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,

v.

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

BRIEF FOR *AMICUS CURIAE* EMERGENCY DEPARTMENT PRACTICE MANAGEMENT ASSOCIATION IN SUPPORT OF RESPONDENTS

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NRAP 26.1 DISCLOSURE

The undersigned counsel of record for amicus curiae, Emergency Department Practice Management Association ("EDPMA"), hereby certifies that it has no parent corporations or publicly held companies having a ten percent or more ownership interest.

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These representations are made in order that the Justices of this Court may evaluate possible disqualification or recusal.

**Counsel will comply with or submit his pro hac vice application pursuant to LR IA 11-2 within 14 days*

Dated this 19th day of September, 2023.

/s/ Hector J. Carbajal II
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STATEMENT OF INTEREST OF AMICUS CURIAE

The Emergency Department Practice Management Association ("EDPMA") is a physician trade association focused on delivering high quality, cost-effective care in emergency departments by advocating for the rights of emergency medicine physicians, physician groups, and their patients. Its membership includes physician groups of all sizes, as well as billing, coding, and other professional support organizations that provide direct patient care or support for approximately half of the 146 million patients that visit emergency departments each year. It has an interest in vindicating the rights of emergency care physicians to reasonable reimbursement for the delivery of care to out-of-network patients, the central issue in this case.

INTRODUCTION

This case concerns the vitally important question of whether emergency-care doctors may seek fair payment from health insurers for the doctors' provision of out-of-network emergency care. The jury intuitively and justly answered *yes* and punished Defendant United Healthcare for its malicious (and successful) efforts to not only deprive doctors of fair payment for providing lifesaving medical care, but also to publicly portray emergency-care doctors as villains simply for seeking such fair compensation. On behalf of its physician members—many of whom have been

subject to similar unfair and abusive practices by United and other insurers who have put profits over principle—EDPMA urges the Court to affirm.

SUMMARY OF ARGUMENT

As the underlying trial demonstrated, insurance companies hold significant bargaining leverage over emergency-care doctors, and United exploits this leverage to the fullest. Emergency-care doctors are required by law to provide emergency care without regard to a patient's ability to pay. But insurance companies have very little incentive to bring them "in-network" by offering fair reimbursement rates. Instead, they pay paltry amounts for out-of-network reimbursements, a strategy that has put a tremendous economic strain on emergency-care providers and that has driven TeamHealth's most prominent competitor into bankruptcy.

When the doctors turn to the legal system for relief, the insurance companies always respond as United does here—that the doctors have no claim for reimbursement. Not under the common law. Not under an implied-contract theory. Not under statutes designed to hold insurance companies accountable for deceptive or unfair practices.

EDMPA asks this Court to reject these arguments, as courts across the country have, and affirm the judgment below. The Restatement of Restitution and Unjust Enrichment—which this Court follows—makes clear that Respondents have

a valid unjust enrichment claim in these precise circumstances. Respondents also were entitled to bring claims under Nevada's Unfair Claims Practices Act ("UCPA"). If necessary, this Court should revisit or limit decisions it rendered decades ago in the liability-insurance context to make clear that they are no barrier to Respondents' recovery in the health-insurance context—particularly in light of the economic realities of the emergency-care market. Otherwise, the Legislature's intent to protect the "public interest" and "all having an interest under insurance policies" will be foiled, and the UCPA will not apply to a huge swath of the Nevada health-insurance market—leaving major insurance players unregulated and free to engage in "misleading," "unfair," and even abusive practices.

ARGUMENT

I. Insurers have exploited their superior leverage to deny emergency-care doctors adequate reimbursement for their services, and United has taken this exploitation to a new level.

A. The emergency-care sphere has been characterized by market imbalances and payor abuse.

Emergency-care doctors are required by law and ethical duty to provide emergency care without regard to a patient's ability to pay or insurance status. *See,* CR:40-41; 42 U.S.C. § 1395dd(a)-(c). But these obligations, while ethical and good policy, leave these doctors with little bargaining power to secure adequate reimbursement for such care. Many insurance companies have taken advantage of

the doctors' inferior leverage by severely underpaying them when they provide out-of-network emergency care to the insurers' members.[1]

Indeed, insurers like United have employed a nationwide two-step strategy to exploit doctors. First, they take advantage of the doctors' lack of bargaining power and their legal duty to provide lifesaving services to the insurers' members by offering only paltry reimbursements for that care, while refusing to engage in the type of meaningful contract negotiations that might bring the doctors in-network at fair rates. Indeed, observers have recognized that "[t]he issue isn't whether emergency physicians try to contract with insurance companies—it is that insurance companies have no interest in contracting with emergency physicians."[2]

Then, when the doctors inevitably seek relief from the insurers' unfair practices in court, the insurers argue (as United does here) that doctors have *no* legal remedy. Not under statutes designed to ensure that insurers engage in fair practices. Not under the common law of quantum meruit or unjust enrichment. Not under an

[1] Dr. Ryan Stanton & Dr. Rebecca Parker, *ACEP Outlines Flaws, Biases in New England Journal of Medicine Story on Balance Billing*, ACEPNOW (Jan. 10, 2017), https://www.acepnow.com/article/acep-outlines-flaws-biases-new-england-journal-medicine-story-balance-billing/?singlepage=1 (last visited Nov. 7, 2021).

[2] *Id.*

implied contract theory. Instead, they tend to blame the doctors (again, as United does here) for allegedly unreasonable reimbursement demands.

From the insurers' standpoint, that makes economic sense: "Why would an insurance company be interested in 'negotiating a fair price' for a service that is mandated" when it could shift the cost to someone else?"[3] But while this strategy might be good economics for insurers, it crushes the doctors who are actually providing emergency care and threatens to unravel the emergency-care market. Indeed, this precise strategy—which often includes "refusing to renew … in-network agreement[s] at commercially reasonable rates and systematically denying payment on … emergency medicine claims"[4]—has driven TeamHealth's most prominent competitor, Envision Healthcare Corporation, into bankruptcy.

B. United's misbehavior is especially pernicious—but not unique.

Within the industry, United is known for its particularly pernicious posture when it comes to paying providers.[5] The Court should hold United to account—as

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[3] *Id.*

[4] Declaration In Support of Envision Healthcare Corporation's Chapter 11 Petition, *In re Envision Healthcare Corp., et al.*, No. 23-90342 (S.D. Tex. Bankr. May 15, 2023).

[5] Industry observers have noted United's history of sharp practices and industry dominance—often at the expense of providers, patients, and other stakeholders. *See* Krista Brown & Sara Sirota, *Health Care's Intertwined Colossus: How decades of policy failures led to the ever-powerful UnitedHealth Group*, THE

the jury did—both because it is legally correct and because the threat of liability will dissuade United and other insurers across the country from engaging in similar practices. Indeed, while this case is an egregious example of sharp insurer practices, it is unfortunately not the exception.

A quick recap on how United's scheme worked: First, in an attempt to boost its own profits, United reimbursed emergency medical claims at exceedingly low rates. That not only allowed United to *save* money on the front end because United paid out less in reimbursement; it also allowed United to *make* money on the back end because United would retain a portion of the "savings"—the difference between the providers' billed charges and what United paid—as fees for itself. (37 AA 9003:14-19.) In other words, United set things up so that by paying providers *less* for providing lifesaving services, United would make *more* for its TPA "services" to self-funded health plans. (*Id.*)

Next, United sought to further reduce its payouts by colluding with a third party called MultiPlan to generate what it touted as objective and fair reimbursement

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AMERICAN PROSPECT (Aug. 2, 2023), *available at* https://prospect.org/health/2023-08-02-health-cares-intertwined-colossus/ ("United has internalized a critical fact about health care: If you sit on every side of the transaction, from doctors to insurers, drug payers to drug prescribers, lifesavers to end-of-life carers, you not only grow as the system grows, but you have the ability to steer the entire system inside your gaping maw. Conflict of interest is really the business model.").

rates, supposedly based on market data. (36 AA 8817:7-18; 37 AA 9020:10-17; 4 RA 540.) But the supposedly objective calculations were secretly dictated to MultiPlan by United—and the result was reimbursement at unconscionably low rates. (4 RA 535-36; 11 RA 1985; 39 AA 9536:21-40:21; 37 AA 9012:9-11.) And unknown to providers, MultiPlan (like United) had an incentive to price claims as low as possible—it too received a shared savings fee as a reward for supporting United's underpayments. (32 AA 7973:4-14; 34 AA 8494:1-3.)

United engaged in this scheme to line its pockets on the back of emergency-care providers *even though* it understood that its underpayments (which meant providers were not being fully compensated) would necessarily expose its members to the risk of balance billing. (13 RA 2366.)

To shield itself from public scrutiny, United also launched a public-relations and lobbying campaign to cast the very doctors it was underpaying as the real problem in the emergency medical care marketplace. Most notably, United commissioned the "Yale Study"—an article written by Mr. Cooper, an ostensibly objective academic—to disparage emergency-medicine doctors as engaging in predatory pricing and balance billing. (2 RA 291, 519-25; 4 RA 519-25; 5 RA 796-98.) The Study gave United further cover for its underpayments, which it framed as a response to supposedly egregious billing by emergency medical providers and rising

costs for out-of-network services. (4 RA 497-502, 554-55.) The Study thus vilified doctors across the country who were simply trying to secure fair payment that would support their continued provision of emergency care.

But as made clear in the trial here, and as doctors have known from the beginning, the Study was a sham—as were the concerns it supposedly brought to light. (*E.g.*, 32 AA 7888:2-90:19; 12 RA 2056.) Indeed, even in the public square, the Study was eventually criticized for being "flawed," making "atrocious claims," using "inflammatory rhetoric from potentially erroneous and biased data sets," and being funded by an organization with ties to the health-insurance industry—so much so that even the Study's author later admitted he "probably overshot on ... blaming the physicians for all of this."[6]

As critics of the Yale Study explain:

> The issue isn't whether emergency physicians try to contract with insurance companies—it is that insurance companies have no interest in contracting with emergency physicians. It isn't in their best interest to take on the responsibilities of the uncompensated care we provide. Why would an insurance company be interested in "negotiating a fair

[6] *See* Eric Berger, *Finding a Balance on Balance Billing*, ANNALS OF EMERGENCY MEDICINE, Vol. 70, Issue 2 (Aug. 2017), *available at* https://www.annemergmed.com/article/S0196-0644(17)30660-1/fulltext (quoting Dr. Ryan Stanton & Dr. Rebecca Parker, *ACEP Outlines Flaws, Biases in New England Journal of Medicine Story on Balance Billing*, ACEPNOW (Jan. 10, 2017), *available at* https://www.acepnow.com/article/acep-outlines-flaws-biases-new-england-journal-medicine-story-balance-billing/?singlepage=1).

> price" for a service that is mandated and having a portion of the economic impact successfully shifted to someone else?
>
> [ER] patients are experiencing balance ***billing because more and more insurance companies refuse to fairly reimburse for the care provided in emergency departments nationwide.*** Emergency care is mandated by federal law, and insurance companies know this. This is why there is no interest by the insurance companies to get emergency physicians "in network."
>
> ...
>
> An unfair burden is being placed on patients as the insurance companies continue to raise rates and decrease or refuse coverage, all while emergency departments are fighting to keep the doors open and beds staffed.[7]

Upon hearing the truth about United's practices, the jury here understandably found that the doctors were entitled to fair compensation from United—and that United should be punished for its misbehavior. The Court should affirm that result.

C. The No Surprises Act does not eliminate the need for state-law remedies and was enacted after the underpayments here.

Congress recognized these concerns and in 2020 enacted the "No Surprises Act" ("NSA") to address the problem of unanticipated balance, or "surprise," medical billing. But while the NSA shows that Congress recognized the imbalances inherent in the emergency-care market, the law did not fully address (or try to fully

[7] Stanton & Parker, *supra* note 1 (emphasis added).

address) the types of inadequate reimbursements at issue in this case and others. Nor does it apply to pre-2022 reimbursement disputes like those here.

Historically, when a patient with private health insurance received out-of-network services from a doctor, the doctor would submit the bill to the patient's insurer, and the insurer, in the absence of a contract with the provider, would unilaterally determine how much (if anything) to reimburse the provider. To recover the difference between the billed charge and what the insurer was willing to pay, the doctor had two options: (1) send a "balance bill" to the patient for the outstanding costs or (2) seek further reimbursement from the insurer via civil litigation. Certain "balance bills" were called "surprise" bills because they could result from situations, such as emergency care, in which patients were unaware they had received out-of-network treatment. These situations became increasingly common as insurers narrowed their networks, forcing more providers out of network, and substantially reduced the amounts they would pay for reimbursements.

The NSA, which went into effect on January 1, 2022, addresses this surprise billing concern by limiting the amount patients must pay for certain out-of-network medical services. In turn, the NSA obligates insurers to pay providers directly at an "out-of-network" rate and requires the Department to establish an independent

dispute resolution (IDR) process to resolve disputes over reasonable out-of-network reimbursement. *See,* 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(II), (b)(1)(D), (c).

The NSA is prospective only. It does not apply to the claims at issue here (or to many similar claims for reimbursement held by doctors across the country), and "[n]o federal requirements directly addressed surprise billing prior to the passage of the [NSA]."[8] And while it addresses a consequence of the market imbalances (namely, surprise billing), it does not purport to fully address other issues inherent in the health insurance market—including when providers are grossly and maliciously underpaid for their provision of emergency-care services. Nor does it preempt preexisting state law remedies.

The NSA's passage thus hardly suggests that doctors who provided emergency care (especially before Congress intervened) are without recourse in the courts against unscrupulous insurers. Rather, multiple state-law causes of action permit providers to seek reimbursement from insurers for out-of-network services. And reliance on these state-law claims is neither novel nor ignoble: In recent decades, *to avoid balance billing or suing the patients* who often have no choice but to

[8] Ryan J. Rosso et al., *Surprise Billing in Private Health Insurance: Overview of Federal Consumer Protections and Payment for Out-of-Network Services*, CONGRESSIONAL RESEARCH SERVICE (July 26, 2021), *available at* https://crsreports.congress.gov/product/pdf/R/R46856.

seek emergency care from an out-of-network provider, providers have increasingly relied on existing and established causes of action to seek reasonable reimbursement directly from insurers.

Specifically, providers—like the Respondents here—have successfully turned to common law claims such as unjust enrichment, quantum meruit,[9] breach of an implied-in-fact contract,[10] and promissory estoppel,[11] as well as to claims based on state statutes addressing unfair insurance practices, among others. These types of claims are well established and essential to ensure that doctors across the country are adequately and fairly compensated for providing lifesaving emergency services. Two of the claims pertinent to this case are discussed below.

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[9] *See, e.g.*, *Certified Fire*, 128 Nev. at 380, 283 P.3d at 256; Order, *InPhyNet S. Broward, LLC v. Bright Health Ins. Co. of Fla., Inc.*, No. CACE22014060 (Broward Cnty. Fla. Ct. Feb. 8, 2023); *Fla. Emergency Physicians Kang & Assocs., M.D., Inc.*, 526 F. Supp. 3d at 1303; *Appalachian Reg'l Healthcare*, 2013 WL 1314154, at *4; *Forest Ambulatory Surgical Assocs., L.P. v. United Healthcare Ins. Co.*, No. 12-CV-2916 PSG (FFMx), 2013 WL 11323600, at *11 (C.D. Cal. Mar. 12, 2013).

[10] *See, e.g.*, Order, *InPhyNet S. Broward, LLC v. AvMed, Inc., Case No.* CACE20-004408 (07) (Broward Cnty. Fla. Ct. Aug. 31 2020).

[11] *See, e.g.*, *Vanguard Plastic Surgery, PLLC v. UnitedHealthcare Ins. Co.*, No. 22-cv-60488, 2023 WL 2257961, at *7-8 (S.D. Fla. Feb. 28, 2023).

II. Respondents' recovery on their unjust enrichment and UCPA claims should be affirmed and United's matter-of-law challenges should be rejected.

A. The Respondents' unjust enrichment claim should be affirmed.

The Court should affirm the jury's holding that the Respondents may recover on the unjust enrichment claim.

This Court has explained that "[u]njust enrichment exists when the plaintiff confers a benefit on the defendant, the defendant appreciates such benefit, and there is acceptance and retention by the defendant of such benefit under circumstances such that it would be inequitable for him to retain the benefit without payment of the value thereof." *Certified Fire Protection Inc. v. Precision Construction, Inc.*, 128 Nev. 371, 381, 283 P.3d 250, 257 (2012). "Where unjust enrichment is found, the law implies a quasi-contract which requires the defendant to pay the plaintiff the value of the benefit conferred, *id.* at 380-81, 283 P.3d at 257. In other words, in Nevada, the law of unjust enrichment ensures that providers have recourse against out-of-network insurers who inequitably accept the discharge of the insurers' statutory duty to provide emergency care to their members without providing reasonable compensation for the providers' services.

That is clear from how the Restatement talks about this precise issue. "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, 543-45 (2021). And Section 20 of the Restatement makes clear that an unjust-enrichment claim exists under these exact circumstances: "The 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 jurisdiction for conferring a benefit in the absences 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); *see also* § 22(1) ("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."). After all, as one court has explained, to hold otherwise would "incentivize insurers ... to pay as little as possible while [providers] remain obligated to treat [their] insureds." *Emergency Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.,* No. 20-cv-9183, 2021 WL 4437166, at *13 (S.D.N.Y. Sept. 28, 2021).

Nevada is not an outlier in recognizing that providers may recover the reasonable value of their out-of-network services on an unjust enrichment theory. Courts across the country have reached the same conclusion. *See, e.g.*, *id.*; *Fla. Emergency Physicians Kang & Assocs., M.D., Inc. v. United Healthcare of Fla., Inc.*, 526

F. Supp. 3d 1282, 1303 (S.D. Fla. 2021); *Se. Emergency Physicians LLC v. Ark. Health & Wellness Health Plan, Inc.*, No. 4:17-cv-00492-KGB, 2018 WL 3039517, at *6 (E.D. Ark. Jan. 31, 2018); *Appalachian Reg'l Healthcare v. Coventry Health & Life Ins. Co.*, No. 5:12-CV-114-KSF, 2013 WL 1314154, at *4 (E.D. Ky. Mar. 28, 2013); *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alternatives, Inc.*, 832 A.2d 501, 508 (Pa. Super. Ct. 2003); *River Park Hosp., Inc. v. BlueCross BlueShield of Tenn., Inc.*, 173 S.W.3d 43, 60 (Tenn. Ct. App. 2002). The jury's unjust enrichment award should stand.

B. Respondents have standing to bring claims under the UCPA against the insurance companies—including the Third Party Administrators—for their failure to reasonably compensate Respondents for the emergency care rendered to their members.

Emergency care doctors should also be able to seek relief from under Nevada's Unfair Claims Practices Act ("UCPA"). That statute prohibits "persons" from engaging in "an unfair method of competition or an unfair or deceptive act or practice in the business of insurance," including "[f]ailing to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear." NRS 686A.020, 686A310(1)(e).

United makes two arguments for why Respondents cannot utilize the UCPA, both based on a provision added in 1987 to permit private rights of action for

violations of NRS 686A.310. (AOB 100[12]). First, it contends that Respondents do not have standing to assert claims under the UCPA because they are not insureds. O.B.A. 100-01 (citing *Gunny v. Allstate Ins. Co.*, 108 Nev. 344, 830 P.2d 1335 (1992)). Second, United argues that Respondents cannot sue the Third Party Administrators[13] because they are not "insurers" under the statute. O.B.A. 108 (relying on *Albert H. Wohlers & Co. v. Bartgis*, 114 Nev. 1249, 969 P.2d 949 (1999)). Both arguments misapprehend the legislative intent behind the UCPA: to make sure that all insurance transactions are covered and that insureds are protected from sharp practices.

The Court's precedent. Neither *Gunny* nor *Bartgis* compel the result sought by United. *Gunny* involved a liability insurance claim for an injury sustained on the boat of the plaintiff's father. *Id.* at 345, 830 P.2d at 1335. The Court held that the plaintiff could not sue under the UCPA because there was no relationship between the plaintiff, a non-policy holder, and the insurer. *Id*. at 346, 830 P.2d at 1336. In that liability-insurance case, the plaintiff was required to sue his father, and if at that point

[12] United's Opening Brief provides a detailed legislative history for NRS 686A.310 which, for brevity's sake, is incorporated by reference here.

[13] The Third Party Administrators, or "TPAs," include United Healthcare Services, Inc. ("UHCS"), UMR, Inc. ("UMR"), and United Healthcare Insurance Company ("UHIC").

the insurer refused to defend him as the policyholder, then the father could have brought a UCPA claim. *See id.*

Health insurance—and particularly the provision of emergency care—arises in an entirely different context. This case involves payment for emergency services that Respondents (whether a third party to the insurance contract or not) are required by law to perform, and for which United is required to pay. Respondents performed the services, billed United directly, and were mistreated by United. So it is Respondents, not their patients, that are directly injured by the unfair payment practices of United. And it is Respondents, not their patients, who are able to vindicate the statutory goals and prohibitions. *See* NRS 679A.140(1)(a), NRS 679A.140(1)(b), NRS 679A.140(1)(e), and NRS 679.140(1)(h). This is exactly the type of relationship that the UCPA is supposed to protect. *Gunny* does not, and should not, control here.

Nor should *Bartgis*. That decision concluded that NRS 686A.310 did not apply to a third-party administrator "because it [was] not an insurer or company within the meaning of the applicable statutory law." 114 Nev. 1249, 969 P.2d at 959-60. But the Court was focused on the meaning of "company" under NRS 686A.620, because "no evidence exist[ed]" that the TPA "financed or paid premiums," the Court concluded that it was not a "company." *Id.*

This case asks a different question: Whether TPAs are "insurers" under NRS 686A.310, thus subjecting them to suit and liability under the statute. NRS 679A.100 provides that an "'insurer' **includes** every person engaged as principal and indemnitor, surety or contractor in the business of entering into contracts of insurance." The term "includes" should be considered expansive, not only because of the statute's remedial purpose, but also given the provisions surrounding NRS 679A.100, through which the Legislature limited the meaning of certain terms. *See,* NRS 679A.030-679A.130. Those related sections and limiting definitions do not contain the term "includes," and are instead very specific concerning what the defined terms mean. The notable exception is NRS 679A.130, which similarly uses the term "includes" in a non-exhaustive fashion. These material variations in the language used and/or the use or non-use of the term "includes" demonstrates that the Legislature intended a different meaning to apply when it used the term "includes." *See Harris v. State*, 133 Nev. 683, 689, 407 P.3d 348, 353 (2017) (quoting Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts,* at 170 (2012)). Accordingly, *Bartgis* does not control this case either.

The Legislature's intent. What *is* controlling, and what *should be* controlling, is what the Legislature was trying to accomplish in the UCPA—including the protection of policyholders "and all having an interest under insurance policies,"

promoting the "public interest" with regard to insurance, "[i]nsur[ing] that policyholders, claimants and insurers are treated fairly and equitably," and "[p]revent[ing] misleading, unfair and monopolistic practices in insurance operations." NSA 679A.140. The Legislature even made clear that the UCPA was to be construed toward these express ends: "The provisions of this Code shall be given reasonable and liberal construction *for the fulfillment of these purposes.*" *Id.* (emphasis added).

None of these purposes are fulfilled by narrowly reading the UCPA, as United advocates. Just the opposite.

As to the standing point, Respondents are the ones being harmed by United's and similarly situated insurers' unfair practices and actions, which clearly violate the UCPA. And they are the only ones who might possibly vindicate the statutory purposes. Indeed, in the emergency-care context, these third-party medical providers are also the best suited for pursuing claims under the UCPA against United. Respondents are obligated to provide the emergency care to United's insureds. United, in turn, is required to pay for the services provided by the third-party medical providers—to those third-party "claimants." So, United's intentional and unfair insurance practices are directed *at Respondents* and harm only *Respondents*. Those actions against *Respondents* are what give rise to claims against United for

violation of the UCPA. And claims by *Respondents* are the only realistic way to "prevent misleading" or "unfair … practices" by United.

This direct harm provides third-party medical providers with requisite standing under the statute to assert claims against their patients' insurance companies when those companies fail to pay for the reasonable costs of the services provided by them. *See, e.g.*, *NEMS PLLC v. Harvard Pilgrim Health Care of Conn. Inc.*, 615 F.Supp.3d 125, 140 (D. Conn. 2022) ("[I]t is not the insured who has suffered injuries from [the insurer's unfair insurance] actions. Rather, it is specifically the Plaintiff [emergency-medicine provider], as it is the one that has not been fully compensated for the services its employees performed. Thus, the allegations under these sections are not third-party claims but direct claims ….").

Any other interpretation would render the statute meaningless, would frustrate the Legislature's intent in enacting the statute, and would give United a complete pass from the only parties that might hold it accountable for its unfair practices. After all, it is the medical providers that are being harmed, so it is the medical providers who should be permitted to pursue damages under the UCPA. *See* NSA 679A.140.

For the same reasons, the Court should read the UCPA "reasonabl[y] and liberal[ly]," such that the TPA defendants are considered "insurers." A contrary reading would carve out a big slice of the health insurance market from the UCPA's

protections. After all, the majority of Nevadans (and indeed Americans) with commercial health insurance have employer-sponsored ERISA plans. *See* Nevada Ass'n of Health Plans' Amicus Curiae Br. at 9. Almost all those plans hire TPAs like United to administer their plans. Thus, *if* TPAs like United are *not* "insurers" under the UCPA, then the UCPA will not apply to a massive swath of the Nevada health-insurance market—leaving major insurance players unregulated and free to engage in "misleading," "unfair," and even abusive practices.[14] Providers might bear the brunt of the initial impact—but, as with any market imbalance, the effects will be felt more broadly. Countenancing such a carveout can hardly be considered as "[i]nsur[ing] the State has an adequate and healthy insurance market." *See* NSA 679A.140.

The Court should give voice to the Legislature's express intention to protect policyholders, to rein in sharp insurance practices, and to promote a flourishing and fair insurance market. Respondents should have standing to recover from Defendants, including the TPAs, for their proven misbehavior.

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[14] The legislative history of NRS 686A.310 is also helpful, and it demonstrates that the TPAs are subject to suit. If they are not, then the Act is rendered meaningless as the TPAs which by their functions are engaged in the very acts prohibited by the UCPA are not subject to suit by the only persons that are in a position to purse redress against them. That absurd result can be avoided only if the TPAs are subject to suit by the medical practitioners who are the ones being harmed by the TPAs' actions in this context.

CONCLUSION

For the foregoing reasons, EDPMA urges this Court to affirm the judgment of the district court.

Respectfully submitted,

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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) because this brief has been prepared in proportionally spaced typeface using Microsoft word in Equity A 14-point font, double spaced.

2. I further certify that this brief complies with the type-volume limitations of NRAP 29(e) because, excluding the parts of the brief exempted by NRAP 32(a)(7)(C), it is proportionately spaced, has a typeface of 14 points, and contains **4723** words.

3. Finally, I hereby certify that I have read this 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 19th day of September 2023.

/s/ Hector J. Carbajal II
Hector J. Carbajal II

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the **Brief for Amicus Curiae Emergency Department Practice Management Association in Support of Respondents** was forwarded to all counsel of record by electronic service through Nevada Supreme Court's electronic filing system on November 3, 2023.

/s/ Hector J. Carbajal II
Hector J. Carbajal II