev. 61, 64, 412 P.3d 56, 59 (2018). Further, courts should construe statutes "in accordance with the general purpose of those statutes and to avoid unreasonable or absurd results[.]" *Id.* at 64, 412 P.3d at 59. To apply *Gunny* and its progeny[41] in the

[41] Other authorities cited by United that follow *Gunny* in holding that the UCPA does not allow for third-party standing likewise involve liability insurance, rather than health insurance. *See, e.g.*, *Fulbrook v. Allstate Ins. Co.*, Nos. 61567, 62199, 2015 WL 439598 (Nev. Jan. 30, 2015) (unpublished disposition); *Talbot v. Sentinel Ins. Co., Ltd.*, 2012 WL 3995562 (D. Nev. Sept. 10, 2012); *Burley v. Nat'l Union Fire Ins. Co. of Pittsburgh PA*, 2015 WL 5829878 (D. Nev. Oct. 6, 2015); *Wilson v. Bristol W. Ins. Grp.*, 2009 WL 3105602 (D. Nev. Sept. 21, 2009).

emergency health insurance context would be the height of unreasonableness and absurdity. Given the nature of the industry, such a holding would have the practical effect of conferring wholesale immunity upon health insurers from private lawsuits under the UCPA, since it virtually always will be the case that the parties asserting claims against health insurers are third party medical providers. That cannot be what the Legislature intended when it amended § 686A.310[42] specifically to add an express private right of action.[43]

Subjecting United to UCPA liability under the present circumstances would also be consistent with the "general purpose" of the statute. *Dezzani*, 134 Nev. at 64, 412 P.3d at 59. The purposes of the Insurance Code are set forth in NRS 679A.140. They include, *inter alia*, to:

- "Protect policyholders and all having an interest under insurance policies," NRS 679A.140(1)(a);
- "Implement the public interest in the business of insurance," NRS 679A.140(1)(b);

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[42] *See Crystal Bay Gen. Improvement Dist. v. Aetna Cas. & Sur. Co.*, 713 F. Supp. 1371, 1376 (D. Nev. 1989) (discussing 1987 amendment).

[43] By its plain terms, the UCPA governs health insurers and affords rights to medical providers. *See, e.g.*, NRS 686A.027 ("It constitutes an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to knowingly access or utilize a contractual discount of a provider of health care pursuant to a provider network contract without a contractual relationship with the provider of health care, health carrier or third party . . . .")

- "Insure that policyholders, ***claimants*** and insurers are treated fairly and equitably," NRS 679A.140(1)(e) (emphasis added); and
- "Prevent misleading, unfair and monopolistic practices in insurance operations," NRS 679A.140(1)(h).

Each of those enumerated purposes would be advanced by a ruling of this Court affirming the district court's holding that the Health Care Providers have standing to bring a UCPA claim against United. Alternatively, they would be obstructed if this Court were to decide the opposite. Indeed, § 679A.140(2) specifically directs that "[t]he provisions of this Code shall be given reasonable and ***liberal*** construction for the fulfillment of these purposes" (emphasis added).

In light of the above, the Health Care Providers—emergency medical providers who treated United's members as part of an ongoing relationship between themselves and United and who were injured by United's unfair claims handling practices—have standing to assert UCPA claims against United. To the extent there is any confusion as to whether *Gunny* is controlling, the Health Care Providers respectfully submit that this Court should clarify in its opinion that *Gunny*'s holding with respect to third-party standing under the UCPA does not apply in the health insurance context, and particularly with regard to the provision of emergency medical services.[44]

[44] United cites to *Texas Medicine Resources, LLP v. Molina Healthcare of Texas, Inc.*, wherein the Texas Supreme Court held in favor of defendant insurers on a claim

2. Liability under the UCPA applies to third-party administrators of employer-sponsored health plans.

United contends that several of the Defendants are entitled to judgment as a matter of law on the UCPA claim, because those entities are TPAs for self-funded health plans.[45] (United Br. at 108-09.) United maintains that the UCPA features a

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asserted by plaintiff emergency medical providers under that State's analogous unfair insurance practices statute. 659 S.W.3d 424, 437-38 (Tex. 2023). United maintains that "[t]he only notable difference between the Texas UCPA and the Nevada UCPA . . . is that the Texas law permits an 'insured ***or beneficiary***' to bring suit." (United Br. at 103 (emphasis in original).)

United is wrong. The Texas Insurance Code features an express right of action available to any "person" injured by a violation of the unfair insurance practices statute; such claims are not limited to insureds and beneficiaries. *Tex. Med. Res.*, 659 S.W.3d at 438 n.101 (citing Tex. Ins. Code § 541.151(1)). Nonetheless, the relevant substantive provision of the statute directs that "[i]t is an . . . unfair or deceptive act or practice in the business of insurance to engage in the following unfair settlement practices ***with respect to a claim by an insured or beneficiary*** . . . failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement . . . ." *Id.* at 437 (citing Tex. Ins. Code § 541.060(a)). In other words, while any "person" has *standing* to assert a claim for violation of the Texas statute, it is a *substantive element* of the legal claim that the violation alleged must have occurred "with respect to a claim by an insured or beneficiary."

In light of that statutory language, the Texas Supreme Court held that the plaintiffs' claim failed because the plaintiffs "are neither insureds nor beneficiaries." *Id.* at 438. In other words, while the Court acknowledged that the plaintiffs had standing to assert the claim, it held—given the language of the statute—that the claim simply lacked merit. *Id.* That holding is of no moment here, because the Nevada UCPA, unlike the Texas statute, does not require that a violation be "with respect to a claim by an insured or beneficiary." *See* NRS 686A.020; 686A.310.

[45] A TPA provides administrative services to self-funded health plans but does not underwrite the insurance coverage. United maintains that two of the United entities—UHC Services and UMR—acted exclusively as TPAs for the underlying

private right of action exclusively for claims against "insurers," and that TPAs are not insurers. (United Br. at 110.) That position should be rejected because, in the context of § 686A.310, TPAs are "insurers."

United's argument is predicated on NRS 679A.100. According to United, that provision defines the term "insurer" as "every person engaged as principal and as indemnitor, surety or contractor in the business of entering into contracts of insurance.'" (United Br. at 110 (citing NRS 679A.100).) But United's selective quotation of the statute omits critical language. Section 679A.100 directs, in full, that "'insurer' ***includes*** every person engaged as principal and as indemnitor, surety or contractor in the business of entering into contracts of insurance." NRS 679A.100 (emphasis added). The word "includes" is significant. "Include" means "[t]o contain as a part of something." *Include*, Black's Law Dictionary (11th ed. 2019) (further noting that "[t]he participle ***including*** typically indicates a partial list" (emphasis in original)). Thus, the language directing that "'insurer' ***includes*** every person engaged as a principal and as indemnitor, surety or contractor . . . ," denotes

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insurance claims at issue. (United Br. at 109.) A third—UHIC—was an underwriter for some of the claims and a TPA for others. (United Br. at 109.) Accordingly, even if United were correct that the UCPA does not create a right of action against TPAs (and it is not), that would result in judgment as a matter of law in favor of two United entities and partial judgment in favor of a third. The claims against the remaining United entities would be unaffected.

that the entities identified as insurers—principals, indemnitors, sureties, contractors—comprise a non-exhaustive list.

The provisions surrounding § 679A.100 reinforce this conclusion. Chapter 679A features nineteen definitions sections, each defining one specific term. *See* NRS 679A.030 – 679A.130. Seventeen of those definitions provide that their respective term either "means" something, "is" something, or "has the meaning ascribed to it in" a different statutory provision. *See, e.g.*, NRS 679A.060 ("'Commissioner' ***means*** the Commissioner of Insurance"); NRS 679A.097 ("'An individual' ***is*** a natural person"); NRS 679A.095 ("'Hospice care' ***has the meaning ascribed to it in*** NRS 449.0115") (emphasis added). This contrast is notable. Had the Legislature intended for the entities identified in § 679A.100 to comprise a complete list of "insurers," it would have employed the same language used in the surrounding sections. That it instead replaced that language with the term "includes" suggests that the definition of "insurer" was *not* intended to be exhaustive. *See Harris v. State*, 133 Nev. 683, 689, 407 P.3d 348, 353 (holding that variation in language between two statutes located in same chapter presumptively suggests variation in meaning). Indeed, the only other definition within Chapter 679A to employ the term "includes" facially provides a non-exhaustive list. *See* NRS 679A.130 ("***In addition to*** other aspects of insurance operations to which provisions

of this Code by their terms apply, "transact" with respect to a business of insurance ***includes*** any of the following . . . ." (emphasis added)).

Given the above, the language of § 679A.100 allows for entities in addition to those listed to be insurers. Here, a holding that TPAs are "insurers" subject to suit under § 686A.310 would be consistent with the context and the overall statutory scheme. *See Dezzani*, 134 Nev. at 64, 412 P.3d at 59 (courts should "interpret provisions within a common statutory scheme harmoniously with one another in accordance with the general purpose of those statutes"); *Torrealba v. Kesmetis*, 124 Nev. 95, 101, 178 P.3d 716, 721 (2008) (same). Relevant here, TPAs are entities that contract with health plans to perform claims processing and other services on behalf of the plans. As United explains, "A self-insured plan sponsor, however, will typically contract with third-party administrators . . . to perform certain administrative functions for the employer and each plan, which might include processing claims, paying claims, and managing the everyday functioning of the plan." (United Br. at 109 (citing *Am.'s Health Ins. Plans v. Hudgens*, 742 F.3d 1319, 1324 (11th Cir. 2014) (quotation marks omitted)).) Further, § 686A.310(1) provides a list of activities considered to be unfair insurance practices. Many of those activities—by their inherent nature—are routinely performed by TPAs.[46] Notably,

[46] *See, e.g.*, NRS 686A.310(1)(b) (failing to respond promptly to claims communications); 686A.310(1)(c) (failing to adopt and implement reasonable

TPAs process and ultimately settle insurance claims, which are the precise activities regulated by § 686A.310(1)(e). And—as United concedes—Nevada's UCPA is unique, in that the Legislature amended the statute in 1987 to add an express private right of action for violations of § 686A.310. (United Br. at 100 (detailing legislative history).) Given these facts and this history, it is undoubtedly the case that TPAs are subject to suit under the UCPA. It would be absurd to conclude that the Legislature amended § 686A.310 specifically to create a private right of action addressing the commission of certain proscribed practices, but that it simultaneously immunized from suit the very parties who—given their functions—would be the ones to engage in those practices. *See Dezzani*, 134 Nev. at 64, 412 P.3d at 59 (courts should construe statutes "to avoid unreasonable or absurd results"); *Torrealba*, 124 Nev. at 101, 178 P.3d at 721 (same).

Finally, United cites *Albert H. Wohlers & Co. v. Bartgis*, 114 Nev. 1249, 1263-65, 969 P.2d 949, 959-60 (1998), wherein this Court held that a plan administrator was not subject to suit under the UCPA. (United Br. at 110-11.) The Health Care Providers respectfully submit that the Court should reconsider this limited aspect of the *Bartgis* decision. The *Bartgis* court did not analyze whether TPAs are "insurers" for purposes of § 686A.310. Instead, it merely rejected a

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procedures for prompt claims investigations and processing).

plaintiff's ill-conceived argument that § 686A.310 applied because the defendant TPA was a "company." *Id.* at 1264, 969 P.2d at 959-60. The plaintiff had relied upon NRS § 686A.520, which directs that § 686A.310 applies to "companies." "Company," in turn, is defined as a person engaged in the business of entering into "agreements," which are contracts under which a person agrees to pay an advance insurance premium on behalf of an insured. NRS 686A.330. Because the *Bartgis* defendant had not paid insurance premiums on behalf of anyone, the Court appropriately sided with the defendant on this issue. 114 Nev. at 1264, 969 P.2d at 959-60. But, given the arguments presented, the Court had no occasion to consider whether a TPA is an "insurer" under § 679A.100, in light of the language of that provision, the context, and the general operation of § 686A.310. For the reasons presented above, the Health Care Providers submit that this Court should answer that question in the affirmative.

3. The Health Care Providers sufficiently proved violations of the UCPA by United.

In addition to contesting the Health Care Providers' standing to assert their UCPA claim, United also contends that the Health Care Providers failed to prove the claim at trial. That position flies in the face of the UCPA's clear statutory language and the extensive record evidence of United's wrongdoing.

Initially, § 686A.310(1) provides a list of activities considered to be "unfair practice[s]." One of these is "[f]ailing to effectuate prompt, fair and equitable

settlements of claims in which liability of the insurer has become reasonably clear." NRS 686A.310(1)(e). Thus, by the plain terms of the statute, a violation consists of two elements: (1) failure to effectuate prompt, fair and equitable settlements of claims, (2) in which liability has become reasonably clear. The jury concluded that both elements were satisfied, and that determination was reasonable in light of the trial record.

Regarding the first element, the statute's conjunctive language denotes that an insurer's settlement of a claim must be prompt, fair, *and* equitable. Conversely, if a plaintiff can show that a settlement was untimely, unfair, *or* inequitable, then the first element is satisfied. Here, the evidence demonstrated that United devised and implemented a comprehensive scheme to drive reimbursements to emergency medical providers as low as possible. (33 AA 8075:11-16; 32 AA 7923:24-25:1, 7973:4-14; 12 RA 2049.) United was aware of the industry standard practice to calculate out-of-network reimbursements using the FAIR Health database, but it deliberately ignored that standard and employed its market power in an attempt to abolish the standard. (121 AA 29921; 126 AAA 31248, 31250; 12 RA 2038, 2049; 37 AA 9031:6-9; 5 RA 724.) It did this out of a desire to enrich itself by retaining for itself funds that had been earmarked by health plans for the payment of emergency medical claims. (32 AA 7752:24-53:13, 7923:24-25:1; 31 AA 7747:18-48:3; 13 RA 2366; 2 RA 297-98.) United's ultimate aim was to slash

reimbursements to emergency medical providers by upwards of [redacted] from their traditional levels. (5 RA 776; 31 AA 7747:14-17, 7750:6-11; 32 AA 7753:21-54:12, 7923:24-25:1.) And it paid the Health Care Providers even lower reimbursement amounts than the reduced rates it paid to other emergency medical providers in Nevada. (44 AA 10906:23-07:6.) Given these facts, it was perfectly reasonable of the jury to conclude that United's settlement of claims was not "fair" or "equitable." As for the second statutory element, it cannot be seriously disputed that United's "liability" on the at-issue claims was "reasonably clear." The fact that United adjudicated those claims as payable and in fact paid them (albeit at unreasonably low rates), shows that United itself agreed that its liability was clear. (46 AA 11416:23-17:4.) Accordingly, the Health Care Providers adduced evidence sufficient to prove their UCPA claim.

United offers several meritless arguments as to why the Health Care Providers purportedly failed to prove their UCPA claim. First, it contends that "[the Health Care Providers] did not even *purport* to adduce evidence that United failed to promptly settle any reasonably clear 'claim' *filed by an insured*." (United Br. at 112-13.) In so arguing, United seeks to impose a novel requirement that does not exist in the statute. As noted above, the statute requires "prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear." It does not address *who* must file the claim.

Next, United contends that there was no UCPA violation because its liability on the claims at issue was not "reasonably clear." It notes that the Health Care Providers argued at trial that the reasonable value of the at-issue claims was the full billed charges but that the jury rejected that proposition, so United's liability for the Health Care Providers' full billed charges could not have been clear. (United Br. at 114.) It adds, relatedly, that United's liability for the amount of damages awarded by the jury could not have been reasonably clear prior to trial, because that amount did not correspond to either party's estimate. (United Br. at 114-15.) Once again, United misconstrues the statute.

As described above, the UCPA defines as an unfair practice "failing to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear." NRS 686A.310(1)(e). In other words, the existence of a claim in which the insurer's liability "has become reasonably clear" triggers an obligation on the part of the insurer "to effectuate [a] prompt, fair and equitable settlement[]." Liability is "[t]he quality, state, or condition of being legally obligated or accountable; legal responsibility to another or to society, enforceable by civil remedy or criminal punishment." *Liability*, Black's Law Dictionary (11th ed. 2019). Here, it was immediately clear to all parties that United was liable on the at-issue reimbursement claims. United conceded as much by adjudicating the claims as payable and then actually paying them. (46 AA 11416:23-17:4.) In short, there

was never any dispute regarding the Health Care Providers' *entitlement* to reimbursement (and United's attendant liability); the only dispute was about the appropriate reimbursement *amount*.

Contra United, the statute does not say that the *precise amount due* on a claim must be reasonably clear. Rather, once it is reasonably clear that the insurer faces "liability"—in any amount—the insurer becomes obligated to settle the claim promptly, fairly, and equitably.[47] Whether the amount the insurer ultimately pays was reasonable under the circumstances is one consideration that a factfinder can take into account in deciding whether the insurer satisfied its statutory obligation. Here, after considering the totality of the evidence—including, *inter alia*, the amounts United paid to the Health Care Providers, the amounts it paid to other similarly situated emergency medical providers, and United's overall strategy to enrich itself by underpaying emergency medical providers, the jury determined that

[47] It would have been exceedingly easy for the Legislature to enact a statute providing that an insurer must promptly, fairly, and equitably settle a claim once the amount of reimbursement owed by the insurer is reasonably clear. That the Legislature did not do so suggests that it intended for the insurer's UCPA obligation to be triggered when liability—in any amount—is reasonably clear. *See Bldg. Energetix Corp. v. EHE, LP*, 129 Nev. 78, 83, 294 P.3d 1228, 1232 (2013) ("The preeminent canon of statutory interpretation requires us to presume that the legislature says in a statute what it means and means in a statute what it says there." (quotation marks and brackets omitted)).

United had not settled the at-issue claims in a prompt, fair, and/or equitable manner. That determination was reasonable.

United's next argument is that the Health Care Providers failed to establish a UCPA violation because the evidence demonstrated nothing more than a good faith disagreement over the amounts due. (United Br. at 115.) But that position ignores the voluminous evidence—described at length above—of United's premeditated plan to enrich itself by deliberately underpaying emergency medical providers and retaining for itself funds earmarked for the payment of those claims. (5 RA 772, 776; 2 PA 459:14-17, 462:6-11, 465:21-66:12; 32 AA 7923:24-25:1; 37 AA 9003:14-19.) The evidence showed that United was aware of an industry standard requiring it to price claims at reasonable and customary rates based upon the FAIR Health database, but it deliberately ignored that standard thousands of times over a period of years. (121 AA 29921; 126 AA 31250, 31248; 12 RA 2038, 2049; 37 AA 9031:6-9; 5 RA 724.) In light of this record, it was reasonable for the jury to conclude that United did not equitably and fairly settle the Health Care Providers' claims. *See Plaza v. Geico Direct*, 430 F. Supp. 3d 689, 691 (D. Nev. 2020) ("[I]f a defendant's valuation is unreasonable, the dispute as to value is not 'genuine,' and the genuine dispute doctrine does not apply.").[48]

[48] United cites *Lubritz v. AIG Claims, Inc.*, 2018 WL 7360623, at *7 (D. Nev. Dec. 18, 2018), and *Big-D Constr. Corp. v. Take It for Granite Too*, 917 F. Supp. 2d 1096,

Next, United argues that the Health Care Providers failed to prove their UCPA claim because there was no evidence that United refused to negotiate settlement of the at-issue claims in good faith. (United Br. at 118-119.) That argument fails for the reasons already presented. There was ample evidence that United made no effort to reimburse the Health Care Providers' claims at reasonable value. (4 PA 951:15-19; 2 PA 465:14-20; 32 AA 7923:24-25:1.) Instead, it implemented a brazen scheme to enrich itself by deliberately underpaying those claims.[49] (5 RA 776; 2 PA 459:14-17, 462:6-11, 465:21-66:12; 32 AA 7923:24-25:1; 34 AA 8492:4-22; 39 AA 9711:5-12; 3 RA 433.)

Finally, United contends that the UCPA claim fails because the Health Care Providers presented no evidence of injuries distinct from the underpayments

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1118-19 (D. Nev. 2013) to support its position that a genuine dispute between the parties should preclude a UCPA claim. (United Br. at 116.) But those cases are inapposite. Both involved genuine disputes as to whether there was coverage under the policies for the claims asserted. In other words, there was a genuine as to the insurer's liability (for *any* reimbursement). Here, as noted, there was never a dispute as to liability. The only dispute was as to the *amount* of reimbursement owed.

[49] To the extent United contends that the Health Care Providers were required to prove something akin to common law bad faith in order to prevail on their UCPA claim, that argument should be rejected. *See Hart v. Prudential Prop & Cas. Ins. Co.*, 848 F. Supp. 900, 904 (D. Nev. 1994) (Nevada UCPA "focuses upon different conduct than does the common law tort of bad faith"); *Arlitz v. Geico Cas. Co.*, ___ F. Supp. 3d ___, 2022 WL 17155941, at *19 (D. Nev. Nov. 22, 2022) ("The protections of NRS 686A.310 are broader than the tort of bad faith and extend to the processing of the claim.").

themselves. (United Br. at 118-20.) That is nonsense. In *Sanders v. Church Mutual Insurance Company*—one of the cases United cites to support its position (United Br. at 119)—the court held that injuries sufficient to support a UCPA claim could involve the costs to the plaintiff of maintaining a lawsuit against the insurer to recover improperly withheld amounts. 2013 WL 663022, at *3 (D. Nev. Feb. 21, 2013). Here, at minimum, the Health Care Providers have incurred millions of dollars in legal fees (which continue to accrue).

III. THE PUNITIVE DAMAGES AWARD WAS APPROPRIATE AND SHOULD BE AFFIRMED

As this Court has recognized, punitive damages are intended not to compensate plaintiffs for their injuries, but to punish defendants for their wrongdoing. *Bongiovi v. Sullivan*, 122 Nev. 556, 580, 138 P.3d 433, 450 (2006). "Punitive damages provide a means by which the community can express community outrage or distaste for the misconduct of an oppressive, fraudulent or malicious defendant and by which others may be deterred and warned that such conduct will not be tolerated." *Id.* at 580, 138 P.3d at 450 (ellipsis omitted). Here, United's malicious conduct—namely, its scheme to enrich itself at the expense of emergency medical providers by underpaying the providers and siphoning off funds earmarked by health plans for the payment of claims—is amply deserving of punishment and deterrence. Indeed, this case presents a textbook example of a fact

pattern amenable to punitive damages. The jury recognized as much and appropriately sanctioned United. That finding should be left undisturbed.

United presents three arguments as to why the punitive damages award should be stricken or reduced. First, it contends that the law does not permit punitive damages in the circumstances presented. (United Br. at 121-27.) Second, it contends that the Due Process Clause of the Fourteenth Amendment mandates a reduction of the punitive damages award. (United Br. at 128-37.) Third, it contends that the statutory exception to Nevada's punitive damages cap for bad faith conduct by an insurer does not apply. (United Br. at 137-41.) As explained below, those positions are erroneous.

A. Nevada Law Permits Punitive Damages Based on the Evidence Presented and the Claims Asserted

Under Nevada law, punitive damages are available where a plaintiff proves by clear and convincing evidence that the defendant is "guilty of oppression, fraud or malice, express or implied." *Bongiovi*, 122 Nev. at 581, 138 P.3d at 450-51. In this context, "oppression" is "despicable conduct that subjects a person to cruel and unjust hardship with conscious disregard of the rights of the person." *Id.* at 581, 138 P.3d at 450-51; *see also* NRS 42.001(4). "Fraud" is "an intentional misrepresentation, deception or concealment of a material fact known to the person with the intent to deprive another person of his rights or property or to otherwise injure another person." *Id.* at 581, 138 P.3d at 450-51; *see also* NRS 42.001(2). And

"express malice" is "conduct which is intended to injure a person," while "implied malice" is "despicable conduct which is engaged in with a conscious disregard of the rights of others." *Id.* at 581, 138 P.3d at 450-51 (ellipsis omitted); *see also* NRS 42.001(3).

Critically, this Court "will not overturn an award of punitive damages if it is supported by substantial evidence of oppression, fraud, or malice. Substantial evidence is evidence that a reasonable mind might accept as adequate to support a conclusion." *Id.* at 581, 138 P.3d at 450-51 (quotation marks omitted). Finally, the Court must "assume that the jury believed all the evidence favorable to the prevailing party and drew all *reasonable* inferences in that party's favor." *Id.* at 581, 138 P.3d at 450-51 (emphasis in original and brackets omitted).

Here, the record featured substantial evidence of United's oppression, fraud, and/or malice. The Court must credit that evidence and uphold the punitive damages award.

1. The Health Care Providers presented substantial evidence of conduct by United involving oppression, fraud, and/or malice.

The Health Care Providers presented substantial evidence of conduct by United involving oppression, fraud, and/or malice. Much of that evidence is summarized in detail above. Notably, while United understood that it had an obligation to pay reasonable reimbursement amounts to out-of-network emergency

medical providers, it implemented a scheme to enrich itself by moving its self-funded health plan clients onto shared savings programs that would allow United to earn massive fees by reimbursing medical providers at unreasonably low rates. (5 RA 772, 776; 2 PA 459:14-17, 462:6-11, 465:21-66:12; 32 AA 7923:24-25:1.) Such conduct involved implied malice, because it is "despicable" and involved conscious disregard for the rights of medical providers. *Bongiovi*, 122 Nev. at 581, 138 P.3d at 450-51. It also involved conscious disregard for the rights of United's members, who would be subjected to balance bills as a result of United's underpayments. United even acknowledged internally that "migration to high reduction programs [*i.e.*, shared savings]" would result in "less member protection." (13 RA 2366.) United also utilized Data iSight to create an impression that its reimbursement amounts were reasonable and had been calculated by a neutral third party based upon market data. (36 AA 8817:7-18; 37 AA 9020:10-17; 4 RA 540.) In reality, United secretly dictated its pre-determined rates to Multiplan, and it used Data iSight to provide a false veneer of objectivity to those subjectively determined amounts. (4 RA 535-36; 11 RA 1985; 39 AA 9536:21-40:21; 37 AA 9012:9-11.) This was fraudulent, because it involved intentional misrepresentation, deception, and concealment with the intent to injure emergency medical providers and United's members. *Bongiovi*, 122 Nev. at 581, 138 P.3d at 450-51.

The trial record included evidence that United reimbursed the Health Care Providers at rates substantially below those that it paid to other similarly situated emergency medical providers in Nevada. (44 AA 10906:23-07:6.) And, despite United's protestations that it paid claims according to the language of the relevant benefit plans, the Health Care Providers presented evidence of plan language requiring reimbursement at reasonable and customary rates—requirements that United ignored in order to generate shared savings fees.[50] (4 RA 507; 32 AA 7923:24-25:1; 5 RA 772, 776; 2 PA 459:14-17, 462:6-11, 465:21-66:12.) All of this provides further support for the jury's finding of oppressive conduct.

United's actions with respect to the Yale Study provide additional support for the punitive damages awarded. (2 RA 289-92; 4 RA 519, 520-22, 523-25; 5 RA 796-98.) As detailed above, documents which only came to light during the discovery process in this case reveal that the Yale Study was the secret linchpin of United's public relations and lobbying efforts in support of its scheme to enrich itself at the expense of emergency medical providers. United colluded with Mr. Cooper

[50] Such conduct is apparently the norm. Less than one month ago, the U.S. Secretary of Labor filed suit against UMR—one of the Defendant United entities in this case—alleging that UMR systematically had violated ERISA regulations and plan benefit provisions in its adjudications of emergency medical claims on behalf of thousands of self-funded health plans over a period of years. *See Su v. UMR, Inc.*, No. 3:23-CV-00513-WMC, at Dkt. 1 (W.D. Wisc. July 31, 2023). The claims period at issue in *Su* overlaps with the claims period here.

to perform and publish the research, it provided him with its own (questionable) data, the ultimate text of the Yale Study was extensively edited and revised by United executives (who were privy to the pre-publication drafts), and United's senior executives made the editorial decision (after much internal debate) to name TeamHealth in the study as a perpetrator of the purported "out-of-network strategy" that Mr. Cooper describes. (2 RA 291; 4 RA 519, 520-22, 523-25; 5 RA 755, 796-98.) United nonetheless made the deliberate decision to conceal its involvement in the Yale Study, so that the study would appear to be independent and unbiased. (5 RA 797; 2 RA 292; 4 RA 520-22.) But it quietly leveraged its extensive media contacts—particularly at the New York Times—to ensure the study would receive maximal exposure. (4 RA 538-39; 5 RA 761-69.) In short, the Yale Study is a massive fraud perpetrated upon the public by an underhanded, self-serving industry actor pulling the strings of a deeply unethical academic (akin to research sponsored by the tobacco industry concluding that smoking has no ill health effects).

Unfortunately, United's efforts largely succeeded. The Yale Study has proven enormously influential, having been cited repeatedly by Members of Congress and federal regulators.[51] Of course, none of these officials were aware of the rampant

[51] *See, e.g.*, Office of the Assistant Sec'y for Planning & Evaluation, U.S. Dep't of Health & Human Servs., *Sec'y of Health & Human Servs. Report on: Addressing Surprise Medical Billing*, July 2020, p. 9., *available at* https://aspe.hhs.gov/sites/default/files/private/pdf/263871/Surprise-Medical-

conflicts of interest infecting the Yale Study when they relied upon it to inform their policymaking decisions, because United actively hid that information from the public. This was further fraudulent activity intended to injure others. *Bongiovi*, 122 Nev. at 581, 138 P.3d at 450-51.

In short, the trial record featured substantial evidence of malicious, fraudulent, and/or oppressive conduct by United. Given the verdict, this Court must assume the jury believed that evidence and that it drew all reasonable inferences in favor of the Health Care Providers. *Bongiovi*, 122 Nev. at 581, 138 P.3d at 450-51.[52]

Billing.pdf (last visited Aug. 27, 2023) (citing Yale Study for conclusion that "when private equity firms enter a market the rate of out-of-network billing increases by large percentages: 66 percent for Envision/Emcare and 13 percent for TeamHealth").

[52] United's authority is easily distinguishable. United cites *Great American Insurance Company v. General Builders, Inc.*, 113 Nev. 346, 355, 934 P.2d 257, 263 (1997) for this Court's holding that punitive damages are inappropriate where two commercial entities "were never in inherently unequal bargaining positions. (United Br. at 122.) Here, the parties *were* in unequal bargaining positions. Because the Health Care Providers are statutorily required to treat all presenting patients irrespective of insurance status, United has always known that its members necessarily will receive treatment, that United can pay out-of-network insurance claims after the fact at whatever rates it unilaterally determines, and that the Health Care Providers will have little recourse to challenge those payments (because they cannot withhold treatment from United's members). This state of affairs afforded United an enormous advantage, which it ruthlessly utilized to enrich itself.

United cites *Polymer Plastics Corp. v. Hartford Casualty Insurance Company*, 389 F. App'x 703, 707-08 (9th Cir. 2010), *Fernandez v. State Farm Mutual Automobile Insurance Company*, 338 F. Supp.3d 1193, 1202 (D. Nev. 2018), and *Lubritz*, 2018 WL 7360623, at *8, for the proposition that Nevada law does not allow punitive damages for wrongful denials of insurance claims. (United Br. at 122.) But those

2. Punitive damages are available under the Health Care Providers' UCPA claim.

United argues that this Court should reverse the punitive damages awarded on the UCPA claim, because "no Nevada case has ever recognized a claim under the UCPA by any party other than an insured suing its insurer." (United Br. at 125.) It cites law holding that punitive damages are unavailable in situations where the defendant could not have known beforehand that the conduct underlying the punitive damages award was proscribed. (United Br. at 125 (citing *Hansen v. Harrah's*, 100 Nev. 60, 65, 675 P.2d 394, 397 (1984); *Mackintosh v. Cal. Fed. Sav. & Loan Ass'n*, 113 Nev. 393, 406, 935 P.2d 1154, 1162 (1997)).) That argument should be rejected out of hand. Here, the evidence showed that United was aware of its obligation to pay reimbursements to the Health Care Providers at reasonable rates. (39 AA 9557:17-19, 9589:13-91:3.) Moreover, the UCPA facially provides that no "person" shall engage in any activity defined in NRS 686A.310(1) as an unfair practice. NRS 686A.020. In short, United at all times was aware of the requirement to process the

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cases all involve denials of an individual claim. They do not feature the sort of comprehensive, systematic wrongful scheme that the jury recognized here.

Finally, *Long Beach Memorial Medical Center v. Kaiser Foundation Health Plan, Inc.*, 286 Cal. Rptr. 3d 419, 430 (Ct. App. 2021) merely held that an insurer's violation of a state statute requiring reimbursement of emergency claims at "reasonable and customary value" does not result in tort liability. It did not hold that punitive damages are unavailable where a jury has found that an insurer engaged in the sort of malicious, fraudulent, and oppressive conduct demonstrated here.

Health Care Providers' claims in a fair and equitable manner, yet it consciously chose to disregard that obligation.

Ultimately, what United is really saying is not that it was unaware of its own wrongdoing, but that it believed it was insulated from any consequences because there was no remedy available to the Health Care Providers. Stated another way, United believed it had license to flout the law and victimize the Health Care Providers with impunity. While that assumption turned out to be incorrect, it certainly provides no basis to reverse the punitive damages award.

3. Punitive damages are available under the Health Care Providers' unjust enrichment claim.

In addition to the UCPA claim, the jury also awarded punitive damages on the Health Care Providers' unjust enrichment claim. (49 AA 12150-52.) United seeks reversal of that determination. Recognizing that the law does not allow for punitive damages on a claim for breach of contract, United contends that the same rule should apply to an unjust enrichment claim because "unjust enrichment is merely the implication of a contract at law." (United Br. 126.) That is wrong. Unjust enrichment sounds in restitution, not contract. *See Certified Fire*, 128 Nev. at 381, 283 P.3d at 256-57 ("When a plaintiff seeks as much as he deserves based on a theory of restitution (as opposed to implied-in-fact contract), he must establish each element of unjust enrichment." (quotation marks, brackets, and ellipsis omitted)). As noted above, the Restatement (Third) of Restitution and Unjust Enrichment—

authoritative in Nevada—directly provides that "a person who performs another's duty to a third person or to the public is entitled to restitution from the other as necessary to prevent unjust enrichment . . . ." RESTATEMENT (THIRD) OF RESTITUTION AND UNJUST ENRICHMENT § 22. And this principle applies in the exact scenario presented here: where a medical provider renders out-of-network emergency care to a patient, entitling the provider to recovery in restitution from the patient's insurer. *Id.* at cmt. g, illus. 10.

Because unjust enrichment sounds in restitution rather than contract, the bar to punitive damages on a contract claim does not apply. Punitive damages resulting from an unjust enrichment claim are particularly appropriate here, as the restitution was made necessary by United's deliberate wrongdoing. In other words, United is not a party that innocently acquired an undeserved benefit which in fairness should be disgorged; its benefit resulted from premeditated, malicious conduct occurring over a lengthy period of time and across numerous transactions.[53] As such, the district court appropriately submitted the punitive damages issue to the jury. *See Hester v. Vision Airlines, Inc.*, 687 F.3d 1162, 1172-73 (9th Cir. 2012) (holding that

[53] United's extensive history of predatory conduct has been well documented. *See, e.g.*, Krista Brown & Sara Sirota, *Health Care's Intertwined Colossus: How Decades of Policy Failures Led to the Ever-Powerful UnitedHealth Group*, THE AMERICAN PROSPECT, Aug. 2, 2023, *available at* https://prospect.org/health/2023-08-02-health-cares-intertwined-colossus/ (last visited Aug. 27, 2023).

employees asserting unjust enrichment and related claims based upon employer's wrongful withholding of hazard pay had sufficiently alleged entitlement to punitive damages under Nevada law).

B. Due Process Does Not Require Reduction of the Punitive Damages Award

United next argues that the punitive damages award violates its due process rights. It complains that the amount was excessive and should be reduced. (United Br. at 128-37.) The Court should reject that argument, because the punitive damages award was entirely reasonable in light of United's size and its pattern of ongoing, premeditated misconduct.

The Due Process Clause of the Fourteenth Amendment prohibits punitive awards that are "grossly excessive or arbitrary." *Wyeth*, 126 Nev. at 474, 244 P.3d at 784; *see also BMW of N. Am., Inc. v. Gore*, 517 U.S. 559, 568 (1996) ("Only when an award can fairly be categorized as ***grossly excessive*** in relation to [the interests of punishment and deterrence] does it enter the zone of arbitrariness that violates the Due Process Clause . . . ." (emphasis added)). In assessing whether an award is grossly excessive or arbitrary, this Court considers three factors: "(1) the degree of reprehensibility of the defendant's conduct, (2) the ratio of the punitive damages award to the actual harm inflicted on the plaintiff, and (3) how the punitive damages award compares to other civil or criminal penalties that could be imposed for comparable misconduct." *Wyeth*, 126 Nev. at 474, 244 P.3d at 784. The most

important factor is the degree of reprehensibility of the defendant's conduct. *Gore*, 517 U.S. at 575. In assessing reprehensibility, the Court should consider the following factors: (1) whether the harm caused was physical or economic; (2) whether the conduct evinced indifference or reckless disregard for the health and safety of others; (3) whether the target of the conduct was financially vulnerable; (4) whether the conduct involved repeated actions or was an isolated incident; and (5) whether the harm was the result of intentional malice, trickery, or deceit, or mere accident. *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408, 419 (2003).

Here, the reprehensibility factors weigh in favor of sustaining the jury's punitive damages award. First, United's conduct was extraordinarily reprehensible. In the preceding sections of this Answering Brief, the Health Care Providers have detailed at length how United implemented a scheme to enrich itself at the expense of hardworking emergency medical providers (with funds earmarked by its plan clients for the payment of medical claims). (*See supra* Statement of Facts, Part E; Argument, Part III.A.1.) Moreover, the jury heard evidence that:

- hospital emergency departments are society's healthcare safety net because federal law requires them to treat all patients, regardless of the patients' ability to pay or insurance status (39 AA 9589:13-91:3);

- failing to adequately pay emergency physicians could undermine that safety net (43 AA 10569:8-18);

- the United Defendants (all of whom are affiliated with each other) not only sell health insurance in Nevada, one of them owns an ER doctor group that competes with the Health Care Providers (45 AA 11192:7-99:8);

- United targeted the Health Care Providers for years by paying them *less than half* of what it paid other similarly situated emergency physicians in Nevada ($246 vs. $528 per claim) (44 AA 10906:23-07:6);

- Defendants Sierra and HPN led the targeting effort by systematically and repeatedly paying the Health Care Providers the same [redacted] per claim, regardless of whether the Health Care Providers had saved a United member from a heart attack or had stitched up a minor kitchen knife wound to a finger (45 AA 11051:13-54:6; 13 RA 2362);

- United's economics expert could provide no explanation for why, if United was not trying to weaken the Health Care Providers to make them more attractive for United to purchase, United paid the Health Care Providers a fraction of what it paid other similarly situated providers (44 AA 10907:20-08:19); and

- United's reimbursement rates for emergency department claims in Nevada were the lowest in the country (49 AA 12215:17-19:17).

In light of this substantial record of calculated wrongdoing, the jury's punitive damages award was entirely warranted and certainly was not grossly excessive or arbitrary. In fact, at least three out of the five reprehensibility factors weigh in favor of sustaining the jury's award. The conduct absolutely exhibited indifference to the health and safety of members of the community writ large, given that it was designed to harm the medical providers who render emergency medical care to all presenting patients. United's conduct also involved repeated actions and was not isolated, as it

persisted for years and involved countless transactions. And United's conduct was intentional, not accidental.[54] *State Farm*, 538 U.S. at 419.

Finally, the ratio of punitive damages to actual harm does not counsel in favor of remittitur. With respect to the ratio, the U.S. Supreme Court has explained that the analysis looks to "whether there is a reasonable relationship between the punitive damages award and ***the harm likely to result*** from the defendant's conduct as well as the harm that actually has occurred." *Gore*, 517 U.S. at 581 (emphasis in original). In other words, this Court should take into account not only the

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[54] The financial vulnerability factor also does not weigh in favor of United. While the jury heard no evidence regarding the Health Care Providers' financials, it would be fair to infer that enormous reductions in the reimbursement amounts paid by the largest commercial payer in the country are likely to render any medical provider vulnerable. Notably, Envision Healthcare Corporation ("Envision"), TeamHealth's primary competitor, recently filed for Chapter 11 protection. In his sworn declaration in support of the bankruptcy petition, Envision's Chief Restructuring Officer cited United's conduct as a primary driver of the company's financial deterioration:

> Envision's largest payor [United] has been uniquely aggressive in its behavior, reducing their total reimbursement by nearly 60% over the past five years, resulting in a revenue decline of more than $400 million. This payor's behavior is an outlier in the industry and has had a disproportionate effect on the business . . . . ***The payor is the only health insurer systematically underpaying to this degree, and their behavior impacts not only Envision but the entire healthcare industry***.

In re Envision Healthcare Corp., No. 23-90342, at Dkt. 2 ¶ 6 (S.D. Tex. Bankr. May 15, 2023) (emphasis added), *available at* https://restructuring.ra.kroll.com/Envision/Home-DocketInfo (last visited Aug. 27, 2023)

compensatory damages recognized by the jury, but those likely to accrue thereafter. Indeed, in its corporate representative's testimony following the verdict, United pointedly declined to confirm that it would revise its reimbursement methodology in response to the verdict. (49 AA 12176:6-80:20.)

Moreover, the Supreme Court has "consistently rejected the notion that the constitutional line is marked by a simple mathematical formula, even one that compares actual ***and potential*** damages to the punitive award." *Gore*, 517 U.S. at 582 (emphasis in original). And, "low awards of compensatory damages may properly support a higher ratio than high compensatory awards, if, for example, a particularly egregious act has resulted in only a small amount of economic damages." *Id.* Ultimately, whether a particular ratio is constitutionally permissible will always be context-specific. Courts performing that analysis must determine whether or not the damages awarded are "grossly excessive" in relation to the State's legitimate interest in punishing wrongful conduct and achieving effective deterrence. *Id.* at 568. Here, the answer to that question plainly is "no." United is one of the largest companies in the world, and the $60 million punitive damages awarded represent approximately 0.01% of its $500 billion market capitalization and

approximately 0.02% of its $322 billion annual revenue. If anything, the punitive damages were *too small* to punish United and achieve effective deterrence.[55]

C. The Statutory Punitive Damages Cap Does Not Apply

Nevada law limits punitive damages to three times the compensatory damages awarded, with certain exceptions. NRS 42.005(1)(a). One such exception applies to actions against "[a]n insurer who acts in bad faith regarding its obligations to provide insurance coverage." NRS 42.005(2)(b). Here, the Health Care Providers brought action against United (an insurer) and demonstrated that United had acted in bad faith regarding its obligation to provide coverage. The district court accordingly recognized that the exception applies, and it declined to cap the punitive damages. United believes that decision was erroneous. (United Br. at 137-41.) It was not.

First, United contends that the cap does not apply because several of the United entities were TPAs who "did not provide insurance to anyone," and, relatedly, because the Health Care Providers "did not and could not allege that United provided an insurance policy to [the Health Care Providers], nor did [they] contend that United breached an obligation to provide insurance coverage to [the

[55] A comparison of the punitive damages awarded to potential civil penalties also does not counsel in favor of remittitur. United as offered no argument or authority suggesting that insurance regulators would not be able to secure a penalty of $60 million (or substantially more) in response to the misconduct demonstrated here.

Health Care Providers]." (United Br. at 139.) In short, United contends that the exception to the cap does not apply because several Defendants were not insurers, and because the Plaintiffs are not insureds. That is wrong. The Health Care Providers have already explained why TPAs fall within the Insurance Code's definition of "insurer." (*See supra* Argument, Part II.C.2.) Moreover, the statute does *not* direct that the cap applies only where an insured brings action. Rather, it merely provides that the action must be brought *against* an insurer, irrespective of the identity of the plaintiff. NRS 42.005(2)(b).

Second, United argues that the exception does not apply because the Health Care Providers "abandoned [their] bad-faith claim before trial." (United Br. at 139.) Once again, United seeks to impose requirements that exist nowhere in the statutory text. On its face, the text does *not* say that exception applies only where a plaintiff asserts and proves a common law claim for breach of the covenant of good faith and fair dealing (*i.e.*, the claim that the Health Care Providers "abandoned"). Rather, it provides that the exception applies where an insurer: (1) "acts in bad faith," (2) "regarding its obligations to provide insurance coverage." NRS 42.005(2)(b). Each of those elements is satisfied. First, bad faith is a broad concept under insurance law. As this Court has explained, "[b]ad faith is established where the insurer acts unreasonably and with knowledge that there is no reasonable basis for its conduct." *Guar. Nat'l Ins. Co. v. Potter*, 112 Nev. 199, 206, 912 P.2d 267, 272 (1996). Here,

there was ample record evidence, detailed above, demonstrating that United acted unreasonably and with knowledge that there was no reasonable basis for its conduct.[56] (*See supra* Statement of Facts, Part E; Argument Part III.A.1.) Next, United's bad faith conduct obviously was "regarding its obligation to provide insurance coverage," because the conduct occurred in the course of United's processing and (under)payment of insurance claims.

Accordingly, the district court did not err in declining to cap the punitive damages.

IV. THE DISTRICT COURT CORRECTLY HELD THAT THE HEALTH CARE PROVIDERS' CLAIMS ARE NOT PREEMPTED BY ERISA

United contends that the Health Care Providers' claims are preempted by ERISA. (United Br. at 151-64.) That argument fails for two reasons: (1) this Court has already held that the Health Care Providers' claims are *not* preempted by ERISA, and (2) that prior holding was absolutely correct on the merits.

[56] United maintains that the concept of bad faith in the insurance context applies only to "an independent tort claim against an insurer for bad faith denial of timely benefits." (United Br. at 139.) That is wrong. *See Potter*, 112 Nev. at 206, 912 P.2d at 272 ("Generally, this court has addressed an insurer's breach of the implied covenant of good faith and fair dealing as the unreasonable denial or delay in payment of a valid claim. This, however, does not mean that the tort of bad faith is limited to such cases." (citations omitted)).

A. This Court Has Already Resolved the Preemption Issue

As United acknowledges, this Court addressed its ERISA preemption defenses when United submitted an earlier petition for a writ of mandamus. (United Br. at 151.) United maintains that the Court "considered the argument ***preliminarily*** on United's petition for interlocutory review and ***suggested*** that despite ERISA's broad preemptive force [the Health Care Providers' claims are not preempted]." (United Br. at 151-52 (emphasis added).) That is nonsense. The Court's consideration was not "preliminary," and its ruling was not a "suggestion." Rather, the Court addressed the preemption issue—a pure issue of law—upon full briefing, and it conclusively held that the Health Care Providers' claims are not preempted. Specifically, the Court declared that "neither theory of ERISA preemption established a legal duty to dismiss the complaint." *United Healthcare Ins. Co. v. Eighth Jud. Dist. Ct.*, No. 81680, 2021 WL 2769032, at *1 (Nev. July 1, 2021) (unpublished disposition). In addressing United's argument for dismissal based upon the doctrine of "complete preemption," the Court noted that the precedent United principally relied upon recently had been reversed by the United States Court of Appeals for the Ninth Circuit.[57] *Id.* In addressing "conflict preemption," the Court bluntly expressed that "conflict preemption does not apply in this case." *Id.*

[57] In that dispute, Arizona-based affiliates of the Health Care Providers had sued United in Arizona state court, asserting claims virtually identical to the claims

Given the above, the ERISA preemption issue is settled: the Health Care Providers' claims are not preempted. United has offered no good reason for the Court to backtrack from its prior ruling.

B. The Health Care Providers' Claims Are Not Preempted

The Court's prior ERISA ruling was fully correct on the merits. ERISA is the rare federal statute giving rise to two distinct varieties of preemption: "complete preemption" and "conflict/defensive" preemption. *Conn. State Dental Ass'n v. Anthem Health Plans, Inc.*, 591 F.3d 1337, 1343-44 (11th Cir. 2009).[58] Complete preemption is a judicially created doctrine which operates as an exception to the

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asserted and proven in this case. United then removed the action to federal court based upon ERISA complete preemption. The Arizona federal district court ruled that the plaintiffs' claims were completely preempted, and it exercised jurisdiction and dismissed the complaint with prejudice for that reason. *Emergency Grp. of Ariz. Prof'l Corp. v. United Healthcare Inc.*, 448 F. Supp. 3d 1077 (D. Ariz. 2020). On appeal, the Ninth Circuit reversed, holding that the claims were *not* completely preempted. *Emergency Grp. of Ariz. Prof'l Corp. v. United Healthcare, Inc.*, 838 F. App'x 299, 300-01 (9th Cir. 2021).

Incidentally, this Court is not the only one to have chided United for citing the *Emergency Group of Arizona* trial court decision while omitting to mention that that decision had since been reversed. *See Emergency Physician Servs. of N.Y.*, 2021 WL 4437166, at *8 n.3 ("Unfortunately, this is not the only authority upon which the attorneys representing United rely that is no longer good law. United also trumpeted its successful dismissal in [*Emergency Group of Arizona*] without mentioning in its reply brief that the decision had since been reversed on appeal . . . .").

[58] The preemptive effect of a federal statute is a question of federal law. *Close v. Sotheby's, Inc.*, 909 F.3d 1204, 1208 (9th Cir. 2018). Accordingly, in addressing ERISA preemption, the Health Care Providers primarily cite to federal authority.

well-pleaded complaint rule. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941, 945 (9th Cir. 2009). It applies where "Congress intended the scope of a federal law to be so broad as to entirely replace any state-law claim." *Id.* (citations and quotation marks omitted). Complete preemption is a "rare" doctrine, by which a "state-created cause of action can be deemed to arise under federal law." *ARCO Env't. Remediation, L.L.C. v. Dep't of Health & Env't Quality of Mont.*, 213 F.3d 1108, 1114 (9th Cir. 2000). Thus, "[e]ven if the only claim in a complaint is a state law claim, if that claim is one that is 'completely preempted' by federal law, federal subject matter jurisdiction exists and removal is appropriate." *Toumajian v. Frailey*, 135 F.3d 648, 653 (9th Cir. 1998).

ERISA conflict preemption is derived from the statute's preemption clause—§ 514(a). 29 U.S.C. § 1144(a); *see also Conn. Dental*, 591 F.3d at 1344. "Unlike complete preemption, preemption that stems from a conflict between federal and state law is a defense to a state law cause of action and, therefore, does not confer federal jurisdiction over the case." *ARCO*, 213 F.3d at 1114. Conflict preemption provides an affirmative defense to a state law claim. *Marin*, 581 F.3d at 949.

United argues that both complete preemption and conflict preemption apply to preclude the Health Care Providers' claims. (United Br. at 155.) That is doubly wrong; those claims are neither completely preempted nor conflict preempted.

1. Complete preemption.

ERISA complete preemption is derived from the statute's civil enforcement provision—§ 502(a)(1)(B)—in which Congress enacted a "comprehensive scheme of civil remedies to enforce ERISA's provisions." *Cleghorn v. Blue Shield of Cal.*, 408 F.3d 1222, 1225 (9th Cir. 2005). The civil enforcement provision directs that:

> A civil action may be brought—by ***a participant or beneficiary***—to recover benefits due to him ***under the terms of his plan***, to enforce his rights ***under the terms of the plan***, or to clarify his rights to future benefits ***under the terms of the plan***.

29 U.S.C. § 1132(a)(1)(B) (emphasis added.)

The Supreme Court has recognized that Congress intended for the ERISA remedy to be exclusive. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208-09 (2004). Thus, any state law remedy that falls within the scope of ERISA's civil enforcement provision is necessarily displaced. *Id.* at 209. Given the plain language of the civil enforcement provision, a state law claim falls within its scope only if: (1) the plaintiff is an ERISA plan participant or beneficiary, and (2) the claim is predicated on the alleged breach of ERISA plan terms. As the Supreme Court explained in *Davila*:

> It follows that if an individual brings suit complaining of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan, and where no legal duty (state or federal) independent of ERISA or the plan terms is violated, then the suit falls within the scope of ERISA § 502(a)(1)(B). In other words, if an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is

> implicated by a defendant's actions, then the individual's cause of action is completely pre-empted by ERISA § 502(a)(1)(B).

Id. at 210 (quotation marks and citations omitted).

Here, the Health Care Providers' claims are not completely preempted because none of the necessary conditions for preemption are satisfied. The Health Care Providers are *not* ERISA plan members or beneficiaries, and their claims are *not* based on breaches of ERISA plan terms.[59] For these reasons, courts consistently hold that analogous state law claims asserted in payer/provider reimbursement disputes are not completely preempted.[60] In fact, that has proven true in this very

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[59] United argued at trial that the amounts it paid to the Health Care Providers were dictated by the terms of its clients' ERISA plans. (6 PA 1264:18-20; 38 AA 9410:3-10.) The Health Care Providers, in turn, presented evidence disproving that assertion. (6 RA 884; 12 RA 2056, 2186; 4 RA 540.) But the actual causes of action asserted and proven are not predicated on breach of ERISA plan terms. Whether United calculated reimbursement amounts consistent with the plan terms is irrelevant to the Health Care Providers' claims.

[60] *See, e.g.*, *Garber v. United Healthcare Corp.*, 2016 WL 1734089, at *4 (E.D.N.Y. May 2, 2016); *Long Island Thoracic Surgery, P.C. v. Bldg. Serv. 32BJ Health Fund*, 2019 WL 5060495, at *2 (E.D.N.Y. Oct. 9, 2019); *Hialeah Anesthesia Specialists, LLC v. Coventry Health Care of Fla., Inc.*, 258 F. Supp. 3d 1323, 1327-30 (S.D. Fla. 2017); *REVA, Inc. v. HealthKeepers, Inc.*, 2018 WL 3323817, at *3-4 (S.D. Fla. July 6, 2018); *Gulf-to-Bay Anesthesiology Assocs., LLC v. UnitedHealthCare of Fla., Inc.*, 2018 WL 3640405, at *3 (M.D. Fla. July 20, 2018); *Comprehensive Spine Care, P.A. v. Oxford Health Ins. Inc.*, 2018 WL 6445593, at *2 (D.N.J. Dec. 10, 2018); *N. Jersey Brain & Spine Ctr. v. United Healthcare Ins. Co.*, 2019 WL 6317390, at *5 (D.N.J. Nov. 25, 2019), *report and recommendation adopted*, 2019 WL 6721652; *MHA, LLC v. Empire Healthchoice HMO, Inc.*, 2018 WL 549641, at *3 (D.N.J. Jan. 25, 2018); *Sobertec LLC v. UnitedHealth Grp., Inc.*, 2019 WL 4201081, at *4 (C.D. Cal. Sept. 5, 2019); *Doctors Med. Ctr. of Modesto, Inc. v. Gardner Trucking, Inc.*, 2017 WL 781498, at *3-4 (E.D. Cal. Feb. 28, 2017).

case. Not only did *this* Court previously recognize that the Health Care Providers' claims are not completely preempted, but a federal district court held the same. United initially removed this action to federal court, alleging that the Health Care Providers' claims were completely preempted. The federal district court then remanded the case back to state court, holding that the claims were *not* completely preempted. *Fremont Emergency Servs. (Mandavia), Ltd. v. UnitedHealth Grp., Inc.*, 446 F. Supp. 3d 700, 705 (D. Nev. 2020). In other words, both this Court and a federal court have already determined that the claims asserted in this case are not completely preempted.

Moreover, the Nevada federal court's holding is fully consistent with those of the numerous other federal courts to address complete preemption in the context of a dispute between affiliates of the Health Care Providers and United. In what has become something of a ritual, every time TeamHealth-affiliated medical practices initiate a reimbursement dispute against United in state court, United promptly removes the action to federal court based on complete preemption. After briefing, the federal court then invariably holds that the plaintiffs' claims—generally identical to the claims in this case—are *not* completely preempted. This has happened no fewer than ***nine times*** in the last several years.[61] Most recently, one (apparently fed

[61] *See Gulf-to-Bay Anesthesiology*, 2018 WL 3640405, at *3; *Fremont Emergency Servs.*, 446 F. Supp. 3d at 705; *Emergency Care Servs. of Pa., P.C. v. UnitedHealth*

up) federal court pointedly admonished United "not to repeat this approach" and threatened to impose sanctions should United persist in asserting complete preemption in future disputes without expressly disclosing that "federal district courts in New Jersey, Pennsylvania, Nevada, Arizona, Florida, and perhaps elsewhere have denied [its] arguments for ERISA preemption." *Atl. ER Physicians*, 2022 WL 950815, at *4. Of course, United disregarded that instruction here.

2. Conflict preemption.

The Court's prior holding on conflict preemption also was correct on the merits. As explained in detail below, the Health Care Providers' claims are not conflict preempted because they merely involve *United's* obligations under state law; they do not impose direct obligations on ERISA plans. The Health Care Providers' claims affect ERISA plans, if at all, only insofar as United may try to pass the added costs resulting from those claims on to the plans that it administers. And, especially in the wake of the U.S. Supreme Court's recent decision in *Rutledge v.*

Grp., Inc., 515 F. Supp. 3d 298, 309-10 (E.D. Pa. 2021); *Emergency Grp. of Ariz.*, 838 F. App'x at 300-01; *Emergency Physician Servs. of N.Y.*, 2021 WL 4437166, at *9; *Fla. Emergency Physicians Kang & Assocs., M.D., Inc. v. United Healthcare of Fla., Inc.*, 526 F. Supp. 3d 1282, 1299 (S.D. Fla. 2021); *Gulf-to-Bay Anesthesiology Assocs., LLC v. United Healthcare of Fla., Inc.*, 2021 WL 1718808, at *5 (M.D. Fla. Apr. 30, 2021); *Emergency Servs. of Okla., P.C. v. United Healthcare Ins. Co.*, ___ F. Supp. 3d ___, 2022 WL 20509275, at *1 (W.D. Okla. Mar. 2, 2022); *Atl. ER Physicians Team Pediatric Assocs., PA v. UnitedHealth Grp., Inc.*, 2022 WL 950815, at *4 (D.N.J. Mar. 30, 2022).

Pharmaceutical Care Management Association, 141 S. Ct. 474 (2020), it is absolutely clear that ERISA does not preempt state laws that indirectly impose costs on ERISA plans without mandating a particular scheme of substantive coverage.

ERISA § 514(a) directs that "this subchapter . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). Courts applying this provision are to avoid "uncritical literalism," recognizing that "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course . . . ." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655-56 (1995). Rather, courts must assume "that the historic police powers of the States were not to be superseded by [federal law] unless that was the clear and manifest purpose of Congress." *Cal. Div. of Lab. Standards Enf't v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 325 (1997).

The Supreme Court has limited the parameters of § 514(a) preemption to two categories of state laws. *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016). Those categories are: (1) laws "with a reference to ERISA plans," which include laws that "act[] immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation," and (2) laws with "an impermissible connection with ERISA plans, meaning a state law that governs a central matter of plan administration or interferes with nationally uniform plan

administration." *Id.*

The Health Care Providers' claims do not fall within either of the two categories. First, Supreme Court precedent makes clear that state laws that regulate ERISA plans and non-ERISA entities in an evenhanded manner and that "function[] irrespective of . . . the existence of an ERISA plan" do not "refer to" ERISA plans for purposes of conflict preemption. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990). In *Dillingham*, the Supreme Court held that a California state law was not preempted because the entities it regulated "need not necessarily be ERISA plans," although they could have been. 519 U.S. at 325. Similarly, the Court in *Travelers* upheld a New York state law that regulated the prices hospitals could charge to health insurers because the law applied regardless of whether the underlying health plans—whose costs were heavily affected by the law—were ERISA or non-ERISA plans. 514 U.S. at 656. These principles control here. The Health Care Providers' legal claims apply to underpaid claims for reimbursement regardless of whether the patients are insured under self-funded ERISA plans or non-ERISA governed health plans. As such, the Health Care Providers' state law claims make no "reference" to ERISA plans.

The Health Care Providers' claims also do not have an "impermissible connection" with ERISA plans. In analyzing the "connection with" standard, the Supreme Court has "cautioned against an 'uncritical literalism' that would make pre-

emption turn on 'infinite connections.'" *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (citations omitted). Rather, courts must "look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." *Id.* (citations and quotation marks omitted). ERISA's primary objective is "to make the benefits promised by an employer more secure by mandating certain oversight systems and other standard procedures." *Gobeille*, 136 S. Ct. at 943. That goal is in no way obstructed by state regulation requiring health insurers to compensate emergency care providers at reasonable rates for the care that these providers are legally obligated to provide. *See Glastein v. Aetna, Inc.*, 2018 WL 4562467, at *3 (D.N.J. Sept. 24. 2018) (out-of-network provider's common law claims challenging insurer's reimbursement rates not preempted because "claims brought by a provider against an insurance company do not implicate ERISA's goals of protecting participants and beneficiaries. Such claims therefore do not have an 'impermissible connection with' an ERISA plan . . . .").

The recent *Rutledge* decision is dispositive of United's ERISA preemption defense. In *Rutledge*, a unanimous Supreme Court, relying upon its prior decision in *Travelers*, held unequivocally that "ERISA does not pre-empt state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage." 141 S. Ct. at

480. *Rutledge* dealt with an Arkansas law regulating pharmacy benefit managers ("PBMs"). *Id.* at 478. PBMs are entities that manage prescription drug benefits for health plans, including ERISA plans. *Id.* This includes setting reimbursement rates and paying reimbursements to pharmacies for the plan members' prescription drugs. *Id.* After reimbursing the pharmacies, the PBMs are reimbursed by the health plans. *Id.* In this sense, PBMs are perfect analogues for TPAs like United that manage health benefits for the plans.[62] Just as PBMs set reimbursement rates and pay reimbursements to pharmacies for pharmaceuticals dispensed to the plan members, United sets reimbursement rates and pays reimbursements to medical providers—such as the Health Care Providers—who render medical care to the plan members.

The state law at issue in *Rutledge* was a direct regulation of the reimbursement rates PBMs pay to pharmacies. Arkansas had sought to prevent the closure of rural pharmacies unable to turn a profit because PBMs set their reimbursement rates below the pharmacies' wholesale acquisition costs for the prescription drugs. *Id.* at 478-79. Arkansas law addressed this problem in part by setting a hard floor for the

[62] Numerous courts have recognized that PBMs are third-party administrators of pharmacy benefits. *See, e.g.*, *Trone Health Servs., Inc. v. Express Scripts Holding Co.*, 974 F.3d 845, 848 (8th Cir. 2020) ("Pharmacy Benefit Managers (PBM) serve as third-party administrators of prescription drug programs sponsored by employers . . . ."); *Rx.com v. Medco Health Sols., Inc.*, 322 F. App'x 394, 396 (5th Cir. 2009) ("Defendants are pharmacy benefit managers ("PBMs"), which are third party administrators of prescription drug programs for health insurance plans, employers . . . .").

reimbursement rates PBMs could pay to pharmacies. *Id.* at 479. A PBM trade association challenged the law as preempted by ERISA § 514(a). The Supreme Court squarely rejected that position.

In reaching its decision, the Supreme Court made several significant findings. One, the Court noted that "not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan." *Id.* at 480. Two, the Court noted that "cost uniformity was almost certainly not an object of pre-emption." *Id.* at 481. Accordingly, the *Rutledge* court held that the Arkansas PBM law did not have an "impermissible connection" with ERISA plans. *Id.* at 481. The Supreme Court further determined that the law did not "refer to" ERISA plans "because it applies to PBMs whether or not they manage an ERISA plan. Indeed, the Act does not directly regulate health benefit plans at all, ERISA or otherwise***. It affects plans only insofar as PBMs may pass along higher pharmacy rates to plans with which they contract.***" *Id.* at 481 (emphasis added). The Court therefore concluded that the PBM law did not "require plan administrators to structure their benefit plans in any particular manner, nor did [it] lead to anything more than potential operational inefficiencies," and thus was not preempted. *Id.* at 482.

The Nevada statutes and common law doctrines at issue in this case are not preempted for the same reasons set forth in *Rutledge*. As noted above, United's

position vis-à-vis the ERISA plans is perfectly analogous to that of the PBMs in *Rutledge*. Rather than manage the plans' prescription drug benefits and reimburse prescription drug claims, United manages the plans' health benefits and reimburses claims for medical services rendered. And just like the law at issue in *Rutledge*, the statutes and common law doctrines that serve as the bases for the Health Care Providers' claims regulate the reimbursement rates that United must pay for covered services rendered to plan members. As in *Rutledge*, the laws here do not impose obligations upon the ERISA plans themselves; they impose obligations upon United, which is a service provider retained to administer the plans.[63] The Health Care Providers did not sue the plans because they do not seek recovery of benefits from the plans or otherwise allege that the plans owe them anything. The Health Care Providers alleged that *United* owes them additional payments based upon its

[63] United argues that the district court's rebuttable presumption instruction, which was based in part on United's failure to produce plan documents, supports United's preemption argument. Per United: "[i]t is impossible for [the Health Care Providers] to defend that instruction while simultaneously asserting that its legal claims had no connection with the very plan documents that provoked the instruction." (United Br. at 161.) That is entirely backwards. The claims asserted and proven by the Health Care Providers were not predicated upon the plan documents. United's *defense* to those claims was that it paid in accordance with the plan documents. That defense was irrelevant as a matter of law because the claims did not arise from the plan terms. Nonetheless, the Health Care Providers were entitled to show the jury that, in any event, United's defense was factually unsupported because United *had not* paid in accordance with the plan documents.

breaches of state law duties requiring *United*—not the plans—to pay certain rates. And while the judgment against United may result in costs being imposed upon the plans as United seeks reimbursement from the plans, *Rutledge* makes clear that this sort of "indirect economic influence" is insufficient to trigger preemption.[64] 141 S. Ct. at 480.

Notably, in the short time since *Rutledge*, numerous courts have relied upon that decision in concluding that claims virtually identical to those in this case—claims asserted by medical providers against ERISA plan administrators challenging the reimbursement rates for out-of-network medical services under state law—are

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[64] United argues that preemption applies because the district court's judgment "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." (United Br. at 160.) Further: "[c]ompliance 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." (United Br. at 160-61.) But the *Rutledge* plaintiff made that same argument, and the Supreme Court squarely rejected it. As the Court explained:

> [The Arkansas law] is merely a form of cost regulation. It requires PBMs to reimburse pharmacies for prescription drugs at a rate equal to or higher than the pharmacy's acquisition cost. ***PBMs may well pass those increased costs on to plans, meaning that ERISA plans may pay more for prescription-drug benefits in Arkansas, than in, say, Arizona.*** But cost uniformity was almost certainly not an object of pre-emption.

141 S. Ct. at 481 (quotation marks omitted and emphasis added).

not preempted by ERISA § 514(a). *See, e.g.*, *Kang*, 526 F. Supp. 3d at 1297-99; *Emergency Servs. of Okla., PC v. Aetna Health, Inc.*, 556 F. Supp. 3d 1259, 1263-65 (W.D. Okla. 2021); *Emergency Physician Servs. of N.Y.*, 2021 WL 4437166, at *8-9; *ACS*, 514 F. Supp. 3d at 939-42; *Vanguard Plastic Surgery, PLLC v. United Health Grp. Inc.*, 2021 WL 4651504, at *3 (S.D. Fla. Sept. 21, 2021).[65] As the *ACS* court aptly recognized, there is "no legally meaningful distinction, for purposes of ERISA preemption, between an Arkansas law that regulates the rate at which PBMs reimburse pharmacies, and the Texas [laws], which regulate the rate at which insurers and insurance plan administrators reimburse [medical providers]." 514 F. Supp. 3d at 941. That conclusion is unassailably correct, and there is no reason for the Court to depart from this clear judicial consensus.[66]

V. THE DISTRICT COURT DID NOT ERR IN AWARDING PROMPT PAY INTEREST AND ATTORNEYS' FEES

The PPA directs that "an administrator shall approve or deny a claim relating to health insurance coverage within 30 days after the administrator receives the

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[65] Notably, many of these cases involve TeamHealth-affiliated medical practices asserting claims against United virtually identical to the claims in this case. *See, e.g.*, *Kang*, 526 F. Supp. 3d at 1297-99; *Emergency Physician Servs. of N.Y.*, 2021 WL 4437166, at *8-9; *ACS*, 514 F. Supp. 3d at 939-42.

[66] In support of its preemption argument, United cites a series of cases that long pre-date *Rutledge*. (United Br. at 156-58.) To the extent those authorities hold that state laws regulating the reimbursement amounts that TPAs must pay to third-party medical providers are preempted, they are no longer good law in light of *Rutledge*.

claim." NRS 683A.0879(1). The statute further directs that "[a]n administrator shall not pay only part of a claim that has been approved and is fully payable." NRS 683A.0879(4).[67] Here, United did *not* fully pay the Health Care Providers' claims within 30 days. Despite having been aware that it was required to reimburse those claims at amounts equaling reasonable value, United deliberately paid less than reasonable value. (4 PA 951:15-19; 2 PA 465:14-20; 32 AA 7923:24-25:1.) In short, it only *partially* paid the claims. For that reason, the district court appropriately held that United had violated the PPA.

United argues that the district court erred for three reasons: (1) the Health Care Providers' claims do not "relate to" health insurance; alternatively, if they do relate to health insurance, they are preempted by ERISA; (2) the Health Care Providers do not have standing to sue based on the PPA violations, and instead were required to await administrative action by the Insurance Commissioner; and (3) the PPA does not apply because United paid the allowed amounts on the claims at issue—*i.e.,* the amounts that it unilaterally determined it would pay—within 30 days. Each of those arguments is without merit.

[67] NRS 689A.410; 689B.255; 695C.185; and 689C.335 govern different forms of health insurance and contain substantively identical PPA requirements.

A. The PPA Applies and the Health Care Providers' Claims Are Not Preempted by ERISA

The PPA governs claims "relating to health insurance." NRS 683A.0879(1). In opposing dismissal based on ERISA preemption, the Health Care Providers have long argued that their claims do not relate to ERISA plans. United contends accordingly that the Health Care Providers are now estopped from arguing that their legal claims *do* relate to health plans. Therefore, per United, the PPA does not apply. (United Br. at 142-44.) United is wrong. While the Health Care Providers have argued (correctly) that their claims do not relate to ERISA plans *as the term "relate to" has been construed in the U.S. Supreme Court's ERISA preemption jurisprudence*, they have never argued that their claims do not relate to health plans based upon the plain meaning of "relate to." Nor could they, as the claims in this case facially challenge the reimbursement amounts that United paid on health insurance claims, many of them under self-funded ERISA plans. The reason for this seeming discrepancy is that "relate to," as set forth in ERISA's preemption clause, has a limited meaning that does *not* comport with common usage. Thus, the Health Care Providers' claims can "relate to" health insurance for purposes of Nevada's PPA, but *not* for purposes of ERISA § 514(a). An understanding of how the Supreme Court's ERISA jurisprudence has evolved over time demonstrates why.

The phrase "relate to," by its plain terms, has an extraordinarily expansive scope. *See Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 383 (1992) ("The

ordinary meaning of ['relating to'] is a broad one—to stand in some relation; to have bearing or concern; to pertain; refer; to bring into association with or connection with . . . ." (quotation marks omitted).) In its earliest ERISA cases, the Supreme Court construed § 514(a) according to the plain meaning of its text, invariably finding—given the broad scope of "relate to"—that the challenged state law was preempted. *See, e.g.*, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). Beginning in the mid-1990s, the Court retreated from that approach, recognizing that the text of § 514(a) suggests an effectively unlimited preemptive reach, which the Court could not countenance. *See, e.g.*, *Travelers*, 514 U.S. at 655 ("If 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course . . . ."). Justice Scalia—joined by Justice Ginsburg—succinctly explained this shift:

> Our earlier cases sought to apply faithfully the statutory prescription that state laws are pre-empted 'insofar as they . . . relate to any employee benefit plan.' . . . But applying the 'relate to' provision according to its terms was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else. ***The statutory text provides an illusory test***, unless the Court is willing to decree a degree of pre-emption that no sensible person could have intended—which it is not.

Dillingham, 519 U.S. at 335-36 (Scalia & Ginsburg, J.J., concurring) (emphasis added).

To render the application of § 514(a) reasonable and workable in practice, the Court fashioned the test for preemption described in Part IV.B.2, *supra*: a state law is preempted only if it refers to, or is impermissibly connected with, ERISA plans. Since *Travelers*, the Court consistently has reaffirmed this more limited preemption jurisprudence, most recently in *Rutledge*. The end result is that there are many state laws (and claims asserted thereunder) which relate to ERISA plans according to the plain-English meaning of "relate to," but which are not preempted because they do not "relate to" ERISA plans according to how the Supreme Court has construed the use of that phrase in § 514(a). The Arkansas statute challenged in *Rutledge* provides a textbook example: it clearly "relates to" ERISA plans because it regulates the amounts that must be paid on claims arising under health plans, including ERISA plans, yet a unanimous Supreme Court held that the law was not preempted.

To the extent the Health Care Providers have in the past contended that their claims do not relate to ERISA plans, that was *always* in the context of opposing United's arguments for preemption. But given the unique construction of "relate to" in § 514(a), the Health Care Providers' prior positions were *not* a concession that their claims do not "relate to" health insurance according to the common meaning of that phrase and its use in the PPA. In short, there is no inconsistency between the

district court's holding that the Health Care Providers' claims are not preempted by ERISA, but that the PPA nonetheless applies.[68]

B. The Health Care Providers Have Standing to Seek PPA Interest and Fees

United contends that the Health Care Providers were required to exhaust administrative remedies before seeking judicial relief for United's violations of the PPA. It principally relies upon this Court's decision in *Allstate Insurance Co. v. Thorpe*, 123 Nev. 565, 170 P.3d 989 (2007), which held that the Nevada Division of Insurance ("NDOI") has exclusive jurisdiction to enforce NRS 690B.012. (United Br. at 145-48.) But *Thorpe* is inapposite, because the PPA provisions at issue here differ markedly from NRS 690B.012. United's position accordingly is without merit.

Thorpe involved a dispute as to whether private litigants could bring suit under the PPA provisions governing casualty insurance policies, which are codified at NRS 690B.012. 123 Nev. at 568, 170 P.3d at 991. The Court answered that question in

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[68] United's references to statements in the Health Care Providers' federal court remand briefing—that their claims are not derivative of, or otherwise dependent on, ERISA plan terms—are even further off base. (United Br. at 143.) The remand briefing exclusively dealt with complete preemption under ERISA § 502(a), because complete preemption is jurisdictional, while conflict preemption under § 514(a) is not. (*See supra* Argument, Part IV.B.) But the two doctrines are not coextensive in reach: a claim can be conflict preempted under § 514(a)—because it "relates to" ERISA plans according to the Supreme Court's test—but still not be completely preempted. *See Conn. Dental*, 591 F.3d at 1344.

the negative, holding that NDOI has exclusive jurisdiction to enforce the casualty insurance PPA, but that affected parties can seek judicial review of NDOI's actions (or non-actions) according to the procedures set forth in the Nevada APA. *Id.* at 576, 170 P.3d at 996. In short, parties who have been aggrieved by casualty insurers' violations of NRS 690B.012 must pursue administrative remedies before running to court. In reaching that conclusion, the Court applied its normal rules of statutory construction, which place paramount importance on legislative intent. *Id.* at 571, 170 P.3d at 993 (citing *U.S. Design & Constr. Corp. v. Int'l Bhd. of Elec. Workers*, 118 Nev. 458, 461, 50 P.3d 170, 172 (2002)).

The contrast between the PPA provisions governing casualty insurance and those governing health insurance demonstrates that the district court was correct in holding that the Health Care Providers have standing to pursue PPA remedies. As noted, casualty insurance is governed by NRS 690B.012. Health insurance is governed by NRS 683A.0879; 689A.410; 689B.255; 695C.185; and 689C.335. Those provisions are similar in certain respects; all of them require an insurer to pay or deny a claim within 30 days. But they contain several critical distinctions. Notably, the health insurance provisions direct that "[a] court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section." NRS 683A.0879(5); 689A.410(5); 689B.255(5); NRS 695C.185(5); 689C.335(5). That language is absent from the casualty insurance provision, and

this inconsistency suggests that the legislature intended the health insurance PPA and casualty insurance PPA to operate differently. *See Harris*, 133 Nev. at 689, 407 P.3d at 353 (holding that variation in language between related statutory provisions presumptively suggests variation in meaning).

The *Thorpe* Court found no indication that the Legislature had intended to create a private right of action in the casualty insurance PPA. But the inclusion in the health insurance PPA of language directing courts to award fees and costs to prevailing parties plainly suggests legislative intent to create a right of action in the health insurance context (otherwise, there would be no "action[s] brought pursuant to this section" in which a party could prevail and become entitled to recover its fees). As this Court recognized in addressing whether a private right of action exists under Nevada's minimum wage statute, "[i]t would be absurd to think that the Legislature intended a private cause of action to obtain attorney fees for an unpaid wages suit but no private cause of action to bring the suit itself." *Neville v. Eighth Jud. Dist. Ct.*, 133 Nev. 777, 783, 406 P.3d 499, 504 (2017);[69] *see also Arora v.*

[69] United attempts to distinguish *Neville* by noting that the minimum wage statute contained references to a "suit" and "verdict," and that such references are absent from the PPA. (United Br. at 148.) While that is true, what the *Neville* Court found determinative was: (1) that "[i]t would be absurd to think that the Legislature intended a private cause of action to obtain attorney fees for an unpaid wages suit but not a private cause of action to bring the suit itself," and (2) the statute was enacted "to protect employees, and the legislative scheme is consistent with private causes of action." 133 Nev. at 783, 406 P.3d at 504. Both considerations apply

Eldorado Resorts Corp., 2016 WL 5867415, at *8 n.3 (D. Nev. Oct. 5, 2016) ("Moreover, the provision within the statute for the payment of attorney fees further supports an implied private right of action. There would be no need for such allowance within the language of the statute if a private right of action were not implied." (quotation marks and brackets omitted)). Significantly, a Nevada federal district court recently addressed this very question, concluding that the health insurance PPA does contain an implied private right of action. *Prime Healthcare*, 2022 WL 1692525, at *9. Citing this Court's precedent in *Neville*, the *Prime Healthcare* court explained:

> [T]here was legislative intent to create a private cause of action under NRS § 683A.0879 for late or unpaid insurance claims. NRS § 683A.0879(5) explicitly provides for an award and assessment of attorney's fees *by a court* "to the prevailing party in an action brought pursuant to this section." The statute's authorization of attorney's fees is consistent with legislative intent for a private right to sue.

Id. (emphasis in original).

The *Prime Healthcare* court went on to distinguish the casualty insurance PPA on the basis that "NRS § 690B.012 does not contain an attorney fee provision and has a different statutory scheme." *Id.*[70]

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equally here.

[70] Courts in jurisdictions across the country—up to and including the U.S. Supreme Court—have long held that the inclusion of fee-shifting language in a statute is strongly indicative of legislative intent to create a private right of action. *See, e.g.*,

United's only response to the self-evident reality that the existence of a fee-shifting provision suggests the existence of a right of action to bring the suit in which fee-shifting would occur is to contend that "the PPA provision makes complete, coherent sense as simply authorizing a *reviewing* court to award fees to the party that prevails *on review*." (United Br. at 148 (emphasis in original).) That is nonsensical. If United were correct that the health insurance PPA operated like the casualty insurance PPA—an aggrieved party must pursue administrative remedies in NDOI and only afterwards can seek judicial review of the agency action—then there could be no "action brought pursuant to this section." NRS 683A.0879(5). The only judicial relief available to an aggrieved party would be through a petition brought pursuant to the APA, NRS 233B.130 *et seq.*, not an action brought pursuant to the PPA. *Thorpe*, 123 Nev. at 574-75, 170 P.3d at 995-96. And, in that case, the prevailing party entitled to recover its fees under the PPA would either be the

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Cannon v. Univ. of Chi., 441 U.S. 677, 699-701 (1979) (fee-shifting provision contained in Title VI indicative of implied private right of action); *Wombold v. Assocs. Fin. Servs. Co. of Mont., Inc.*, 104 P.3d 1080, 1087 (Mont. 2004) ("The inclusion of the attorney fee provision is proof of a legislative intent to recognize a private right of action under the CLA."); *Coleman v. Casey Cty. Bd. of Educ.*, 510 F. Supp. 301, 303 (W.D. Ky. 1980) ("Further evidence that Congress intended to permit private actions is found in the availability of attorneys' fees under the Rehabilitation Act."); *Cal. Paralyzed Veterans Ass'n v. F.C.C.*, 496 F. Supp. 125, 129 (C.D. Cal. 1980) ("[P]assage of the 1978 attorneys fee provision [is] persuasive evidence of Congress' original intent to provide an individual private action under section 503.").

petitioner or NDOI. But it is absurd to think that fee-shifting would be authorized in an administrative review proceeding where an agency is the party. Indeed, the APA contains no generally applicable fee-shifting provision, and there is no reason to think the Legislature created a lone exception for review of administrative actions dealing with health insurance PPA violations. *See Zenor v. State, Dep't of Transp.*, 134 Nev. 109, 110, 412 P.3d 28, 30 (2018) (holding that the APA does not authorize fee-shifting in proceedings for judicial review of agency actions).

In any event, the fee-shifting provision is not the only factor differentiating the health insurance PPA from the casualty insurance PPA. In fact, unlike the health insurance PPA, the casualty insurance PPA does *not* include language directing that an insurer "shall not pay only part of a claim that has been approved and is fully payable," NRS 683A.0879(4), which is the very requirement that the Health Care Providers proved United had violated. (48 AA 11995; 38 AA 9462.) In other words, the specific statutory subsection that was the basis for the district court's award of interest and fees does not even exist in the casualty insurance PPA (which contains no private right of action). All of these distinctions are highly meaningful, because provisions of the Insurance Code "relative to a particular kind of insurance or type of insurer or particular matter shall prevail over provisions relating to insurance in general or insurers in general or to such matter in general." NRS 679A.170.

In short, the specific code provisions addressing health insurance plainly indicate that the Legislature *did* intend to create a private right of action under the PPA, and *Thorpe* therefore is inapposite. The district court correctly held that the Health Care Providers were not required to exhaust administrative remedies.

C. The PPA Applies Because United Did Not Promptly Pay the Full Amounts Due to the Health Care Providers

United observes that 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." (United Br. at 149 (emphasis in original).) United contends that it did not run afoul of that requirement because it paid the (unreasonably low) amounts that it (unilaterally) allowed on the disputed claims within 30 days. (United Br. at 149-50.) In short, United argues that "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 Br. at 151.) And it maintains that that is what it did here: it paid the allowed amounts in a timely fashion but contested its obligation to pay any more. Given the record, that position should be rejected.

Initially, United is correct in one limited respect: by its plain terms, the PPA regulates *timing* of payment, not *amount* of payment. *See* NRS 683A.079(1). Thus, whether the amount due on a given claim is, say, $1,000, or $100, the PPA would apply in the same manner: the insurer is required to make the payment within 30 days. And United is also correct that the PPA does not require payment within 30

days of a contested portion of a claim. But what the PPA *does* proscribe is an insurer's making only partial payment of a claim "that has been approved and is ***fully payable***." NRS 683A.079(4) (emphasis added).

Given the above, the PPA applies here. None of the underlying claims were "contested," because the Health Care Providers challenged the reimbursements paid only on claims that United had adjudicated as fully payable. (46 AA 11416:23-17:4.) When United underpaid the Health Care Providers, it did precisely what the PPA proscribes: it paid "only part of" claims that had "been approved" and were "fully payable." Moreover, United's position that application of the PPA would operate as a regulation of reimbursement *amounts* is simply wrong. Rather, the amount of reimbursement due was established by the law set forth above, requiring reimbursement at reasonable amounts. And the trial evidence showed that United always had known that it was required to pay reasonable amounts and that the amounts it was paying were *not* reasonable. (39 AA 9557:17-19; 4 RA 507, 517; 12 RA 2036; 37 AA 9030:21-31:9; 5 RA 772, 776; 31 AA 7747:14-17, 7750:6-11; 32 AA 7923:24-25:1, 7753:21-54:12.) That is a clear PPA violation, because United made a deliberate choice to withhold portions of the payments due on approved, fully payable claims. To this day, United still has not paid them.[71]

[71] United cites *Emergency Department Physicians P.C. v. United Healthcare, Inc.*, 507 F. Supp. 3d 814, 832-33 (E.D. Mich. 2020), as support for its position. But that

VI. THE DISTRICT COURT DID NOT ERR IN REFUSING TO SEAL THE TRIAL RECORD

Cognizant of the strong public policy favoring open access to court records, the district court appropriately denied United's request that large swaths of the trial record be sealed in perpetuity. In its mandamus petition (Case No. 85656), United seeks an extraordinary writ reversing that determination. The Court should deny United's request for two independent reasons. First, United waived any protection over the materials at issue when it allowed them to be introduced at a public trial (that was broadcast over the internet) without any confidentiality reservation. Second, the district court's decision was correct on the merits. At minimum, that decision was well within the court's discretion.

Writ relief "will only be granted when the petitioner has a clear right to the relief requested and there is no plain, speedy and adequate remedy in the ordinary course of the law." *Halverson v. Miller*, 124 Nev. 484, 487, 118 P.3d 893, 896 (2008); *see also Archon Corp. v. Eighth Jud. Dist. Ct.*, 133 Nev. 816, 819, 407 P.3d 702, 706 (2017) (same). This Court will grant a writ petition only where the district court manifestly abused its discretion or acted arbitrarily or capriciously. *Walker v. Second Jud. Dist. Ct.*, 136 Nev. 678, 680, 476 P.3d 1194, 1196 (2020) (citations

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case is inapposite. *Emergency Department* merely held that there is no private right of action under Michigan's PPA. As explained in Part V.B, *supra*, Nevada's health insurance PPA *does* contain a private right of action.

omitted). A manifest abuse of discretion is "a clearly erroneous interpretation of the law or a clearly erroneous application of a law or rule." *See State v. Eighth Jud. Dist. Ct. (Armstrong)*, 127 Nev. 927, 932, 267 P.3d 777, 780 (2011) (brackets omitted). An arbitrary or capricious act is one "founded on prejudice or preference rather than on reason . . . or contrary to the evidence or established rules of law." *Id*.

A. United Waived Any Right to Confidentiality When It Failed to Seek Protection of Its Materials During Trial

The district court made abundantly clear, before any exhibits were admitted, that it would not seal or redact "anything that's admitted." (1 PA 236:3-9, 237:17-22, 239:10-13, 239:23-25.) Thus, United was on notice that it needed to object prior to trial or at trial to the introduction of any purportedly confidential materials. But United did not do so. Prior to trial, United sought protection only for the 19 AEO Exhibits. (1 PA 218:17-19:9, 234:15-19; 30 PA 7179; 31 PA 7439:2-9.) During trial, numerous other documents that had been marked "Confidential" or "AEO" were introduced into evidence, and the parties and witnesses openly discussed them on the record. United did not object. In fact, United itself introduced many of those documents and sponsored the related testimony.

It was not until the Motion to Seal, served well *after* the conclusion of trial, that United first raised the prospect of sealing numerous trial exhibits (which were, by then, in the public record). In fact, United subsequently *withdrew* its proposed redactions to a number of exhibits that it now contends the district court erroneously

refused to seal. (*Compare* Pet'n at 38-39, *with* 2 RA 302-44.) As such, United plainly waived any protection. *See Phillips v. C.R. Bard, Inc.*, 2015 WL 3485039, *1-2 (D. Nev. June 1, 2015) (finding that defendants' failure to move during trial for sealing of certain portions of trial record operated as a waiver of confidentiality protection).[72]

B. The District Court Did Not Abuse Its Discretion in Partially Granting and Partially Denying United's Sealing Request

Putting aside the waiver issue, the district court's partial denial of United's sealing request was correct on the merits. Judicial records are public documents, and courts have long recognized a general right to inspect and copy public records. *See Nixon v. Warner Commc'ns, Inc.*, 435 U.S. 589, 597 (1978). As the U.S. Court of Appeals for the Firth Circuit has explained, "[j]udicial records belong to the people; they are public, not private, documents. And the public's right of access to judicial records is a fundamental element of the rule of law." *June Med. Servs., L.L.C. v. Phillips*, 22 F.4th 512, 519 (5th Cir. 2022) (citations, quotation marks, and brackets omitted). The open court presumption in Nevada is well-established, and it is reflected in the Nevada Rules for Sealing and Redacting Court Records. *See* SRCR 1(3) ("All court records in civil actions are available to the public, except as

[72] On their face, many of the documents that United sought to have sealed after trial did not merit protection. The Vince Lombardi document was one of numerous examples. (29 PA 6869; 31 PA 7408:6-11.)

otherwise provided in these rules or by statute.") Indeed, Nevada law mandates that (1) the "sitting of every court of justice shall be public" and (2) "[e]very trial on the merits must be conducted in open court." NRS 1.090; NRCP 77(b). Nevada courts may seal records in a civil action only where a party demonstrates that the public right of access is outweighed by a "significant competing interest." *Jones v. Nev. Comm'n on Jud. Discipline*, 130 Nev. 99, 109, 318 P.3d 1078, 1085 (2014). The court must use the "least restrictive" means and duration for any order sealing or redacting court records. SRCR 3(6).

The district court faithfully applied these principles in partially denying United's request to seal or redact the trial exhibits. After carefully weighing the public interest in open access to court records against United's purported privacy interests, the district court determined that the majority of the records should remain unsealed. (15 PA 3663-806 ¶¶ 3 and 4; 31 PA 7493:13-96:23.) United makes several arguments to the contrary, none of which have merit.[73]

First, United contends that the district court should have sealed certain portions of admitted trial exhibits that were not "shown to the jury or discussed in open court." (Pet'n at 36.) In other words, United apparently believes that materials

[73] Throughout its Petition, United wrongly conflates the standard for sealing trial exhibits with the standard for confidentiality under a protective order. For obvious reasons, the two are different: trial exhibits enjoy substantially less protection. *See June*, 22 F.4th at 521.

admitted into evidence in a public trial are not available to the public unless specifically highlighted during argument or witness testimony. That is obviously wrong; the Rules do not contemplate exemptions from the open access requirement for portions of the record that were not specifically discussed during trial proceedings. *See* SRCR 2(2) (defining "court record" to include "[a]ny document, information, exhibit, or other thing that is maintained by a court in connection with a judicial proceeding"); SRCR 1(3) (directing that "court records in civil actions are available to the public.") And that policy is eminently sensible, because *all* materials admitted into evidence are present in the jury room and available for the jury's consideration. United's alternative construction would place parties and courts in the untenable position of having to speculate as to which portions of the record the jury found persuasive during its secret deliberations.

In any event, much of the information that United sought to protect had already been disclosed or was otherwise publicly available and therefore could not constitute trade secrets. The district court meticulously reviewed each redaction on each page of each document at issue, and it made careful determinations in accordance with SRCR 3(4). (15 PA 3663-806; 31 PA 7493:13-96:23.) In so doing, the district court made several specific findings. Notably, the court recognized that:

- Because United is a public company, "most of [its] financial information had been disclosed in 10-Ks, 10-Qs and otherwise," and there was "no evidence that [United] used proprietary methods of analysis." (31 PA 7493:17-20.)

- Many of United's so-called "strategic business plans" were not trade secrets because companies in the insurance industry "are almost identical," insurance companies "know a lot more about each other," and the business models and metrics are identical.[74] (31 PA 7493:17-20, 21-25.)

- Much of the financial information that United wished to seal was upwards of five years old and therefore was not entitled to trade secret protection.[75] (12 AA 2989-90.)

Ultimately, United wholly failed to satisfy the heavy burden of establishing that its information should be sealed. The only evidence United submitted to support its Motion to Seal was two nonspecific declarations from individuals who were not even trial witnesses. (17 PA 3949-54, 56-63.) This scant showing did not even come close to establishing that the records at issue were so sensitive that the harm to United's cognizable interests from their disclosure would override the public interest in open access to court records. Nor could it, because the records are not in fact commercially sensitive. Rather, the *real* reason that United has fought tooth and nail to keep these records secret is because they document United's history of wrongdoing and therefore would prove embarrassing if publicized. That is not a legitimate reason to seal them. *See Phillips*, 2015 WL 3485039, *1 ("Preventing

[74] United effectively conceded this at trial. (2 PA 397:3-98:2.)

[75] *See U.S. v. Int'l Bus. Mach. Corp.*, 67 F.R.D. 40, 46 (1975) (noting that "disclosure of two-and-a-half-year-old sales data" will not result in a "clearly defined, serious injury").

lawsuits due to the release of inculpating information is not a compelling reason to seal otherwise public legal proceedings.").

Second, United contends that the district court erred in issuing a blanket ruling that it would "not seal any exhibit admitted at trial." (Pet'n at 38-43.) Not so. While the district court made that statement preliminarily, it later clarified that it potentially would allow sealing of AEO information, even if that information was shown to the jury. (32 PA 7630:16-31:4.) In keeping with that determination, the district court granted United's proposed redactions to several admitted trial exhibits. (15 PA 3666-16 PA 3800; 32 PA 7654:23-55:2; 65:1-4, 67:3-6, 72:4-7.)

Finally, United challenges the district court's decision not to conduct a further evidentiary hearing on the Motion to Seal. Again, that is wrong. Nevada law does not require district courts to hold evidentiary hearings on motions to seal. *See* SRCR 3(3). Nevertheless, the district court did not make its sealing decisions in a vacuum. Rather, it presided over nearly two years of pretrial matters and a lengthy jury trial. In so doing, the district court reviewed the exhibits, heard from the witnesses who had sponsored the exhibits, and ultimately gained a firm grasp of the issues. It is absurd to suggest that the district court committed error by failing to conduct a further evidentiary hearing on matters with which it was intimately familiar.

Ultimately, the district court's sealing decision was well-reasoned and should be left undisturbed.

CONCLUSION

For all the foregoing reasons, the district court's judgment should be affirmed and United's mandamus petition should be denied.

DATED this 28th day of August, 2023.

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NRAP 28.2 CERTIFICATE OF COMPLIANCE

1. I hereby certify that this brief complies with the formatting requirements of NRAP 32(a)(4), the typeface requirements of NRAP 32(a)(5) and the type-style requirements of NRAP 32(a)(6). This brief has been prepared in a proportionally-spaced typeface using Microsoft Word in Times New Roman font 14.

2. I further certify that this brief exceeds the page- or type-volume limitations of NRAP 32(a)(7) because, excluding the parts of the brief exempted by NRAP 32(a)(7)(C), it contains 36,741 words.

3. Finally, I hereby certify that I have read this appellate brief, and, to the best of my knowledge, information, and belief, it is not frivolous or interposed for any improper purpose. I further certify that this brief complies with all applicable Nevada Rules of Appellate Procedure, in particular NRAP 28(e)(1), which requires every assertion in the brief regarding matters in the record to be supported by a reference to the page and volume number, if any, of the transcript or appendix where the matter relied on is to be found. I understand that I may be subject to sanctions in the event that the accompanying brief is not in conformity with the requirements of the Nevada Rules of Appellate Procedure.

DATED this 28th day of August, 2023.

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CERTIFICATE OF SERVICE

I certify that I am an employee of BAILEY❖KENNEDY and that on the 28th day of August, 2023, service of the foregoing **Respondents' Answering Brief – Redacted** was made by electronic service through Nevada Supreme Court's electronic filing system and/or by depositing a true and correct copy in the U.S. Mail, first class postage prepaid, and addressed to the following at their last known address:

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RULE 28(f) ADDENDUM OF STATE COURT DECISIONS

Tab No.	Date	Document Description	Page(s)
1	12/1/2020	Order Denying Defendants' Motion to Compel Discovery Regarding Plaintiff's Internal Cost Structure in the matter styled *Gulf-to-Bay Anesthesiology Associates, LLC v. UnitedHealthcare of Florida, Inc. and UnitedHealthcare Insurance Co.,* Case No. 17-CA-011207	000001-000007
2	6/27/2023	Report of Recommendation in the matter styled *Atlantic ER, et al. v. United HealthGroup, et al.,* Docket GLO-L-1196-20	000008

1

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

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, LLC,

CASE NO.: 17-CA-011207

Plaintiff,

v.

UNITEDHEALTHCARE OF FLORIDA, INC., and UNITEDHEALTHCARE INSURANCE CO.,

The Insurance Companies.

_____/

ORDER DENYING DEFENDANTS' MOTION TO COMPEL DISCOVERY REGARDING PLAINTIFF'S INTERNAL COST STRUCTURE

THIS MATTER came before the Court on September 24, 2020, on UnitedHealthcare of Florida, Inc. and UnitedHealthcare Insurance Co.'s (collectively, "Defendants") Motion to Compel Plaintiff's Supplemental Responses to Defendants' First Request for Production filed August 21, 2020 ("Defendants' RFP Motion") and Motion to Compel Plaintiff's Supplemental Responses to Defendants' First Set of Interrogatories filed August 25, 2020, (collectively "Defendants' Discovery Motions"). This Order addresses Requests for Production Numbers 2-7, 29-30, 55, 62-64 and Interrogatory Numbers 19 and 30, which seek production of documents and information from Plaintiff, Gulf to Bay Anesthesiology Associates, LLC ("Plaintiff"), relating to Plaintiff's internal cost structure ("Cost Discovery"). The Court having reviewed Defendants' Discovery Motions, Plaintiff's Omnibus Response to Defendants' Motions filed September 14, 2020 ("Omnibus Response"), having heard argument of counsel, having reviewed the Court file, and being otherwise fully advised in the premises, hereby ORDERS AND ADJUDGES as follows:

1. This case involves Plaintiff's claims for damages for medical services provided to Defendants' commercial members. Plaintiff alleges that since May 2017, there has been no written

agreement between the parties that dictates the amount Defendants should pay for these medical services, and Plaintiff alleges that Defendants have reimbursed Plaintiff at below fair market rates (the "Disputed Commercial Claims"). In the Amended Complaint, Plaintiff alleges six causes of action, as follows: (1) violation of section 627.64194, Florida Statutes, which sets forth the rates at which preferred provider organizations (PPOs) must reimburse out-of-network healthcare providers (Count I); (2) violation of section 641.513, Florida Statutes, which sets forth the rates at which health maintenance organizations (HMOs) must reimburse out-of-network healthcare providers (Count II); (3) breach of contract implied-in-fact (Count III); (4) quantum meruit (Count IV); (5) unjust enrichment (Count V); and (6) declaratory relief (Count VI).

2. Defendants answered the Amended Complaint on February 22, 2019. Defendants did not raise any affirmative defenses challenging the reasonableness of Plaintiff's rates, charges, or pricing. Additionally, Defendants did not assert any counterclaims that would otherwise expand the issues as framed by the Amended Complaint.

3. The relevant framework for analyzing the appropriate reimbursement of the Disputed Commercial Claims arises out of sections 641.513(5)[1] for HMOs and 627.64194(4) for PPOs (which incorporates section 641.513(5) to the analysis of both emergent and non-emergent services). This framework provides as follows:

> (5) Reimbursement for services pursuant to this section by a provider who does not have a contract with the health maintenance organization shall be the lesser of:

[1] While section 641.513 expressly applies to emergency services, Rule 69O-191.049, Florida Administrative Code, extends the obligation of an HMO to pay hospital-based providers, including anesthesiologists, for "medically necessary and approved physician care rendered to a non-Medicare subscriber at a contracted hospital." Moreover, section 641.3154 obligates HMOs to pay providers, such as Healthcare Provider, for authorized services without regard to the location where the medical services were rendered. As alleged in the Amended Complaint, the Disputed Claims were all authorized and determined by Defendants to be medically necessary.

(a) The provider's charges;
(b) The usual and customary provider charges for similar services in the community where the services were provided; or
(c) The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.

4. Notably, the statute focuses on "charges." There is no provision of this statute that identifies the provider's "costs" as a relevant consideration in the analysis.

5. The leading case interpreting section 641.513(5) is *Baker Cty. Medical Svcs., Inc. v. Aetna Health Mgmt., LLC*, 31 So. 3d 842, 845-46 (Fla. 1st DCA 2010). In that case, the First District analyzed the wording of the statute and the relevant provisions and concluded:

> The term "charges" is not defined in section 641.513(5). When a statute does not define a term, we rely on the dictionary to determine the definition. *See Green v. State*, 604 So.2d 471, 473 (Fla.1992). "Charge" is defined as a "[p]rice, cost, or expense." BLACK'S LAW DICTIONARY 248 (8th ed. 2004). In paragraph (5)(a), the term "charge" is modified by the terms "usual" and "customary." "Usual" is defined as "[o]rdinary; customary" and "[e]xpected based on previous experience." *Id.* at 1579. "Customary" is defined as "[a] record of all of the established legal and quasi-legal practices in a community." *Id.* at 413. **In the context of the statute, it is clear what is called for is the fair market value of the services provided. Fair market value is the price that a willing buyer will pay and a willing seller will accept in an arm's-length transaction.** *See United States v. Cartwright*, 411 U.S. 546, 551, 93 S.Ct. 1713, 36 L.Ed.2d 528 (1973).

Id. at 845 (emphasis added).

6. The *Baker County* Court then concluded that in determining the fair market value of the services, it is appropriate to consider the amounts billed and the amounts accepted by providers, except for patients covered by Medicare and Medicaid. *Id.* at 845-46. Consistent with the plain language of section 641.513(5), the First District did not mention or reference "costs" as having any relevance or impact on the analysis of the statute or the determination of "fair market value." *Id.*

7. The Defendants' Discovery Motions seek to compel Cost Discovery, arguing that such discovery is relevant to the reasonableness of Plaintiff's charge. Defendants rely on *Giacalone v. Helen Ellis Mem'l Hosp. Found*., 8 So. 3d 1233 (Fla. 2d DCA 2009) in support of its position[2]. In opposition, Plaintiff argues that Cost Discovery is irrelevant and not likely to lead to the discovery of admissible evidence based on the applicable statutes and case law related specifically to the claims and defenses asserted in this case. Plaintiff further contends that *Giacolone* is distinguishable, because the legal claims and issues in that case are materially different from those asserted here.

8. After careful consideration, the Court finds that the Cost Discovery is irrelevant and not likely to lead to the discovery of admissible evidence under Rule 1.280, Fla.R.Civ.P.[3] The legal theories asserted by Plaintiff and at issue in this case involve the determination of the lesser of its charges or the "usual and customary provider charges for similar services in the community where the services were provided." There is no mention of "costs" in the applicable statutes as a relevant factor in the analysis. And, the reasonableness of its charges is measured against the

[2] Defendants also rely on a news article in *Pro Publica* purporting to review a case and case materials pending in a court in Texas, that were subsequently sealed. Defendants have not identified the specific legal claims and defenses in the Texas case, how any issues in that case relate to the specific issues in this case or why this Court should rely on third-hand discussions in a news article to inform this Court on how to address the specific issues under Florida law. Accordingly, the Court does not consider this article as probative or informative for purposes of ruling on the pending Motions.

[3] Under Rule 1.280, Fla.R.Civ.P., a party may obtain discovery regarding any non-privileged matter that is relevant to any party's claim or defense and/or likely to lead to the discovery of admissible evidence. *See, e.g., Allstate Ins. Co. v. Langston*, 655 So. 2d 91, 94 (Fla. 1995). While the scope of discovery is broad, it is not unlimited. For example, discovery is not intended to be a "fishing expedition," and courts routinely foreclose a party's attempt to use discovery in that manner. *See, e.g., Walter v. Page*, 638 So. 2d 1030, 1031-32 (Fla. 2nd DCA 1994); *see also State Farm Mut. Auto. Ins. Co. v. Parrish*, 800 So. 2d 706, 707 (Fla. 5th DCA 2001); *Sugarmill Woods Civic Ass'n v. Southern States Utilities*, 687 So. 2d. 1346, 1351 (Fla. 1st DCA 1997). Put simply, a litigant is not entitled "carte blanche to irrelevant discovery." *Langston*, 655 So. 2d at 95.

"usual and customary provider charges for similar services in the community." The statute does not expressly contemplate any analysis of provider costs, either of the Plaintiff or of other providers in the community, and the Court refuses to read such a provision into the statute.

9. Likewise, the *Baker County* Court also determined that the relevant inquiry was in the "fair market value" of the services provided, defined as "the price that a willing buyer will pay and a willing seller will accept in an arm's length transaction." *Baker County*, 31 So. 3d at 845. As explained by the First District, that analysis focuses solely the price of the services, rather than the costs of the services. Importantly, the First District did not identify costs as a factor in the analysis or having any relevance to this determination.

10. Additionally, the Florida Standard Jury Instructions provide that the determination of damages for breach of implied-in-fact contract, *quantum meruit*, and unjust enrichment is based upon the fair compensation for the services rendered and/or benefit conferred – not the costs to provide the service. *See* Florida Standard Jury Instructions in Contract and Business Cases, § 416.7, Restatement (First) of Restitution § 1 cmt. b (1937). Plaintiff's internal cost structure is therefore irrelevant to the analysis of the value of the services conferred by the Plaintiff or the factors to be considered by the jury.

11. The Court has carefully considered Defendants' arguments and reliance on *Giacalone;* however, *Giacolone* is distinguishable. *Giacalone* involved a contract dispute between an uninsured patient and a hospital regarding the patient's agreement to pay for services in accordance with "the regular rates and terms of the hospital." *Id.* at 1234. The hospital sued to collect its full billed charges, claiming those charges reflected the "reasonable value" of the services. The defendant/patient asserted defenses of unconscionability (unreasonable pricing), and asserted counterclaims for unfair or deceptive trade practices. *Id.* The Second DCA characterized

the defendant's "primary claim" as the charges were unreasonable. There were no claims asserted under section 641.513 or 627.64194, Florida Statutes, and *Giacolone* did not discuss those statutes or *Baker County*.

12. At issue before the Second DCA in *Giacolone* was the trial court's form order issuing a blanket denial and containing no explanation of its decision to deny discovery regarding the hospital's charges and discounts provided to various categories of patients (including Medicare and Medicaid),[4] and the hospital's internal cost structure. *Id.* at 1235. The Second DCA did not find specifically that internal cost discovery was relevant or discoverable, but remanded the case back to the trial court for specific consideration of the individual requests in the context of the claims asserted by an uninsured patient against a hospital for breach of contract. *Id.* at 1236.

13. By contrast, Defendants have not raised any unreasonable pricing claims here, either by affirmative defense or counterclaim. Instead, the pleadings here focus on a statutory analysis that addresses the fair market value of the services provided, determined by the price a willing buyer would pay and willing seller would accept. *Baker County*, 31 So. 3d at 845-846. The focus of that analysis is on market pricing.[5] The Court has carefully considered the Cost Discovery requests in the context of this case, and finds that *Giacolone* is not controlling regarding discovery here.

14. Finally, the Court notes that the parties have already exchanged discovery contemplated by *Baker County*, including, for example, (a) information regarding Plaintiff's

[4] As noted above, the *Baker County* Court held that payments from Medicare and Medicaid were not relevant to the determination under section 641.513, Florida Statutes.

[5] Notably, Defendants have not explained how discovery of Plaintiff's internal cost structure would be relevant to a market rate analysis, how Defendants would compare Plaintiff's internal cost structure to the internal cost structure of others in the market, or how Defendants would even obtain that cost information from non-parties.

charges; (b) amounts accepted by Plaintiff for similar services by other commercial insurers; and (c) amounts paid by Defendants for commercial insurance products for similar services in the community. This is precisely the information that is discoverable and is to be weighed by the jury in determining the fair market value of Plaintiff's anesthesia services. In contrast, Plaintiff's internal cost structure is wholly irrelevant and not likely to lead to the discovery of admissible evidence.

Based on the foregoing, it is hereupon **ORDERED** and **ADJUDGED** that Defendants' Motions to obtain documents and information regarding Plaintiff's internal costs and discovery requests related thereto are **DENIED**.[6]

DONE and ORDERED this ___ day of _____ 2020, in Tampa, Hillsborough County, Florida.

Electronically Conformed 12/1/2020
Christopher Sabella

CIRCUIT COURT JUDGE

Copies furnished to:
Counsel of Record

[6] This Order also applies to any third party discovery issued by the Defendants, including but not limited to Defendants' Notice of Intent to Serve *Subpoena Duces Tecum* Without Deposition Pursuant to Rule 1.351, Fla.R.Civ.P. for Production of Documents from Non-Party TeamHealth Holdings, Inc. and Notice of Intent to Serve *Subpoena Duces Tecum* Without Deposition Pursuant to Rule 1.351, Fla.R.Civ.P. for Production of Documents from Non-Party Collect RX, Inc.

2

Atlantic ER et al v. United HealthGroup, et al
Docket GLO-L- 1196-20

June 27, 2023

Report of Recommendation

I. The court appointed special discovery master has reviewed and considered defendant's motion to compel plaintiff to produce cost data information. Oral argument was heard via remote platform on June 26, 2023. Having considered the arguments of counsel, written and oral, the special discovery master recommends that defendant's motion be denied.
Baer v. Chase persuasively articulates controlling New Jersey law and the prevailing view that the market value method of calculating damages is the appropriate measure of damages in a quantum meruit claim such as the matter before the court. Therefore, defendants focus on cost data analysis is not relevant nor likely to lead to relevant and admissible information. To the contrary, information concerning the reasonable and customary charges within the healthcare market are the appropriate, relevant and likely admissible quantum of damages. Within the language of New Jersey Court rule 4:10–2, pursuit of cost data is not "reasonably calculated to lead to the discovery of admissible evidence."
Nothing in this recommendation, nor in the foregoing discussion, is intended to interfere with plaintiffs agreement to provide responses to RFP #52 concerning facility by facility cost breakdown information and physicians agreements as represented by counsel at oral argument.

II. The court appointed special discovery master has reviewed and considered plaintiffs motion to compel defendant to produce documents relative to academic studies, journal articles, etc. as more fully described in RFP # 19 and 24-26. Oral argument was heard via remote platform on June 26, 2023. Having considered the arguments of counsel, written and oral, the special discovery master recommends that plaintiffs motion be denied.
Plaintiffs have failed to demonstrate sufficient nexus to the issues involved in the case at bar so as to render the information sought (much of it already in plaintiffs' hands), relevant to the pending action or tending to lead to relevant information within the contemplation of New Jersey Court rule 4:10-2. The articles and related information sought by plaintiff are remote in time, appear not to reflect information, studies or analysis specific to New Jersey, and any utility beyond information already in plaintiffs possession is speculative.

Respectfully submitted,

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