Case Nos. 85525 & 85656

In the Supreme Court of Nevada

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

MOTION TO SEAL UNREDACTED REPLY BRIEF
and
MOTION FOR LEAVE TO FILE REDACTED VERSION OF REPLY BRIEF

Consistent with the opening and answering briefs and portions of the appendix already filed under seal, appellants (collectively "United") seek leave to file an unredacted reply brief under seal and to redact certain portions of the publicly filed version. Like the other briefs, United's reply contains sensitive business and financial information that was disclosed in the district court under a protective order, is the subject of United's request for sealing on appeal, and is also subject to this Court's order staying the district court's unsealing orders. United therefore requests permission to file the unredacted brief under seal and to redact those portions of the brief in the public filing to comply with the terms of the protective order and preserve the confidentiality of United's sensitive information pending appeal. *See* SRCR 3(4)(b). (7 App. 1520–34.) (Exhibit A.)

DATED this 9th day of January, 2024.

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EXHIBIT A

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In the Supreme Court of Nevada

UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTH CARE SERVICES, INC.; UMR, INC.; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; and HEALTH PLAN OF NEVADA, INC., Appellants, *vs.* FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; and CRUM STEFANKO AND JONES, LTD., Respondents.	Case No. 85525
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APPEAL
from the Eighth Judicial District Court, Clark County
The Honorable NANCY L. ALLF, District Judge
District Court Case No. A-19-792978

APPELLANTS' REPLY BRIEF (REDACTED)

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INTRODUCTION

TeamHealth is not a victim. Far from it. It is a sophisticated commercial party and an affiliate of one of the nation's largest and most lucrative healthcare provider staffing companies. Its staffing model is to pay its providers fixed, agreed-upon fees for performing specified services, so it was impossible for United's reimbursements to reduce provider compensation. Proving the point, TeamHealth did not introduce a whisper of evidence establishing that either providers or care quality in Nevada were affected in any way by this reimbursement dispute. The only issue genuinely at stake is the extent to which TeamHealth's private equity owners are entitled to surplus profits.

TeamHealth can claim victimhood only by misrepresenting the law. According to TeamHealth, its providers are legally required to treat all patients who present at emergency rooms, which TeamHealth says gives United unfair leverage in bargaining over payment for such treatment. In fact, unlike some providers, TeamHealth has voluntarily *chosen*—presumably for its own financial reasons—to accept that requirement as a condition of participating in Medicare. If anything, the true bargaining dynamic is just the opposite. TeamHealth knows

that people experiencing emergencies ordinarily have no opportunity to find a "network" provider. So, rather than negotiating reasonable rates to remain in United's network, TeamHealth abandoned those negotiations and went "out-of-network" so that it could unilaterally demand that United pay TeamHealth's full billed charges. Those exorbitant charges bore no connection whatsoever to real-world market prices for the same services, but the jury never learned that essential fact because the district court excluded virtually all the relevant market-based evidence. The court did so based on its flawed view of this case as a "debt collection" matter, but the *amount* of the supposed debt—the objective "reasonable value" of the services at issue—was precisely what the jury was supposed to decide based on its consideration of all the relevant market-based evidence. Nevertheless, even on the one-sided record, the jury recognized the absurdity of TeamHealth's reimbursement demands, awarding only a fraction of what it sought.

TeamHealth musters no meaningful defense of the district court's refusal to allow jurors to consider United's "reasonable value" evidence.

TeamHealth instead mainly proffers trial arguments about the *weight* the evidence should have been given. But arguments about the weight of evidence are for jurors to resolve. As to the threshold question of admissibility, TeamHealth does not cite one case from any jurisdiction holding that the reasonable value of a product or service can fairly be determined without considering the market-based evidence that was so broadly excluded here.

The indefensible exclusion of United's "reasonable value" evidence warrants a new trial at a minimum. But even with the evidentiary scales tipped decisively in its favor, TeamHealth *still* failed to prove its claims as a matter of law. This Court previously expressed doubts about whether TeamHealth could actually prove that an implied-in-fact contract existed between TeamHealth and United, and TeamHealth's brief confirms those doubts: nowhere does TeamHealth identify any evidence establishing that United implicitly agreed to pay TeamHealth more than the amounts owed by the underlying employee benefit health plans. Absent evidence proving such an agreement, there is no valid contract at all, much less a contract independent of the benefit plans

themselves, as required to avoid preemption by the Employee Retirement Income Security Act of 1974 ("ERISA"). Indeed, TeamHealth itself vigorously insists that United's liability was *not* independent of the plans. According to TeamHealth, United's liability—especially its punitive damages liability (legally indefensible on its own terms)—was imposed specifically because United supposedly violated benefit plan terms concerning the use of plan funds for out-of-network services. By TeamHealth's own account, then, its state-law claims are preempted by ERISA.

For these and other reasons explained in this reply, the judgment should be reversed.

I.

UNITED IS ENTITLED TO A NEW TRIAL

A. TeamHealth Fails to Justify the Exclusion of Highly Probative Evidence of Reasonable Value

TeamHealth agrees that the "key" issue at trial was the "reasonable value" of the emergency medicine services provided to patients who were members of health plans insured or administered by

the United defendants. RB45, 67. In *Certified Fire Protection Inc. v. Precision Construction*, 128 Nev. 371, 283 P.3d 250 (2012), this Court held that the "reasonable value" of a service refers to its objective market value, *id.* at 256-57, and even TeamHealth now finally concedes that "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." RB53; *accord* AOB47. In other words, contrary to its position before the district court, TeamHealth now recognizes that "reasonable value" is not *ipso facto* whatever charge TeamHealth unilaterally decided to bill for the services. Courts nationwide agree: "Due to the realities of today's insurance and reimbursement system, in any given case, this [reasonable value] determination is not necessarily the amount of the original bill or the amount paid. Instead, [it] is a matter for the jury to determine from all relevant evidence." *Robinson v. Bates*, 857 N.E.2d 1195, 1200-01 (Ohio 2006); *see Nassau Anesthesia Assocs., P.C. v. Chin*, 924 N.Y.S.2d 252 (N.Y. App. Ct. 2011) (reliance on hospital's "published rates" alone is "untenable" because "the price that the hospital

unilaterally sets bears no relationship to the amount typically paid [by insurance policies and federal health programs] for those services" (cleaned up)); *United States v. Berkeley Heartlab, Inc.*, 2017 WL 2972143 (D.S.C. 2017) ("It is no secret that the sticker prices of services listed in physician bills and hospital chargemasters are totally unmoored from the reality of arm's-length transactions actually taking place in the marketplace." (cleaned up)).

TeamHealth's belated concession about the nature of the reasonable value determination illuminates the central problem that plagued the proceedings below from discovery through trial. While the objective market value of the services at issue should have been the central issue for jurors to resolve, the district court—at TeamHealth's urging—viewed the entire case as about simply enforcing TeamHealth's right to receive its full billed charges, which the court likened to a "bank collections" case. AOB2-3, 58; 24App.5,902-03. The district court accordingly excluded broad categories of evidence that courts nationwide have consistently held to be directly relevant to determining the objective market value of medical services, including:

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

AOB44-76 (collecting cases).

TeamHealth does not dispute that the jury was precluded from considering all such "reasonable value" evidence. Nor does TeamHealth cite any precedent upholding a "reasonable value" determination in the complete absence of such evidence. The arguments TeamHealth does advance provide no good reason this Court should be the first to affirm a "reasonable value" determination made without considering multiple key market-based factors.

1. Excluding United's Reasonable Value Evidence Was Not Harmless

TeamHealth's main argument is that any error in excluding probative "reasonable value" evidence was "harmless" because United was allowed to introduce *some* relevant evidence, i.e., "out of network" rates. RB45. TeamHealth further contends that United could not have

been prejudiced by exclusion of *additional* "reasonable value" evidence, because even though the jury rejected United's position, the jury *also* rejected TeamHealth's position by finding that the reasonable value was less than 50% of TeamHealth's billed charges. RB47.

To state this argument is to refute it. The fact that the jury adopted a middle ground on *this* record hardly shows that it would have done the same on a *different and full* record. To the contrary, if United had been allowed to present a complete record on reasonable value, the jury could well have rejected TeamHealth's claims outright. The prejudice United suffered from exclusion of its evidence—indeed, almost its entire defense—is incontestable.

2. The Near-Blanket Exclusion of United's Evidence Was Not a Valid Exercise of Discretionary Balancing

TeamHealth next argues that in excluding the vast majority of United's "reasonable value" evidence, the trial court merely made a discretionary determination under NRS 48.035 that the evidence would create a potential for "prejudice and/or jury confusion" that outweighed the "relevance and probative value" of the evidence. RB48.

TeamHealth, however, cites nothing in the district court's findings that evince such balancing. The court's ruling instead rested explicitly on its *substantive* determination that United's evidence was *not legally relevant*, based on the court's erroneous view that the "reasonable value" standard requires no more analysis than a "bank collections" case, where the amount owed is simply determined by the obligation specified in the loan documents. AOB2-3, 58; *see* 11App.2,679 ("The relevant inquiry in this action is the proper rate of reimbursement which is based on the amount billed by the Health Care Providers and the amount paid by United."). That purely legal error in misconstruing the "reasonable value" standard infected the court's entire approach to the case. There was no exercise of discretionary "balancing" to which this Court must defer.

TeamHealth likewise errs in asserting that United's "reasonable value" evidence was too voluminous to be addressed efficiently. RB48n.23. TeamHealth gets it backward: the fact that a party has extensive evidence supporting its position is reason to allow the evidence, not to categorically prohibit all of it. *Cf.* NRS 52.275; *Pandelis*

Const. Co., Inc. v. Jones-Viking Assocs., 103 Nev. 129, 131, 734 P.2d 1236, 1237 (1987) ("We are at a loss to explain how something properly admitted under a rule of evidence could not be evidence."). Had the evidence been allowed, the parties and court would have identified mechanisms for presenting it effectively to the jury. Indeed, every other case involving reasonable value has involved consideration of the kind of evidence excluded below. AOB48-49. There was no reason to make this case the sole exception.

3. TeamHealth Fails to Justify Exclusion of Any Specific Category of "Reasonable Value" Evidence Offered by United

TeamHealth also fails to justify exclusion of United's "reasonable value" evidence on a category-by-category basis.

a. NETWORK REIMBURSEMENT RATES

TeamHealth first addresses the exclusion of network rates TeamHealth agreed to accept from similarly-situated payers. RB49-51. Many courts have recognized the probative value of such evidence. AOB48-53 (collecting cases); *see also Patchett v. Lee*, 60 N.E.3d 1025, 1033 (Ind. 2016) (when payer seeks to counter evidence of billed charges

with evidence of reduced payments accepted by providers, "the permissible circumstances for excluding such evidence under Rule 403 will be few and far between"); *West v. Shelby Cnty. Healthcare Corp.*, 459 S.W.3d 33, 45 (Tenn. 2014) ("Because virtually no public or private insurer actually pays full charges, a more realistic standard is what insurers actually pay and what the hospitals are willing to accept." (cleaned up) (collecting cases)); *Allstate Ins. Co. v. Holy Cross Hosp., Inc.*, 961 So. 2d 328, 335 (Fla. 2007); *Nassau Anesthesia*, 924 N.Y.S.2d at 254-55.

Moreover, both the Nevada Legislature and the U.S. Congress have specifically determined that, as a matter of public policy, network rates are *highly* probative of reasonable reimbursement for emergency medicine services—indeed, so probative that they alone establish the decisive baseline in many circumstances. AOB53-54.

TeamHealth's only argument in defense of the evidentiary exclusion is a jury argument that TeamHealth would have made about the *weight* to give network rates, if the district court had admitted the evidence. According to TeamHealth, "out-of-network claims are

qualitatively different from in-network claims and command different market rates." RB49. On that basis, TeamHealth leaps to the conclusion that evidence of TeamHealth's network rates with other payers is categorically irrelevant to determining reasonable value. RB51.

The conclusion plainly does not follow from the premise, as the Nevada Legislature, U.S. Congress, and other courts have implicitly recognized in allowing or even mandating consideration of such evidence. It is true that reimbursement rates typically are not identical in the market because the willingness of buyers and sellers differ, resulting in a range of network and out-of-network payment rates. *See Children's Hospital*, *Children's Hospital Cent. Calif. v. Blue Cross of Calif.*, 172 Cal. Rptr. 3d 861, 872 (Ct. App. 2014); *Stanley v. Walker*, 906 N.E.2d 852, 858 (Ind. 2009). And United has never argued that some particular network rate establishes the precise dollar-for-dollar measure of "reasonable value." Indeed, United's expert opined that reasonable value is not a precise number, but a monetary range based on the reimbursement rates negotiated between willing buyers and

sellers, which is best evidenced by the median network rates paid by the United defendants to other emergency medicine providers and accepted by TeamHealth plaintiffs from other commercial payors. 44App.10,832:21-10,837:13; 110App.27,282:3-21. But the fact that reimbursement rates—whether network or out-of-network—are subject to different market forces does not mean that all network rates are *categorically inadmissible* to determining the objective market value of the services. TeamHealth cites nothing to support that categorical exclusion; meanwhile, every relevant authority permits juries to evaluate the weight that should be given such rates when determining reasonable value. AOB48-51.

TeamHealth ignores the fact that evidence of contracted network rates would not be introduced and assessed in a vacuum. Rather, it would be contextualized by, for instance, arguments and expert testimony explaining the different market forces affecting network and out-of-network reimbursement and measuring the objective value of those differences. *See, e.g.*, 43App.10,734:1-10,736:3; 44App.10,813:18-10,814:2, 10,817:1-10,821:16 (explaining market forces, including

willing buyer and seller dynamics, while being precluded from discussing network rates). For example, TeamHealth's main objection to network rate comparisons is that providers agree to lower contracted rates to obtain "steerage of the insureds' members to the in-network providers." *Id.* TeamHealth cites no record evidence supporting this supposed fact, but it does cite several cases emphasizing the value that patient "volume" generally brings to providers who enter network contracts. RB50. TeamHealth would have been free to develop this argument before the jury. But if it had, United would have responded by showing that in the context of *emergency medicine* services, the steerage/volume effect is essentially nonexistent, because such services are provided on an emergent basis *before* the patient can be "steered" to any particular network provider. *See* 22App.5253 ¶ 39; 43App.10,690:12-23; 44App.10,820:11-10,824:7, 10,826:10-10,829:13. Reasonable jurors easily could have evaluated the parties' competing evidence on that and other similar issues in determining how much weight to afford network rates in the "reasonable value" determination.

Moreover, differences between network and out-of-network rates

certainly do not make the provider's *own* full billed charges the single valid measure of "reasonable value," as the district court's rulings enabled TeamHealth to argue at trial. Courts broadly agree that a provider's own billed charges generally are "arbitrarily large amounts" billed "with the knowledge and expectation that no one will ever be required to pay so high a figure." *Higgs v. Costa Crociere S.p.A.*, 969 F.3d 1295, 1315 (11th Cir. 2020); *see* AOB51n.8. At trial, TeamHealth's counsel even conceded to the jury that TeamHealth was reimbursed those full billed charges only about one percent of the time. 31App.7,659. But because the district court misunderstood the "reasonable value" standard, it wrongly precluded the jury from considering evidence of payment rates that TeamHealth willingly accepted from other payers in network contracts as fair compensation for emergency medicine services.

b. THE PARTIES' COURSE OF DEALING

TeamHealth next addresses the exclusion of United's evidence concerning the parties' own course of dealing. TeamHealth first argues that evidence of prior network rates with United is legally irrelevant for

the same reasons network rates with *other* payers are legally irrelevant. RB52. That argument is wrong for the reasons just given.

TeamHealth also argues that its prior United network contract rates are not necessary to establish the existence of an implied-in-fact contract because the payment rate can be established separately in quantum meruit. RB52. But before a plaintiff can rely upon quantum meruit to fill in missing price terms, it must first prove "that the parties intended to contract," and the "general obligations" of the intended contract "must be sufficiently clear." *Certified Fire*, 128 Nev. at 380, 283 P.3d at 256. The undisputed fact that the parties expressly agreed *not* to contract immediately before and during the period in dispute was directly relevant to establishing that the parties did not mutually assent to contract on the rate terms that TeamHealth demanded at trial. *See id.* ("There are simply too many gaps to fill in the asserted contract for quantum meruit to take hold. [They] never agreed to a contract for [this type of] work, the parties never agreed to a price for that work, and they disputed the time of performance."); *see also Emergency Grp. of Ariz. Prof. Corp. v. UnitedHealthcare of Ariz., Inc.*,

CV 2019-004510 (Sup. Ct. of Ariz., Maricopa Cnty. Nov. 20, 2023), Rule 28(f) Addendum at 19 ¶¶ 25-31 (granting summary judgment because TeamHealth affiliates and United affiliates never entered implied contract given prior failed negotiations, missing price term, and indefinite duration term); AOB89-90.

The parties' course of dealing was also directly relevant to the price term implied through quantum meruit, which applies only to the extent "it is appropriate to imply the parties agreed to a reasonable price." *Certified Fire*, 128 Nev. at 380, 283 P.3d at 256. The evidence most probative of an implied reasonable price would be the price ranges the same parties wrote into their own prior express contracts and exchanged in negotiations over the proposed renewal of those agreements.

Again, United's argument is not that the reasonable reimbursement rate must be identical to a rate specified in one particular network contract. The point, rather, is that the price terms expressed in prior contracts or exchanged in contract negotiations between the same parties on the same topic in the same circumstances

were highly *relevant* to rebutting TeamHealth's trial argument that United impliedly agreed to reimburse the disputed services at TeamHealth's full billed charges. The parties of course would contextualize that evidence for the jury and argue about the weight to give it when considering whether the parties mutually assented to a contract and, if so, a reasonable implied payment rate. TeamHealth proffers no basis for doubting the jury's ability to decide whether and how the course-of-dealing evidence should affect the reasonable value determination.

c. MEDICARE REIMBURSEMENT RATES

TeamHealth next contends that the district court properly excluded evidence and argument that reimbursement rates paid by Medicare were reasonable in and of themselves. RB52-56. That argument attacks a straw man. United is not arguing that Medicare rates *by themselves* determine objective market value. United's argument instead is that it was improperly barred from introducing evidence to explain how and why United *used* Medicare rates as *part of* its rate setting process. AOB63.

Critically, United's reimbursement process for out-of-network services did not simply adopt "the Medicare rate." Rather, some defendants (not all) used Medicare as one baseline *component* in identifying a reasonable payment rate, which reimbursed emergency medicine services at rates that were *higher* than the Medicare fee schedule itself. AOB65 (citing evidence of average rates of "164% of Medicare"). United, however, was precluded from explaining how Medicare rates are created and why it is industry custom to utilize those rates as part of the reimbursement process. United would have explained that Medicare is the largest payer for healthcare in the country and its payment rates are derived from a system that considers providers' cost of service, which creates reliable reimbursement information. 110App.27,280-81. United then uses the published Medicare rates to benchmark the reimbursements for the health plans that it insures or administers.

Additionally, defendant SHL determined reimbursement for amounts using the Affordable Care Act's "Greatest of Three" methodology, under which the Medicare rate was the allowed amount

for the emergency medicine service only if two other reasonable, market-based rates were *lower* than the Medicare rate. AOB66. Yet a key SHL witness was prohibited by the district court's *in limine* ruling from explaining how SHL determined the disputed reimbursement rate and that it was greater than the Medicare rate. *Id.* Thus, the jury was allowed to hear TeamHealth's allegation that SHL's reimbursement was unreasonably low but denied the ability to hear SHL's explanation for why it believed the reimbursement methodology produced a reasonable rate.

TeamHealth proffers no meaningful defense of the district court's restriction on United's testimony. It asserts that the court "merely prevented" SHL's witness "from testifying that Medicare rates are reasonable, not from explaining how United calculated the amounts it paid." RB54-55. Not so. SHL sought to explain how it reimbursed the disputed benefit claims and why it believed those payments were reasonable. 110App.27,277:20-27,281:11. The court prohibited SHL from establishing those essential rebuttal points.

TeamHealth also asserts that United was properly barred from

defending the use of Medicare even as a reference because Medicare rates are an inapplicable comparator. RB52-57. But courts have repeatedly recognized that juries should "hear evidence of reduced amounts a provider accepts as payment in full, even when the payer is a government healthcare program," because that evidence relates to the "salient fact" that a "provider has agreed to accept the lower rates as payment in full." *Patchett*, 60 N.E.3d at 1030-31. In other words, "the amounts plaintiff would have accepted from major private insurers or the federal government under Medicare … reflect[], in one way or another, the supposed 'value' of the plaintiff's services." *Nassau Anesthesia*, 924 N.Y.S.2d at 254-55.

According to TeamHealth, that premise is wrong because the federal Emergency Medical Treatment and Labor Act ("EMTALA") *requires* providers to treat Medicare-insured patients and accept Medicare rates for services. BR53-54. It does not. On its own, EMTALA does not impose obligations on any hospital. *Correa v. Hosp. San Francisco*, 69 F.3d 1184, 1190 (1st Cir. 1995). Hospitals assume EMTALA obligations only if they voluntarily opt-in to the Medicare

program. *See id.*; *Baker Cnty. Med. Servs., Inc. v. U.S. Atty Gen.*, 763 F.3d 1274, 1279 (11th Cir. 2014) (hospitals "voluntarily undertake providing emergency treatment to all patients when they opt into Medicare and become subject to EMTALA" (cleaned up)). Many hospitals *do* opt-in to Medicare because its reimbursements are "a lucrative source of institutional revenue." *Correa*, 69 F.3d 1184, 1190 (1st Cir. 1995); *see Burditt v. U.S. Dep't of Health and Human Servs.*, 934 F.2d 1362, 1376 (5th Cir. 1991) (explaining that "physicians only voluntarily accept responsibilities under EMTALA if they consider it in their best interest to do so" because they are "free to negotiate with [the] hospital regarding [their] responsibility to facilitate a hospital's compliance with EMTALA"). But the obligation assumed under EMTALA "does not diminish the underlying voluntariness of the Hospital's participation in Medicare." *Baker*, 763 F.3d at 1276. Indeed, there are "low barriers to exit" government health programs and "many providers can and do leave." *Patchett*, 60 N.E.3d at 1032.

Given the voluntariness of participation in Medicare (and hence EMTALA), those who do participate are necessarily "at least tacitly

agreeable to the terms of participation, including the reimbursement rates." *Id.* "Because participating providers accept these reduced rates in full satisfaction of the services rendered," these "rates are relevant, probative evidence of the reasonable value of medical services." *Id.* TeamHealth's own decision to contract with hospitals that opt to participate in Medicare evinces its recognition that Medicare rates are within the range of reasonable value for emergency medicine services.

Finally, TeamHealth argues that SHL was properly barred from explaining and defending its use of the ACA's Greatest of Three methodology because the issue at trial was "not what federal law has to say about the calculation of out-of-network rates, but what is required under Nevada law." RB56. That argument is nonsensical. Evidence that federal regulators have deemed a particular minimum rate to be *reasonable as a matter of federal law* is plainly relevant to determining whether United's reimbursement rates above that regulatory minimum were *un*reasonable as a matter of state law. 83 Fed. Reg. 19431 at 19435 (explaining reimbursements made pursuant to Greatest of Three regulation "reflect amounts that the federal government itself or group

health plans and health insurance issuers have established as reasonable"). TeamHealth cites nothing to suggest that a properly instructed jury would be incapable of grasping the difference between federal law and state law or comprehend TeamHealth's argument for why Nevada law should mandate even higher minimum reimbursement rates.

d. COSTS OF THE DISPUTED SERVICES

Finally, TeamHealth contends that the district court properly excluded all evidence of the costs incurred to provide the emergency medicine services at issue. RB57-58. TeamHealth does not deny that courts in many other states—including Alaska, Florida, Illinois, Indiana, Missouri, New York, Oregon, Ohio, Tennessee, and Wyoming—have held that cost evidence is relevant to determining whether a healthcare provider's full billed charges are reasonable. AOB69-71 (citing cases). These decisions recognize cost evidence as relevant in multiple ways. AOB69-73. It is affirmative evidence of market value—the jury can combine a provider's cost data with evidence of "the ordinary industry allowance for overhead and profit" to make a market-

based judgment about "the reasonable value of the services." *Portland v. Hoffman Construction Co.*, 596 P.2d 1305, 1314 (Or. 1979). The evidence also can rebut a provider's contention that its own full-billed charges are *ipso facto* reasonable by showing, for example, that "hospitals grossly overcharge for services relative to their costs." *Colomar v. Mercy Hosp., Inc.*, 461 F. Supp. 2d 1265, 1272 (S.D. Fla. 2006).

Cost information also would have been directly relevant to rebutting TeamHealth's unsupported and false contention that its affiliated providers were harmed by United's reimbursement rates. Cost information would have proved that United's reimbursements fully covered provider salaries and shown that TeamHealth's demands were actually about increasing profits for its private equity investors. This point is confirmed by a recent decision rejecting similar reimbursement claims by TeamHealth affiliates in Arizona because, in part, it was "undisputed that all of Plaintiffs' expenses have been covered, and all of the medical professionals who provide services on behalf of Plaintiffs have been paid in full." *Emergency Grp. of Ariz.*, Addendum at 16-17 ¶¶

8-10, 14. Cost information would have proved the same point here, had the district court permitted full discovery and then admitted such evidence.

TeamHealth advances no persuasive reason this Court should reject the foregoing decisions. Indeed, TeamHealth barely even acknowledges them. And the one case it does cite—*Emergency Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.*, Case No. 1:20-cv-09183 (S.D.N.Y.)—directly refutes its position. RB59n.29. In that case—an action filed against United affiliates by TeamHealth affiliates—the district court reversed a magistrate judge's order denying discovery of TeamHealth's cost information. According to TeamHealth, the mere fact that two jurists reached different conclusions as to the relevance of this evidence proves that the district court here did not abuse its discretion in denying the same discovery. *Id.* But the district court in *Emergency Physician* reversed the magistrate's ruling precisely *because* that ruling was an abuse of discretion. *Em. Physician Servs. of N.Y.*, Addendum at 3, 7. The same is true here.

TeamHealth next turns to this Court's decision in *Certified Fire*,

which TeamHealth misreads as conclusively prohibiting the use of cost evidence in the reasonable value analysis. RB57-58. But *Certified Fire* does not even mention cost evidence, much less resolve its admissibility. Rather, the Court simply observed in a footnote that "quantum meruit is not the only measure of damages available in restitution," 128 Nev. at 382 n.3, 283 P.3d at 257 n.3, citing § 49 of the Restatement (Third) of Restitution and Unjust Enrichment ("Restatement"), which identifies "the cost to the claimant of conferring the benefit" as one potentially relevant measure of reasonable value, Restatement § 49(3)(b). If anything, that reference supports *United's* position.

TeamHealth, however, hopscotches from Restatement § 49(3)(b) across various other Restatement provisions and eventually lands on an *illustration* to a *comment* to a *different provision*, which states that a provider of emergency-medicine services is entitled to payment of "his reasonable and customary charge." RB58-59 (quoting Restatement § 20 cmt. c, illus. 8 (2011)). But TeamHealth ignores the Reporter's Note to that illustration and comment, which explains that the "market value of services" is based on "simulating a competitive market," and that "in

such a market, price is based on the *cost to the seller*." Restatement § 20, Reporter's Note, cmt. c, illus. 8 (quotation omitted) (emphasis added). According to TeamHealth's own authority, then, evidence of cost is directly relevant to assessing objective market value.

B. The District Court's Unjustified Spoliation Instruction Requires a New Trial

A rebuttable presumption instruction based on "spoliation" is justified only when the party *lost or destroyed* evidence with intent to harm its opponent. United did no such thing and TeamHealth cites no evidence showing otherwise. The baseless instruction necessarily inflamed the jury and unfairly prejudiced United.

TeamHealth asserts that district courts have "broad discretion to impose discovery sanctions and settle jury instructions," RB60, but in the very cases TeamHealth cites for that proposition, this Court *overturned jury verdicts* because the district courts *abused* their discretion, *see MDB Trucking, LLC v. Versa Prod. Co., Inc.*, 136 Nev. 626, 475 P.3d 397 (2020); *Bass-Davis v. Davis*, 122 Nev. 442, 134 P.3d 103 (2006)). The Court did the same recently in *Rives v. Farris*, 138

Nev. 138, 506 P.3d 1064 (2022), and it should do so again here.

As TeamHealth admits, a rebuttable presumption instruction is permissible only for "the *loss or destruction* of evidence," RB60 (emphasis added), and even then "only in cases … in which the party *destroying evidence* intends to harm another party," *Bass-Davis*, 122 Nev. at 445, 134 P.3d at 105 (emphasis added); *see Rives*, 138 Nev. at 147 n.7, 506 P.3d at 1072 n.7 (rebuttable presumption improper unless "evidence is lost or destroyed"). The district court here explicitly rejected any contention that United destroyed evidence. 18App.4396 ¶ 32 ("the Court does not believe there has been any destruction or fabrication of evidence"). The instruction instead was based entirely on technical *discovery* issues, including a supposedly inadequate privilege log, mass rather than rolling productions (even though TeamHealth admits the production was timely), and supposedly excessive confidentiality designations. RB61-62. As just shown, however, a rebuttable presumption instruction is permissible only when a party *willfully eliminates* evidence with intent to harm the other party—a finding the court rejected here.

Even if a rebuttable presumption instruction could be justified by an inadequate privilege log and other technical discovery issues, the instruction here went much further, repeatedly and falsely telling jurors that United had "destroyed" evidence. AOB34-35. The instruction told jurors that United had engaged in "willful suppression" of evidence, which it defined as "the willful or intentional *spoilation* of evidence," meaning in turn that United had "the intent to harm [TeamHealth] through its *destruction*." *Id.* (emphasis added). The instruction falsely told jurors that TeamHealth had "demonstrated that the evidence was *destroyed* with intent to harm," and that United was "the *destroying* party" with the burden to prove that "the *destroyed* evidence was not unfavorable[]." *Id.* The instruction then went even further, advising jurors that because United did not carry that burden, jurors were "required to presume that the evidence was adverse to the *destroying* party." *Id.* In short, the instruction started from the explicit—but unambiguously false—premise that United had destroyed evidence, and then proceeded to advise jurors how that false "fact" could be used against United in rendering their verdict. And while

TeamHealth now concedes that there was no evidence that United destroyed documents, RB63n.33, its counsel at trial took full advantage of the false instruction, citing it during closing in urging the jury to award massive punitive damages, AOB37-39, 81.

TeamHealth contends that the repeated false statements about United's destruction of evidence were permissible because they were simply lifted verbatim from the Pattern Jury Instruction. RB63n.33. But pattern instructions are supposed to be "tailored to fit the individual facts of each issue." *Woosley v. State Farm Ins. Co.*, 117 Nev. 182, 192, 18 P.2d 317, 323 (2001). Even if *some* instruction was permissible on this record, there is no justification for delivering the pattern instruction without adjustment for context, thereby misleading the jury with false and inflammatory statements about United's discovery conduct.

Of course, the fact that the pattern instruction expressly refers to document destruction simply confirms that the instruction was never applicable here at all. The district court gave the instruction solely because United supposedly did not adequately produce all (1)

communications supporting United's position that its clients wanted United to constrain rising health care costs; and (2) health plan documents—such as certificates of coverage, summary plan descriptions and administrative services agreements. 146App.36,166-67.

As to the first category, there is no evidence that United's production was incomplete in any way. AOB79-81. Remarkably, TeamHealth's brief *does not disagree*. Nowhere does TeamHealth argue that United failed to produce all relevant documents on that topic, nor does TeamHealth attempt to defend the district court's decision to issue a rebuttable presumption instruction for this category of documents. The tacit admission that the instruction lacks support on that basis is by itself grounds for reversal. *Nationstar Mortg., LLC v. Saticoy Bay LLC Series 2227 Shadow Canyon*, 133 Nev. 740, 752, 405 P.3d 641, 650 (2017).

TeamHealth focuses instead only on the plan documents, but it cannot refute United's showings that (a) United ultimately produced more than 200,000 pages of administrative records, including more than 7,000 plan documents and explanation of benefit forms associated with

almost 16,446 unique benefit claims, *thousands* more than the 11,563 individual benefit claims TeamHealth presented at trial; and (b) that United's inability to produce additional plan documents resulted from TeamHealth's disputed claims list fluctuating by more than 10,000 benefit claims during discovery and through trial, United's lack of access to plan documents for self-funded plans, and the inadequate timeframe for compliance imposed by the district court. AOB32-33, 79. Nor can TeamHealth show that the unproduced plan documents meaningfully differed on payment terms for out-of-network services from the many plan documents that were produced. To the contrary, TeamHealth acknowledges that many of the admitted plan documents had "terms requiring reimbursement at reasonable rates," RB62n.32, and TeamHealth does not suggest that the unavailable plan documents contained terms somehow requiring reimbursement at *higher* than "reasonable rates." TeamHealth thus cannot show that its position was adversely affected by lack of access to *even more* self-funded plan documents than it already had. And it certainly cannot show that United's inability to produce every one of those documents was based on

an intent to harm TeamHealth's case. If it were, United never would have produced documents covering 16,446 unique benefit claims it *could* identify—a feat it accomplished in the limited time available only by developing special computer programs to reduce the manual work required to search for and retrieve the documents.

The unwarranted and inflammatory rebuttable presumption instruction requires a new trial.

II.

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

A. TeamHealth Did Not Prove an Implied-in-Fact Contract

Other courts have repeatedly rejected arguments that health insurers and benefit plan administrators entered into implied contracts with TeamHealth and similar entities to make payments independent of, and greater than, the benefit amounts already owed under ERISA-governed health plans. AOB89-90. This Court should do the same. TeamHealth did not prove either (1) that United agreed to pay TeamHealth's full billed charges, or (2) that TeamHealth provided any

consideration in exchange for United's supposed promise to pay.

1. United Did Not Accept an Independent Contractual Obligation to Pay TeamHealth's Full Billed Charges

"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." *Certified Fire*, 128 Nev. at 379-80, 283 P.3d at 256. An implied-in-fact contract "cannot exist when material terms are lacking or are insufficiently certain and definite." *May v. Anderson*, 121 Nev. 668, 672, 119 P.3d 1254, 1257 (2005).

TeamHealth concedes that the parties never agreed on an amount TeamHealth would be paid for emergency medicine services rendered to United's members. RB66-67. According to TeamHealth, however, the jury could have found that United agreed to pay TeamHealth the "reasonable value" of the services so long as TeamHealth sought reimbursement for them on a United-approved form. RB65, 67. There are two problems with that response.

First, the only independent implied-in-fact contract TeamHealth

sought to prove below was an agreement to pay its *full billed charges*. AOB27-28, 83. As TeamHealth puts it, *only* its full charges represented "reasonable value." RB67. TeamHealth never argued at trial—much less introduced evidence showing—that it intended to enter contracts for payment of amounts less than its full charges. TeamHealth shifts its argument before this Court because the jury rejected its contention that "reasonable value" equated to its full charges. TeamHealth should not be permitted to shift theories on appeal and defend an implied-in-fact contract that *even TeamHealth never intended to enter* and as to which *it never offered any evidence to support*.

Second, while quantum meruit may supply a price term when price is the *only* missing term, the contract failure here is more fundamental. *See Certified Fire*, 120 Nev. at 380, 119 P.3d at 256 ("There are simply too many gaps to fill in the asserted contract for quantum meruit to take hold."); *Matter of Est. of Kern*, 107 Nev. 988, 991, 823 P.2d 275, 276-77 (1991) (rejecting alleged contract where "several essential elements of a valid contract are missing" including "subject matter, price, payment terms, quantity, and quality"); *see also*

Emergency Grp. of Ariz., Addendum at 19 ¶ 25 (ten percent fluctuation in out-of-network reimbursement rates received by TeamHealth affiliates from United affiliates was "too indefinite to be enforceable" as a price term). TeamHealth cites no evidence establishing that United ever accepted an obligation of *any* kind to TeamHealth independent of United's obligations to plan members under their ERISA-governed plans.

According to TeamHealth, United's intent to contract can be implied from evidence showing that "United executives understood that [TeamHealth] had provided valuable services to United's members and that United was obligated to reimburse the Health Care Providers for those services." RB67-68. The evidence showed no such thing. Every cited passage shows only that United understood its obligations *to plan members* to approve reimbursement *to them* in accordance with their plan documents. Whether United satisfied that obligation is governed exclusively by the terms of the plan documents and thus by ERISA. *See infra* 83-95. To avoid ERISA preemption, TeamHealth had to prove that United *separately* agreed with TeamHealth to reimburse

TeamHealth for amounts beyond those owed to members under the plans themselves. *See Marin Gen. Hosp. v. Modesto & Empire Traction, Co.*, 581 F.3d 941, 944, 947-48 (9th Cir. 2009) (alleging oral contract separate from health plan terms). TeamHealth proved no such agreement.

In fact, TeamHealth brought this suit precisely because United and TeamHealth did *not* agree to an independent network contract. AOB13-18, 87. It is perverse to imply a mutual intent to reach precisely the kind of independent contract the parties had just expressly *refused* to enter.

2. No Evidence Shows That TeamHealth Provided Consideration to United

TeamHealth also failed to prove that it provided any consideration for United's supposed promise to pay TeamHealth additional reimbursements beyond those required under the applicable health plans. AOB90. "Consideration is not adequate when it is a mere promise to perform that which the promisor is already bound to do." *Clark County v. Bonanza No. 1*, 96 Nev. 643, 650-51, 615 P.2d 939, 944

(1980). In this context, treating members of United-administered or -insured benefit plans "does not amount to consideration" because the treatment is provided "not in exchange for United's payments but instead out of a pre-existing legal obligation." *Emergency Health Physicians*, 2021 WL 4437166, at *12 (S.D.N.Y. 2021) (cleaned up); *see Temple Univ. Hosp., Inc. v. Philla.*, 2006 WL 51206, at *3 (Pa. Ct. Com. Pl. 2006) ("no exchange of consideration" when healthcare provider "was legally bound to provide emergency care services").

TeamHealth does not argue otherwise on appeal. To the contrary, it concedes that, having joined Medicare to obtain Medicare reimbursements, it became legally obligated to provide emergency medicine services to all patients who presented to the emergency rooms staffed by TeamHealth. RB10. And it makes no argument that treating members of a health plan pursuant to a preexisting legal obligation constitutes consideration for an independent contract with the plan's administrator or insurer.

TeamHealth argues only one form of "valid consideration," i.e., "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." RB68n.36. But the so-called "form preferred by United" is *also* a preexisting legal obligation. The "form" is the "CMS 1500," which is "a standard form in the industry that's required for providers to complete" when they submit claims. 46App.11,387:1-8. The form is not United's form; it is called the "CMS 1500" because it was created by the Centers for Medicare and Medicaid Services ("CMS"),[1] then approved for use in Nevada by the Insurance Commissioner. NAC 686A.288; *see* 46App.11,387:115-19 (TeamHealth "submit[s]" forms "electronically to a data clearinghouse," which then "forward[s]" them to applicable insurer). TeamHealth and United were required by Nevada regulation to submit and accept, respectively, the CMS 1500. NAC 686A.288(1); *see* NAC 686A.282 (defining "clean claim" as claim compliant with CMS 1500); 43App.10,567 (testimony describing clean claim).

TeamHealth's use of the form required for *any* claim in Nevada

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[1] CMS, Professional Paper Claim Form (CMS-1500), *available at* https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500.

under a benefit plan does not constitute consideration for an independent obligation on United's part to pay TeamHealth amounts exceeding the benefits owed under the plans themselves. United's acceptance of CMS 1500 establishes only that United complied with its obligations to plan members to process, approve, and/or pay their claims under the plans. It does not confer on TeamHealth a distinct, implied contractual right to additional payments for the same services.

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

TeamHealth concedes that if it prevails on its implied-in-fact contract claim, its unjust enrichment claim—which is one of the two bases for its punitive damages award—necessarily fails. RB75n.40. Accordingly, if its implied-in-fact contract judgment is affirmed, its unjust enrichment judgment must be reversed and cannot support punitive damages.

But its unjust enrichment claim also fails on its own terms. TeamHealth admits that to prove unjust enrichment it had to establish that it provided a benefit *to United*. RB69-70; *see Korte Constr. Co. v.*

Nev. on Relation of the Bd. of Regents of the Nev. Sys. of Higher Educ., 137 Nev. 378, 381, 492 P.3d 540, 543-44 (2021) (recognizing "fundamental requirement of unjust enrichment" that defendant "obtain a valuable benefit" from plaintiff "without paying anyone for it"). TeamHealth says it provided a benefit to United when TeamHealth-affiliated providers treated members of United-administered or -insured benefit plans, because the treatments discharged United's own duty to provide medical care to plan members. RB74.

That theory depends on the demonstrably false premise that United had its own duty to provide medical care to plan members. It did not. United's sole legal duty was to administer benefit claims for self-funded health plans and to pay claims for fully insured plans. *See* 148ReplyApp.36298, 36300 ("We pay Benefits for Covered Health Services …. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan."), 36361 (insured's "Benefits" are defined as a "right to payment"). United

nowhere assumed any obligation to provide medical services to health plan members. *See* 148ReplyApp.36298 ("We do not make decisions about the kind of care you should or should not receive…. It is [the insured's] responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals … to participate in a Network…. These professionals … are independent practitioners … that are solely responsible for the care they deliver."), 36345 ("[United] do[es] not provide medical services or make treatment decisions…. We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits."). Because United had no duty to provide emergency medicine services to plan members, TeamHealth did not discharge such a duty when TeamHealth-affiliated providers treated them.

TeamHealth's misplaced reliance on Comment A to § 20 of the Restatement confirms its error. Section 20 addresses only the relationship between the provider and *the patient*, not the relationship between the provider and a third-party payer or plan administrator.

Section 20 itself states that a "person who performs … professional services required for the protection of *another's life or health* is entitled to restitution from *the other*," i.e., the recipient of life/health-saving services. As Comment A and associated illustrations explain, the recipient of emergency services owes restitution because in an emergency, the parties typically cannot negotiate a contract before the patient receives beneficial services. Restatement § 20, cmt. A; *see id.* § 20, illus. 1 ("Doctor has a claim in restitution … against" patient "who is lying unconscious"), illus. 8 ("Physician provided emergency medical assistance to unconscious [patient].").

Comment A to § 20 adds the corollary that a healthcare provider may seek restitution not only from the patient, but also from "a successor" or "a representative" of the patient. TeamHealth misconstrues this language as authorizing restitution from *the patient's insurer*, RB71, but an insurer is not a "successor" or "representative" of the patient. That language instead refers to a party that is responsible for the patient's affairs, i.e., a person or entity that can stand in the shoes of the patient as a named defendant. *See* Restatement § 20, illus.

8 ("Physician is entitled to restitution from Estate" even though services did not save decedent's life); *Larisa's Home Care, LLC v. Nicols-Shields*, 362 Or. 115, 120, 404 P.3d 912 (Or. 2017) (unjust enrichment action to "recover the reasonable value of [provider's] services" is "properly brought against [estate's] personal representative"); Black's Law Dictionary (defining "personal representative" to mean "[s]omeone who manages the legal affairs of another because of incapacity or death, such as the executor of an estate"). Moreover, United is not even an *insurer* for many of the disputed benefit claims in this case—it is instead a third-party administrator ("TPA") that provides only *administrative services* to self-funded health plans, which are solely responsible for paying benefit claims under the plans.[2] Whether acting as plan insurer or plan administrator, United is not a "successor" or "representative" of the patient in any cognizable legal sense.

TeamHealth also cites Illustration 10 to Comment G of

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[2] Even as to insured benefit plans, the plans explicitly state that as between United and the plan, the *plan* is "responsible for the difference between the amount billed by the non-Network provider and the amount" owed by the plan. 148ReplyApp.36267, 36291-92, 36299.

Restatement § 22, which addresses restitution by a provider from a specific type of "Managed Care Organization" ("MCO"). RB 72. TeamHealth again misconstrues this language as encompassing United. It does not. Illustration 10 is based on *River Park Hosp., Inc. v. BlueCross BlueShield of Tenn., Inc.*, 173 S.W.3d 43 (Tenn. Ct. App. 2002). *See* § 22 Reporter's Note, cmt. g. The MCO at issue in *River Park* managed Medicaid plans ("Managed Medicaid MCO") for the state of Tennessee pursuant to an agreement that required the MCO to "*arrange for the provision* of medically necessary services to its enrollee." 173 S.W.3d at 47-48 (emphasis added). The MCO itself thus had a duty to ensure care for the enrollee, giving rise to a concomitant obligation to ensure providers were paid for care the MCO arranged. *Id.* The MCO described in Illustration 10 is not a traditional insurer or a TPA, which have *no* duty to arrange for care for benefit plan members, only a duty to reimburse *members* for care secured *by the members*. Because United is at most only a payer, a healthcare provider who treats a member of a United-administered or -insured plan does not discharge any treatment duty owed by United and thus

does not confer any benefit on United.

In addition to erroneous invocation of the Restatement, TeamHealth cites a panoply of distinguishable and irrelevant judicial decisions. RB73-74. It cites *El Paso Healthcare System, Ltd. v. Molina Healthcare of New Mexico, Inc.*, 683 F. Supp. 2d 454 (W.D. Tex. 2010), which involved another Managed Medicaid MCO with a legal duty to provide care to its members. *Id*. at 456-57, 461-62. Notably, the Texas Supreme Court later rejected *El Paso Healthcare* in holding that health insurers are *not* subject to unjust enrichment claims because they—unlike Managed Medicaid MCOs—do not have a duty to provide medical care to their members. *See Texas Medicine Resources, LLP v. Molina Healthcare of Texas, Inc.*, 659 S.W.3d 424, 436-37 & n.92 (Tex. 2023).[3]

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[3] Four of the cases cited in TeamHealth's lengthy string-cited footnote (RB73n.39) also involve Managed Medicaid MCOs or rely on the principle that Managed Medicaid MCOs have a legal duty to provide medical care to their members. *River Park*, 173 S.W.3d at 47-48; *Appalachian Reg'l Healthcare v. Coventry Health & Life Ins. Co.*, 2013 WL 1314154 (E.D. Ky. 2013); *HCA Health Servs. of Va., Inc. v. CoreSource, Inc.*, 2020 WL 4036197, at *6 (E.D. Va. 2020) (relying on

TeamHealth also cites *South Broward Hospital District v. ELAP Services, LLC*, 2020 WL 7074645, at *7 (S.D. Fla. 2020), but that court subsequently *reversed* itself precisely because the defendant had no legal duty to provide medical care to the patients treated by the plaintiff provider. 2023 WL 6547748, at *11 (S.D. Fla. 2023); *see also Vanguard Plastic Surgery*, 2022 WL 19037216, at *4 ("Though this Court previously recognized a split of authority in evaluating the benefit that flows from a healthcare provider to an insured's insurer … upon careful review of recent cases … overwhelming authority support[s] dismissal[.]").

TeamHealth's reliance on *Prime Healthcare Servs. – Reno, LLC v. Hometown Health Providers Ins. Co.*, 2022 WL 1692525 (D. Nev. 2022), and *Emergency Physician Servs. of N.Y. v. UnitedHealth Grp., Inc.*, 2021 WL 4437166 (S.D.N.Y. 2021), fares no better. Those decisions

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Appalachian Reg'l); *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc.*, 832 A.2d 501. The cited Florida cases, meanwhile, all rest on the false premise that an insurer owes a treatment duty to its insureds and have since been rejected by "overwhelming authority." *Vanguard Plastic Surgery, PLLC v. UnitedHealthcare Ins. Co.*, 2022 WL 19037216, at *4 (S.D. Fla. 2022).

were issued at the pleading stage where the courts were obligated to accept as true the plaintiffs' allegations that they discharged treatment duties owed by the health insurers or that the insurers requested the performance of the plaintiffs' services. *Prime Healthcare*, 2022 WL 1692525, at *8; *Emergency Physician Servs. of N.Y.*, 2021 WL 4437166, at *12. In this case, by contrast, there is a factual record, and while it is woefully incomplete from United's perspective, it at least establishes that United had no legal duty to provide medical care to patients treated by TeamHealth-affiliated providers. *See, e.g.*, *supra* 4-27, 40-41. Because those treatments accordingly did not provide United the benefit of discharging United's own treatment duty, the "fundamental requirement of unjust enrichment" is not satisfied. *Korte*, 137 Nev. at 381, 492 P.3d at 543-44.

C. TeamHealth's UCPA Claim Fails as a Matter of Law

The UCPA unambiguously creates a cause of action only against an "insurer" by "its insured":

> In addition to any rights or remedies available to the 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 [NRS 686A.310(1)(a)-(p)] as an unfair practice.

NRS 686A.310(2). TeamHealth is not an "insured" and several of the United defendants are not "insurers." AOB99-111. And TeamHealth did not establish a substantive violation of the UCPA in any event, only a good-faith dispute over the amount owed to TeamHealth, if any. AOB111-20. TeamHealth's responses are meritless.

1. TeamHealth Is Not an "Insured"

In response to United's showing that TeamHealth does not qualify as an "insured" under the UCPA, TeamHealth first misconstrues United's position as "rest[ing] largely upon this Court's decision in *Gunny v. Allstate Insurance Co.*, 108 Nev. 344, 830 P.2d 1335 (1992)," which TeamHealth then labors to distinguish on its facts, RB76-78. In fact, United's position rests mainly on the *plain language of the UCPA*, which creates a cause of action against an insurer *only* by "its insured," and TeamHealth simply is not an "insured" of any United defendant by any conceivable definition of the term. The same would be true if *Gunny* had never been decided.

But *Gunny* is nonetheless relevant because it illustrates the correct application of the UCPA's plain language in refusing to allow suit by a party who is not an "insured." Other decisions uniformly agree. *See Tweet v. Webster*, 614 F. Supp. 1190, 1195 (D. Nev. 1985); *Crystal Bay Gen. Improvement Dist. v. Aetna Casualty & Surety Co.*, 713 F. Supp. 1371, 1376 (D. Nev. 1989).[4] *Gunny* and other precedents all simply confirm that the UCPA, in creating a cause of action for an "insured," does not *also* implicitly permit actions by third parties who are not "insureds." In *Gunny*, it was the injured son of the insured. Here, it is a large staffing company whose affiliated healthcare providers treated insureds. They are different types of third parties, but what matters is that neither third party is an "insured" by *any* definition of that term.

The same is true for other distinctions cited by TeamHealth. For

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[4] *Accord Burley v. National Union Fire Insurance Company of Pittsburg PA*, 2016 WL 4467892, *2 (D. Nev. 2016); *Talbot v. Sentinel Ins. Co., Ltd.*, 2012 WL 3995562, *3 (D. Nev. 2012); *Wilson v. Bristol West Ins. Group*, 2009 WL 3105602, *2 (D. Nev. 2009); *Weast v. Travelers Cas. & Sur. Co.*, 7 F. Supp. 2d 1129, 1132 (D. Nev. 1998).

instance, TeamHealth notes that *Gunny* involved liability insurance, whereas this case involves health insurance. RB77. But either way, TeamHealth is not United's "insured." TeamHealth cites nothing in the statute or legislative history indicating that the term's plain meaning should expand to encompass *non*-insured entities merely because health insurance is involved rather than liability coverage. RB77-80.

It is similarly irrelevant that in *Gunny*, the insured's injured son had no contract with the insurer—he was a "stranger" to the insurer-insured relationship, RB78—whereas here TeamHealth alleges an implied-in-fact contract between TeamHealth and United. For starters, there is no such contract between TeamHealth and United. *See supra* 33-39. But even if there were, that contract would not transform TeamHealth into United's "insured" under the applicable benefit plans. To the contrary, the alleged contract supposedly exists *independent* of the insurance relationship between United and the insured plans and their members—otherwise TeamHealth's claims would be preempted by ERISA. *See infra* 83-95.

TeamHealth next suggests in a footnote that it can sue under the

UCPA because NRS 686A.027 "affords rights to medical providers." RB79n.43. But "affording rights" is not the same as "allowing private suit." *See Texas Medicine Resources*, 659 S.W.3d at 438 (observing that while physicians qualify as "persons" under a different statutory section, they "still can never prevail on the [Texas UCPA] claim they have pleaded because it requires 'a claim by an insured'"). Providers' rights under NRS 686A.027 are enforced entirely through fines issued by the insurance Commissioner. As the legislative counsel's digest notes state, NRS 686A.027 "provides that it is an unfair method of competition *subject to an administrative fine* pursuant to NRS 686A.187 to knowingly utilize a provider of health care's contractual discount without a contractual relationship." 2019 Nevada Laws, Ch. 282, *Legislative Counsel's Digest* (S.B. 365) (emphasis added). Enforcing the statute by its terms does not immunize insurers from sanction for unfair practices that harm healthcare providers, RB79-80—it simply leaves such sanctions exclusively in the Commissioner's hands. *See Allstate Ins. Co. v. Thorpe*, 123 Nev. 565, 572, 170 P.3d 989, 994 (2007) ("NRS 686A.015(1) grants the Insurance Commissioner 'exclusive

jurisdiction in regulating the subject of trade practices in the business of insurance in this state.'").

2. UHS, UMR, And UHIC Acting as TPAs Are Not "Insurers" Under the UCPA

UHS, UMR, and UHIC (as to some disputed benefit claims), are not subject to suit under the UCPA for the independent reason that they are TPAs, not "insurers."

In *Albert H. Wohlers & Co. v. Bartgis*, 114 Nev. 1249, 1263, 969 P.2d 949, 959 (1998), this Court expressly held that TPAs are not subject to suit under the UCPA because they are not insurers and "there is no indication that the legislature intended NRS 686A.310 to apply to other entities beyond insurers." *Id.* at 1263, 969 P.3d at 959. TeamHealth admits that to affirm liability for the United TPAs, the Court would have to overrule *Wohlers*. RB85-86. But "under the doctrine of *stare decisis*, [this Court] will not overturn [precedent] absent compelling reasons for so doing." *Miller v. Burk*, 124 Nev. 579, 597, 188 P.3d 1112, 1124 (2008). *Stare decisis* has particular force as to decisions construing statutes, because if the Legislature does not

subsequently amend the statute to "correct" the decision, "it is presumed that the legislature approves of [the Court's] interpretation of the provision." *N. Nevada Ass'n of Injured Workers v. Nevada State Indus. Ins.*, 107 Nev. 108, 112, 807 P.2d 728, 730 (1991); *see Gamble v. United States*, 139 S. Ct. 1960, 1969 (2019) (heightened justification required to overturn decision interpreting statute).

Not only does TeamHealth fail to provide any extraordinary justification for overruling *Wohlers*, it identifies no error in the decision at all. Simply put, NRS 686A.310(2)'s use of "insurer" does not encompass *non*-insurers like TPAs, which do not issue insurance policies. NRS 679A.100 defines "insurer" as follows:

> "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. When acting as TPAs, UHS, UMR, and UHIC did not enter "contracts of insurance." *See* 36App.8,953; *Davidson v. American Freightways, Inc.*, 25 S.W.3d 94, 98 (Ky. 2000) (interpreting statute identical to NRS 679A.100 to mean that UCPA only applies to those "in

the business of entering into contracts of insurance"); *Self-Insurance Institute of Am. v. Gallagher*, 1989 WL 143288, at *13-14 (N.D. Fla. 1989) ("administrative services with respect to processing of claims is not an integral part of the policy relationship between the insurer and the insured"). Although a TPA *administers* insurance contracts, the TPA is *not a party to the contract*. *See* 14 Couch on Ins. § 198.17 (3d ed.) (agent of insurer "does not also incur personal liability to the insured" due to "[t]he lack of contractual privity").

TeamHealth argues that NRS 679A.100's definition of "insurer" is non-exhaustive, so a TPA could still be an "insurer." RB82. This Court rejected a similar argument in *MGM Mirage v. Nevada Ins. Guar. Ass'n*, 125 Nev. 223, 209 P.3d 766 (2009). There, the parties argued that NRS 679A.100's definition of "insurer" did not necessarily mean the same thing as "insurer" under a different act, because NRS 679A.100's use of "includes" meant there were other possible definitions. *MGM Mirage*, 125 Nev. at 230, 209 P.3d at 770. The Court observed that "NRS 679A.100's definition may not be 'all inclusive,'" but it nevertheless prescribes "the commonplace meaning" of "insurer" and thus was

applicable to the other act. *Id.* Under those circumstances, the Court held that a self-funded employer was not an "insurer" because it was not "in the business of insurance." *Id.*

The same analysis applies here. A TPA providing administrative services to a self-funded employer is not an "insurer" because a TPA is not "in the business of entering into contracts of insurance." *Gallagher*, 1989 WL 143288, at *13-14. The statutes themselves draw a distinction between being *in the business of insurance* and being in the business of *entering into contracts of insurance.* Any "person engaged in the business of insurance" is a "Provider of insurance." NRS 679A.118. Both insurers and TPAs, along with various other entities, are expressly listed as "Providers of insurance." NRS 679A.118. But only entities "in the business of entering into contracts of insurance" qualify as "Insurers." NRS 679A.100.

A court cannot amend the UCPA to allow private actions against not only "insurers," but also "providers of insurance." *Holiday Retirement Corp. v. State, DIR*, 128 Nev. at 154, 274 P.3d at 761. This is especially true given that the Legislature added the definition of

"providers of insurance" in 2001 *after* the 1998 decision in *Wohlers*, but did not amend NRS 686A.310(2) to allow civil liability for TPAs. Given the legislative silence in response to *Wohlers*, it should be "presumed that the legislature approve[d]" of the Court's ruling that TPAs are not subject to liability under the statute. *Injured Workers*, 107 Nev. at 112, 807 P.2d at 730.

3. TeamHealth Failed to Establish a Substantive Violation of the UCPA

Even if non-insureds can sue non-insurers under the UCPA, TeamHealth did not prove a violation of the Act. NRS 686A.310(1)(e) provides that it is an unfair practice to fail "to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear."

Again, TeamHealth's theory is that it was asserting rights under Nevada law that were independent from any rights under the ERISA-governed health benefit plans, which necessarily means TeamHealth did not make insurance "claims" under those plans triggering obligations under NRS 686A.310(1)(e). Additionally, to the extent

TeamHealth did make a "claim" subject to NRS 686A.310(1)(e), United's liability was not "reasonably clear" until the jury rendered its verdict—a verdict that found "reasonable value" in an amount that was never presented by any party during trial. The jury's compromise verdict thus confirms that this lawsuit constitutes, at worst, a good-faith "dispute over the value of claim," which is not actionable under NRS 686A.310. *Clifford v. Geico Cas. Co.*, 428 F. Supp. 3d 317, 325-26 (D. Nev. 2019); *see Lubritz v. AIG Claims, Inc.*, 2018 WL 7360623, *7 (D. Nev. 2018) (finding that "the extent of [the insurer's] liability has not become reasonably clear" when experts disputed amount of damages). Moreover, TeamHealth presented no evidence that United failed to negotiate in good faith regarding potential liability for any claim. *See Harter v. Gov't Employees Ins. Co.*, 2020 WL 458692, at *4 (D. Nev. 2020) (granting summary judgment under UCPA when insurer responded to demands and negotiated in good faith); *Amini v. CSAA General Ins. Co.*, 2016 WL 6573949, *6 (D. Nev. 2016) (same).

III.

THE PUNITIVE DAMAGES AWARD MUST BE REVERSED OR REDUCED

TeamHealth's core defense of the grossly excessive $60 million punitive damage award is that it was decided by a jury and thus is functionally immune from review by this Court. But this Court routinely vacates jury awards of punitive damages when the factual record, even viewed favorably toward the plaintiff, does not warrant the extraordinary remedy of punitive damages under Nevada law. AOB121. So it is here. The award must be overturned or, dramatically reduced.

A. Nevada Law Forbids Punitive Damages n These Facts

1. Punitive Damages Are Not Permissible in a Purely Commercial Dispute Between Sophisticated Business Entities With Comparable Bargaining Power and Only Compensable Economic Losses at Issue

Punitive damages are unavailable here because despite TeamHealth's hyperbole, this is an "ordinary breach of contract case" involving "experienced commercial entities" that "were never in inherently unequal bargaining positions," where the "only harm" TeamHealth even alleged was "easily compensated with money

damages." *Great Am. Ins. Co. v. General Builders, Inc.*, 113 Nev. 346, 354-56, 934 P.2d 257, 263 (1997). TeamHealth does not deny that it is a highly sophisticated commercial entity controlled by a billion-dollar Wall Street investment firm. Nor does it deny that its alleged injury was solely a business loss fully compensable in money damages. *Cf. Winchell v. Schiff*, 124 Nev. 938, 948, 193 P.3d 946, 953 (2008) (punitive damages unavailable for business losses).

TeamHealth nevertheless insists that it was in an "unequal bargaining position" because its affiliated providers are required under EMTALA to provide emergency medicine services to patients regardless of their ability to pay when those patients present to hospital emergency rooms; thus, when those patients happen to be members of United-administered or -insured plans, TeamHealth cannot bargain with United at the point of service over the fees payable for those services. RB99n.52. The point is both wrong and irrelevant. As discussed above, TeamHealth voluntarily elected to facilitate the hospitals' EMTALA obligations because doing so was in its best financial interests. *See supra* 20-22.

More importantly, TeamHealth's facilitation of EMTALA obligations does not create the kind of vulnerability to predation that can justify punitive damages. Even absent EMTALA, United has a contractual obligation under the health plans to approve payment for the services based on the terms of the health plans. EMTALA does not somehow authorize United to ignore those terms. If anything, EMTALA provides *TeamHealth* with enhanced bargaining power because it knows health plans must provide coverage for emergency medicine services and patients experiencing emergency do not have the luxury of selecting a network provider. Indeed, it is TeamHealth—not United—that has sought to leverage EMTALA by abandoning negotiations for network contracts and then unilaterally demanding full billed charges for its supposedly mandatory services.

TeamHealth also argues that United's conduct was "despicable" because United sought to "enrich itself" by disputing TeamHealth's full billed charges. RB94-96, 99n.52, 104. Again, hyperbole aside, TeamHealth's argument is just another way of complaining that United sought to avoid high costs and grow profits—decidedly normal business

behavior. *See Long Beach Memorial Medical Center v. Kaiser Foundation Health Plan, Inc.*, 286 Cal. Rptr. 3d 419, 430 (Ct. App. 2021) (rejecting claim that health insurer deserved punitive damages for intentionally underpaying hospital "with the alleged bad motive of trying to save money and turn a profit"). Punitive damages require much more, such as proof that United concealed its reimbursement rates or somehow tricked TeamHealth into improperly valuing its own services. AOB135. The record shows, however, that [redacted]. 109App.27,130:16-19. In fact, [redacted]. *See* 109App.27,126:15-20, 27,128:14-16, 27, 129:11-132:12; 110App.27,149:25-27,150:24; 148ReplyApp.36430. Most important, TeamHealth knew at all times what emergency medicine services were at issue, what TeamHealth itself believed about their value, and what benefit amounts United

allowed under the applicable health plans. There was no deception. At worst, United simply allowed reimbursement at rates lower than those TeamHealth was demanding. This case thus exemplifies precisely the kind of purely commercial dispute between sophisticated business entities for which punitive damages are unavailable under Nevada law.

TeamHealth's focus on United's business relationship with MultiPlan is baffling. MultiPlan is a third-party vendor that United retained to help determine reasonable reimbursement rates for out-of-network services under some but not all health plans. According to TeamHealth, United "secretly dictated" the rates MultiPlan recommended on the basis of MultiPlan's Data iSight pricing engine, giving a "false veneer of objectivity" to those rates. RB16-18, 96. Even on that inaccurate and tendentious characterization of the record, TeamHealth does not and cannot show how it ever was tricked into accepting reimbursements it otherwise would not have accepted. As just noted, TeamHealth always knew everything it needed to know about its own services and about the amount United allowed in reimbursement for those services.

TeamHealth in any event grossly misstates the record. Only two defendants used Data iSight to process less than six percent (6%) of the disputed claims. 42App.10,421:6-10,422:14, 10,488:20-10,492:4 (TeamHealth expert conceding "vast majority of disputed claims … do not touch Data iSight"). Data iSight—which TeamHealth's expert agreed was widely used by United's competitors, *see id.* 10,502:24-10,504:3; 37App.9,080:4-9,082:21, 9,088:12-25—on its own would "calculate[] an amount" that MultiPlan would identify as the "the reasonable reimbursement rate." 37App.9,012:24-9,013:8. TeamHealth presented no evidence that United dictated Data iSight's reimbursement rates; rather, to ensure compliance with certain federal regulations, United implemented an override that could only *increase* the reimbursement rate paid to the healthcare provider. *Id.* 9,011:4-9,013:8 ("if Data iSight is lower than the floor that we give, that claim[] gets" raised). Nothing in that record supports a punitive damages award.

TeamHealth also insists that "United was aware of its obligation to pay reimbursements to the Health Care Providers at reasonable

rates." RB100. But the question is whether United was aware of an obligation to pay reimbursements to TeamHealth *independent of United's obligations to plan members*. The answer is no. Additionally, the whole point of the trial was to establish what reimbursement rates were "reasonable" as a matter of Nevada common law. Even if United knew it was supposed to approve "reasonable" rates (whether under the plans or otherwise), TeamHealth cites nothing establishing that United somehow *knew* before trial what that unwritten Nevada legal standard was and that United *willfully* allowed payment at rates below that unknown standard.

Unable to show any fraud or oppression directed toward TeamHealth itself, TeamHealth focuses on harms supposedly suffered by *third parties*. RB104-05. According to TeamHealth, United should be punished severely because its conduct (1) harmed United's own members by causing TeamHealth to "balance bill" them for their treatments, and (2) harmed emergency-medicine patients in Nevada by reducing the statewide quality of care. RB96, 104-05. The argument is frivolous.

First, "the Constitution's Due Process Clause forbids a State to use a punitive damages award to punish a defendant for injury that it inflicts upon nonparties." *Philip Morris USA v. Williams*, 549 U.S. 346, 353 (2007).

Second, there is zero record evidence that TeamHealth balance-billed a single plan member for the disputed services. In fact, TeamHealth insisted below that its corporate policy *prohibited* balance billing and, in any event, TeamHealth successfully blocked discovery concerning its balance-billing practices. 40App.9,885:3-9,886:16; 29App.7,184-88.

Third, there is no evidence that United's business dispute with TeamHealth reduced the quality of emergency-medical care in Nevada. TeamHealth's contrary argument assumes that United's reimbursements reduced provider compensation, thereby attracting fewer or less competent doctors and nurses. RB1-2, 104. But TeamHealth itself *successfully opposed* United's efforts to discover and introduce evidence concerning the effect of reimbursement rates on the compensation of its affiliated providers. AOB21, 37, 46, 68-75. Had the

district court allowed litigation of such issues, the evidence would have shown that TeamHealth's *own* conduct reduced provider compensation. *See* Isaac Arnsdorf, *Medical Staffing Companies Cut Doctors' Pay While Spending Millions on Political Ads*, ProPublica (April 20, 2020), https://www.propublica.org/article/medical-staffing-companies-cut-doctors-pay-while-spending-millions-on-political-ads ("While cutting benefits for emergency room doctors and other medical workers, TeamHealth and Envision have spent millions on ads … to [oppose] legislation to cap out-of-network costs for Americans."). TeamHealth's need to justify punitive damages by fabricating claims about harms to nonparties confirms the complete absence of any basis in *this record* to support punitive damages.

TeamHealth also argues that even though it suffered only readily-compensable pecuniary injury, punitive damages are allowable because of United's involvement in a prominent academic study conducted by a leading professor of public health at Yale University, Dr. Zack Cooper. RB97-99. Dr. Cooper's work confirmed that emergency medicine providers' unilateral billed charges generally bear little to no connection

to actual rates paid for their services. *See* Z. Cooper et al., *Surprise! Out-of-Network Billing for Emergency Care in the United States*, J. Pol. Econ., Vol. 128; No. 9 (2020) ("Yale Study"), https://www.journals.uchicago.edu/doi/10.1086/708819.[5] According to TeamHealth, the Yale Study was a "massive fraud" akin to a study falsely showing that smoking has no ill effects. RB98. Yet remarkably, TeamHealth does not even *argue* that the Yale Study's conclusions were wrong in any way. Nor could it. The Study built upon and expanded other independent empirical work similarly finding that healthcare providers' "list prices" generally "are grossly inflated because they are set to be discounted rather than paid" and "certainly do not represent the usual price actually paid for the listed goods and services." George A. Nation III, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private*

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[5]Dr. Cooper first issued the Yale Study as a working paper in 2017 through the National Bureau of Economic Research, a "very respected premier economic research entity." 43App.10,741:4-10,742:11; Z. Cooper et al., *Surprise! Out-of-Network Billing for Emergency Care in the United States*, NBER (Working Paper 23623) (July 2017), https://www.nber.org/papers/w23623.

Insurers and Uninsured Patients, 65 Baylor L. Rev. 425, 429-430 (2013); *see What's The Cost?: Proposals To Provide Consumers With Better Information About Healthcare Service Costs, before the Committee On Energy And Commerce House Of Representatives*, 109th Cong. (2006) (Statement of Dr. Gerald F. Anderson, Johns Hopkins, Bloomberg School Of Public Health, Health Policy And Management) ("Too often list prices have no relationship to the prices that are actually being paid by insurers."). Courts nationwide have likewise agreed that healthcare providers' invoiced charges bear little connection to actual rates paid and accepted. AOB51n.8.

Although TeamHealth itself made the Yale Study an issue at trial, it somehow persuaded the district court to exclude the Study from the record, *see* 37App.9,232:7-9,234:6; 47App.11,566:8-21, hindering United's ability to rebut TeamHealth's baseless attacks. That indefensible asymmetry alone should preclude reliance on the Study to justify the punitive damages award.

In any event, TeamHealth's argument for punishing United because of Dr. Cooper's published research fails on its own terms. As

noted, TeamHealth does not dispute the accuracy of Dr. Cooper's conclusions. TeamHealth instead mainly complains that Dr. Cooper used data provided by United, but TeamHealth cites no flaws or omissions in the data, and there is no wrongdoing in obtaining data from commercial insurance companies, which "is essentially the only way to get this kind of information" because "you can't get this data just downloaded off the internet." 43App.10,744:10-10,745:23.[6]

TeamHealth also complains that United commented on a draft of the Yale Study before it was published, but that complaint is flatly contradicted by the trial record. TeamHealth confuses the Yale Study with the earlier NEJM Article, which did not mention TeamHealth and as to which United provided only minimal feedback. 4RA520-22 (PX32); 37App.9,232:4-9,234:6. And contrary to TeamHealth's suggestion that Dr. Cooper acted as United's paid mouthpiece, RB19, 97-98, the

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[6] Dr. Cooper disclosed in one of the world's most prestigious peer-reviewed medical journals that he "analyzed claims data from a large commercial insurer." Z. Cooper et al., *Out-of-Network Emergency-Physician Bills – An Unwelcome Surprise*, New England J. of Med., Vol 275; No. 1 (November 17, 2016) ("NEJM Article"), https://zackcooper.com/wp-content/uploads/2023/10/nejm-oon.pdf.

undisputed evidence showed that United never provided any funding for Dr. Cooper's work, 37App.9,232:7-9,234:6. Nor did United ask the *New York Times* to publicize the Yale Study—only Dr. Cooper himself "had extensive discussions with" the *New York Times*, 148ReplyApp.36428-29, and of course the Study's incontestable conclusions about inflated charges by emergency medicine providers were newsworthy research findings.

TeamHealth's position ultimately reduces to an argument that *United* was properly punished for *Dr. Cooper's* conduct. Yet even on TeamHealth's own account, Dr. Cooper's conduct in no way caused any of the economic harm for which TeamHealth was awarded compensatory damages in this case. Those damages arose solely from specific reimbursement disputes between TeamHealth and United over specific emergency medicine services rendered to specific United members in Nevada. The Yale Study had nothing to do with whether TeamHealth was underpaid for those specific services, unlike a tobacco study directly creating injuries by inducing consumers to smoke through false claims about tobacco safety. TeamHealth's complaints

about the Study are both unfounded and irrelevant.

2. Any UCPA Liability Here Would Be Entirely Novel and Thus Could Not Support Punitive Damages

Even if this Court holds in this case—for the first time—that the UCPA applies to a contract between a party that is often not acting as an "insurer" and a party that is not "its insured," such a novel UCPA liability theory could not support punitive damages. Under Nevada law, punitive damages cannot be awarded in a case where "the cause of action underlying any award of punitive damages was first adopted by this [C]ourt." *Mackintosh v. California Federal Sav. & Loan Ass'n*, 113 Nev. 393, 406, 935 P.2d 1154, 1163 (1997).

TeamHealth's only response is that United knew it was required to approve reimbursements at "reasonable rates." RB100. But what matters is whether TeamHealth proved that United knew its reimbursement rates for the disputed services were *un*reasonable because they violated unwritten Nevada common law standards. *See supra* 33-47. TeamHealth proved no such thing. Under these circumstances, *Mackintosh*—and the fair-notice principle it embodies—

precludes an award of punitive damages based on a violation of the UCPA.

3. The Unjust Enrichment Claim Is a De Facto Contract Claim and Thus Cannot Support Punitive Damages

TeamHealth's unjust enrichment claim cannot support an award of punitive damages because it is functionally a breach-of-contract claim. The only distinction is that the contract is implied in *law*, rather than in *fact*. AOB126-28.

It is beside the point that unjust enrichment "sounds in restitution rather than contract." RB102. Under Nevada law, even when a claim is not *labeled* "contract," punitive damages are unavailable if it *functions* as a contract claim. AOB127. The unjust enrichment claim certainly does so: its whole point is to imply a contract-at-law in the absence of a contract-in-fact. If the UCPA judgment is reversed—as it must be—then there is no tort or tort-like liability, which is the normal basis for punitive damages. Liability arises only from breach of a quasi-contract implied specifically to substitute for express contracts the parties did not enter.

TeamHealth insinuates that United's liability is more like tort than contract because United engaged in "deliberate wrongdoing." RB102. But as already discussed, there is no evidence that United knew in advance and deliberately violated unwritten Nevada common law standards of "reasonable value." *See supra* 33-47. And even when a party intentionally violates an express contract, Nevada law prohibits punitive damages for such "deliberate wrongdoing." *Sprouse v. Wentz*, 105 Nev. 597, 602, 781 P.2d 1136, 1139 (1989). If punitive damages are unavailable for the willful breach of explicitly-stated contractual obligations, they certainly cannot be available for the breach of unknown, unwritten obligations determined only after the fact.

B. The Punitive Damages Award at Least Must Be Reduced to Comply With Due Process Limitations

If the Court holds that Nevada law permits punitive damages in this purely commercial dispute, the award at least must be reduced to an amount below the $2.65 million compensatory damages award. AOB128-36.

1. Punitive Damages Cannot Exceed a 1:1 Ratio With Compensatory Damages in This Purely Commercial Dispute

TeamHealth quotes (RB107) the observation in *BMW of N. Am., Inc. v. Gore*, 517 U.S. 559 (1996), that due process limitations on the size of punitive damages awards are not subject to a "simple mathematical formula," *id.* at 582, but TeamHealth ignores the U.S. Supreme Court's subsequent declarations that the "ratio between compensatory and punitive damages" is a "central feature" of the "due process analysis," *Exxon Shipping Co. v. Baker*, 554 U.S. 471, 507 (2008), that "few awards exceeding a single-digit ratio between punitive and compensatory damages … satisfy due process," and that when compensatory damages are "substantial, then a lesser ratio, perhaps only equal to compensatory damages, can reach the outermost limit of the due process guarantee," *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408, 425 (2003). TeamHealth also ignores this Court's precedents requiring or affirming ratios in the 1:1 range in commercial disputes between business parties of comparable sophistication. AOB130-31. Perhaps most notably, TeamHealth does not cite a *single*

precedent upholding a ratio exceeding 1:1 in a commercial dispute involving readily-compensable economic losses, let alone a ratio approaching the outlandish nearly 23:1 aggregate ratio here.

2. The Due Process Reprehensibility Factors Do Not Justify a Ratio Exceeding 1:1

TeamHealth essentially concedes that two of the five due process "reprehensibility" factors militate *against* substantial punitive damages: only economic harm is at issue, and TeamHealth is not financially vulnerable. RB105.[7] Contrary to TeamHealth's submission, the other factors do too. AOB132-37.

TeamHealth mainly argues that United "evinced indifference or reckless disregard for the health and safety of others," *Gore*, 517 U.S. at 576, because it "implemented a scheme to enrich itself at the expense of hardworking emergency medical providers," RB104. But as already shown, TeamHealth itself blocked United from introducing evidence that reimbursement rates had *no* effect on provider compensation. In

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[7] TeamHealth passingly asserts that financial vulnerability could apply here, but it admits that "the jury heard no evidence regarding [TeamHealth's] financials." RB106n.54.

other words, TeamHealth itself ensured that this case was *not* about harms to doctors and nurses, but remained strictly a commercial dispute between a sophisticated health insurer and a sophisticated staffing company.

TeamHealth also contends that United's conduct was "intentional, not accidental," RB106, which is true only in the sense that United's reimbursements to TeamHealth were not *mistakes*. But essentially *all* commercial disputes will involve "intentional" conduct insofar as each party knows what position it takes and why. TeamHealth needed but failed to prove that United committed "deliberate false statements, acts of affirmative misconduct, or concealment." *Gore*, 517 U.S. at 579. There is no evidence that United knew its reimbursement rates were lower than whatever amount was required by unwritten Nevada common law or that United somehow tricked TeamHealth into accepting unreasonably low reimbursements. *See supra* 33-47. Indeed, TeamHealth *never asserted a fraud claim* and affirmatively *abandoned* any bad-faith claim before trial, *see infra* 76, tacitly conceding that it lacked evidence relevant to the due process reprehensibility factor.

TeamHealth also tries to justify the grossly inflated ratio here based on the "potential" or "likely" harm from United's conduct. RB106-07 (quotations omitted). But "potential harm" is legally relevant only as to "harm potentially caused *the plaintiff*," *Philip Morris*, 549 U.S. at 354, and TeamHealth cites no evidence of *any* potential further harm *to TeamHealth*, let alone any harm that would not be fully compensated by a damages award.

Finally, TeamHealth asserts in passing that the award is justified merely because of United's overall financial resources. RB107-08. The "wealth of a defendant," however, "cannot justify an otherwise unconstitutional punitive damages award." *State Farm*, 538 U.S. at 427. And this award is patently unconstitutional, as every relevant factor confirms.

C. Any Punitive Damages Award Is Subject to a Statutory Cap

If the Court holds that due process permits an award greater than compensatory damages, the statutory cap on punitive damages in NRS 42.005(1) would be triggered, limiting punitive damages here to three times compensatory damages, or about $7.95 million.

According to TeamHealth, however, the statutory cap does not apply because of the exception for claims against an "insurer who acts in bad faith regarding its obligations to provide insurance coverage." NRS 42.005(2)(b). But TeamHealth is not seeking "insurance coverage"—the only insureds are the health plans and their members, and their benefit claims are governed exclusively by ERISA. *See infra* 83-95.

The insurance bad-faith exception to the punitive damages cap also does not apply because TeamHealth abandoned any "bad faith" tort claim before trial, 47App.11,582 ("We're not pursuing bad faith as a basis for punitive damages."), and its second amended complaint included no claim for breach of the covenant of good faith and fair dealing, *see* 21App.5,246-5,264. According to TeamHealth, however, this Court held in *Guaranty National Insurance Co. v. Potter*, 112 Nev. 199, 912 P.2d 267 (1996), that bad faith can be found even absent a tort claim whenever the insurer acted "unreasonably and with knowledge that there is no reasonable basis for its conduct." RB109 (quoting *Potter*, 112 Nev. at 206, 912 P.2d at 272). *Potter* holds no such thing.

To the contrary, *Potter involved a bad faith tort claim*—the passage TeamHealth quotes merely explains that the tort claim can be proved with evidence that the insurer knew it was acting unreasonably. *See* 112 Nev. at 206, 912 P.2d at 272. Nothing in *Potter* suggests that the bad-faith insurance exception to the punitive damages cap applies even when no insurance bad-faith tort claim is asserted.

IV.

THE DISTRICT COURT ERRED IN AWARDING PENALTY PREJUDGMENT INTEREST AND ATTORNEYS' FEES UNDER THE PROMPT PAY ACT

The district court awarded $12 million in attorneys' fees and $800,000 in prejudgment penalty interest under the Prompt Pay Act ("PPA"),[8] which requires prompt and full payment of claims that have been "approved" and are "fully payable." Repeating the court's error, TeamHealth argues that even if a claim is approved and promptly paid at a certain amount, the insurer is still liable under the PPA if a court

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[8] As in the opening brief (AOB141n.20), this reply cites the PPA as "PPA(#)" for ease of reference.

later determines that the insurer should have allowed a higher payment amount. RB136-37. TeamHealth is wrong for multiple reasons.

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

The PPA requires timely payment for "a claim relating to health insurance coverage." PPA(1). Either TeamHealth did not make claims for coverage under the applicable health plans because its claims for relief arise under state law and are independent of the plans, in which case the PPA does not apply, or TeamHealth disputed United's payment of benefit claims under the health plans, which is a process governed exclusively by ERISA. AOB142-44.

TeamHealth tries to escape this dilemma through a lengthy and confusing discursion on preemption under ERISA § 514. According to TeamHealth, even if its action "relates to" the ERISA-governed benefit plans in a colloquial sense, it does not "relate to" them within the meaning of § 514. RB127-30. TeamHealth is wrong about § 514, *see infra* 83-95, but the more important point here is that to avoid § 514

preemption, TeamHealth has repeatedly asserted that its suit *does not seek benefits under the health plans at all*. 1App.111 (asserting that liability theory is "not derivative or dependent upon the terms of any particular patient's benefit plan in any way—the terms of the patients' benefit plans are irrelevant"); 21App.5,247n.1 (Second Amended Complaint); 4App.763n.7 ("[The Health Care Providers] are not seeking to recover against United for any claims arising under their plans with their insured."). Accepting that assertion at face value, TeamHealth cannot now change course to defend the PPA judgment by arguing that its suit *does* assert "claims" for benefits as an "insured" under ERISA-governed plans. *Cf. S. Cal. Edison v. First Judicial Dist. Court*, 127 Nev. 276, 285-86, 255 P.3d 231, 237 (2011) (applying judicial estoppel where party took "inconsistent positions"). But if TeamHealth did make benefit claims under the health plans, then its civil action is unambiguously preempted both by ERISA § 514 and ERISA § 502(a). *See infra* 83-95.

B. TeamHealth Failed to Exhaust Its Administrative Remedies

The PPA does not provide an express private cause of action. But even if the Court decides to imply a private right of action, TeamHealth was *at least* required to exhaust its administrative remedies before filing suit. TeamHealth admittedly did not do so, precluding suit under the PPA.

Rather than provide for enforcement through private suit, the Nevada insurance code confers on the Insurance Commissioner "*exclusive* jurisdiction in regulating the subject of trade practices in the business of insurance in this state." NRS 686A.015(1) (emphasis added); *see Thorpe*, 123 Nev. at 571, 170 P.3d at 993. Nothing in the PPA expressly overrides that provision by authorizing a district court to exercise original jurisdiction over a PPA claim. TeamHealth argues only that a private right of action can be indirectly *implied* from the PPA's provision for an award of attorneys' fees to a prevailing party. RB132. But as United has shown, that provision allows an attorneys' fee award for the prevailing party in a petition for judicial review of the

Commissioner's rulings, which is consistent with the Commissioner's exclusive jurisdiction to resolve insurance disputes in the first instance. NRS 686A.015(1). That reading also makes sense of the PPA's statement that "the Commissioner determines" whether the challenged conduct complies with the PPA and whether to take remedial action. PPA(8). Because the PPA establishes the underlying substantive rights, the proceeding would qualify as an "action brought pursuant to" the PPA, contrary to TeamHealth's submission. RB134. And the fact that attorneys' fees are otherwise *generally* unavailable in judicial review proceedings involving agencies (RB134) merely confirms that the Legislature wanted successful PPA petitioners *in particular* to be made whole when they successfully appeal the Commissioner's adverse findings.

Even if this Court were to imply a private right of action based on the PPA's attorneys' fees provision, that action would not become ripe until claimants first exhausted their remedies before the Commissioner. *Cf. Richardson Const., Inc. v. Clark Cty. School Dist.*, 123 Nev. 61, 66, 156 P.3d 21, 24 (2007) (acknowledging "the doctrine of primary

jurisdiction occasionally requires courts to refrain from exercising jurisdiction, so that technical issues can first be considered by a governmental body"). "The exhaustion doctrine gives administrative agencies an opportunity to correct mistakes and conserve judicial resources, so its purpose is valuable; requiring exhaustion of administrative remedies often resolves disputes without the need for judicial involvement." *Thorpe*, 123 Nev. at 571-72, 170 P.3d at 993-94. When an administrative agency has primary jurisdiction over a claim, the failure to exhaust administrative remedies with that agency "renders the controversy nonjusticiable." *Id.* at 571, 170 P.3d at 993.

In short, if the PPA applies at all, the district court lacked jurisdiction either because the Commissioner's jurisdiction is exclusive, or because it is primary and TeamHealth did not exhaust the Commissioner's remedies.

C. United Made Timely Payments in the Amounts Allowed by the Applicable Benefit Plans

The PPA is not a statute governing the substantive bases on which health plan members and healthcare providers may challenge the

benefits allowed under the members' health insurance plans. As its name suggests, the PPA ensures only *timely* approval or denial of benefit claims and *timely* payment of the sums certain an insurer has approved. *See* PPA(1). It does not provide a civil remedy for alleged *substantive underpayments* of benefit claims. That is, the PPA solely "regulates *how quickly* an insurer must pay," not "*how much* an insurer must pay." *Em. Dep't Physicians P.C. v. United Healthcare, Inc.*, 507 F. Supp. 3d 814, 825 (E.D. Mich. 2020).

The PPA prohibits partial payment only "of a claim that *has been approved* and *is fully payable*." PPA(4) (emphasis added). Here, the amounts in dispute were not "approved" or deemed "fully payable." TeamHealth contends that "fully payable" means "whatever amount a jury later decides was owed," RB137, but it cites no authority supporting that remarkable interpretation, which contradicts its own admission that "the PPA regulates *timing* of payment, not *amount* of payment." RB136. TeamHealth also asserts that United *knew* what amounts were "fully payable," *id.*, but as already noted, there is no evidence in the record that United knew what amounts a jury

ultimately would decide were required by Nevada's unwritten common law, *see supra* 33-47. Indeed, TeamHealth itself had no clue how much was actually owed—it demanded only its full billed charges, which the jury flatly rejected, awarding only a small fraction of that exorbitant demand.

V.

TEAMHEALTH'S BRIEF CONFIRMS THAT THIS LAWSUIT IS PREEMPTED BY ERISA § 514 AND § 502(A)

This Court's prior order did not "conclusively" hold that TeamHealth's suit was "not preempted." RB110. The Court instead denied a writ of mandamus at the pleading stage, where the Court was compelled to accept as true the *allegation* that TeamHealth had entered an "implied-in-fact contract with United" that established only "a *rate* of payment" for services, which the Court considered to be "separate" from any "*right* to benefits" established by the ERISA-governed health plans themselves. *United Healthcare Insurance Company v. Eighth Judicial Dist. Court*, Case No. 81680 (Order Denying Petition, July 1, 2021), at 3 (emphasis in original). Now that the trial has been conducted and a

factual record established, this Court is no longer bound by the allegations and theories asserted in an untested complaint. The Court instead is bound by the actual basis for liability established at trial, and TeamHealth's brief aggressively insists that United was held liable for violating the plan terms, which compels preemption under long-settled doctrine.

Two strands of ERISA preemption doctrine are relevant here. First, ERISA § 514 expressly preempts "any and all State laws"—including common-law claims—"insofar as they may … relate to any employee benefit plan." ERISA § 514, 28 U.S.C. 1104. Contrary to TeamHealth's response brief—and a few erroneous judicial opinions—§ 514 preemption is not a doctrine of *implied* "conflict" preemption, where the preemptive effect of a federal statute is implied from a conflict between federal and state law. *See Pharma. Care Mgmt. Assoc. v. Mulready*, 78 F.4th 1183, 1192-93 (10th Cir. 2023) (distinguishing express preemption from implied conflict preemption); *Nathaniel L. Tindel, M.D., LLC, v. Excellus Blue Cross Blue Shield*, 2023 WL 3318489, at *4-6 (N.D.N.Y. 2023) (same). Rather, § 514 preemption is

an *explicit statutory command* that requires courts to reject enforcement of any state law, regulation, or common-law rule that makes "reference to" or has a "connection with" employee benefit plans. *See N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 653 (1995).[9]

Second, § 514 preemption includes a narrower (but more powerful) form of preemption under ERISA § 502(a), 42 U.S.C. § 1132(a), which establishes the exclusive scheme for the enforcement of employee benefit plan terms. Section 502(a) preempts state laws (including tort claims) that do not just "relate to" benefit plans, but in particular provide alternative remedies for violation of plan terms, because § 502(a)'s exclusive remedial structure "would be completely undermined if ERISA-plan participants and beneficiaries were free to

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[9] TeamHealth wrongly asserts that the "relates to" phrase in § 514 "does not comport with common usage." RB127. The phrase must be afforded "broad *common-sense* meaning, such that a state law 'relates to' a benefit plan in the *normal sense* of the phrase," rather than "to the furthest stretch of indeterminacy." *Pilot Life*, 481 U.S. at 81 (emphasis added). That "common-sense" understanding is reflected in the "connection with" and "reference to" standards. *See Travelers*, 514 U.S. at 653.

obtain remedies under state law that Congress rejected in ERISA." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). A state-law claim triggers § 502(a) preemption if the plaintiff, "at some point in time, could have brought his claim under" ERISA § 502(a), and the state-law claim does not implicate an "independent duty" apart from the defendant's plan obligations. *See Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004).[10]

Any state-law claim that seeks to remedy a violation of plan terms necessarily "relates to" those plan terms and thus triggers preemption under both § 502(a) and § 514. But as TeamHealth admits (RB130n.68), § 514 preemption "is significantly broader than complete preemption." *Cotton v. Massachusetts Mut. Life Ins. Co.*, 402 F.3d 1267, 1281 (11th Cir. 2005); *see Darcangelo v. Verizon Comms., Inc.*, 292 F.3d

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[10] The narrower but more powerful form of preemption under § 502(a) is described as "complete" because § 502(a)'s remedial scheme is deemed *so* exclusive that it not only *bars* state-law claims seeking alternative remedies for the violation of plan terms, but *transforms* them into federal claims under § 502(a) itself, thereby allowing for removal to federal court. *See id* at 208-09; *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 65-66 (1987).

181, 191 n.3 (4th Cir. 2002); *Tindel*, 2023 WL 3318489, at *5 n.6. Section 514 preemption thus can apply even when § 502(a) does not, i.e., even when the plaintiff lacked its own § 502(a) claims and even when the claim implicates an independent legal duty.

TeamHealth's brief confirms that its claims are preempted under the foregoing principles. While its complaint may have *alleged* the existence and breach of a state-law duty independent of the health plans, TeamHealth's response brief repeatedly declares that its suit *as tried* rested on supposed proof that United *violated the plans' terms*. According to TeamHealth, United's liability arises from what TeamHealth says is the "despicable" practice of "retaining for itself funds that had been earmarked by health plans for the payment of emergency medical claims." RB87; *see* RB4, RB15, RB42, RB91, RB93, RB104; *see also* RB97 (TeamHealth "presented evidence of plan language requiring reimbursement at reasonable and customary rates—requirements that United ignored"). As TeamHealth now admits, United's liability thus derived directly from its supposed violation of health plan terms governing reimbursements—a claim that

necessarily "relates to" those plan terms.

As this Court previously recognized, ERISA would preempt TeamHealth's state-law claims if they challenged United's compliance with payment obligations under the terms of the health plans themselves, rather than its compliance with wholly independent state-law duties. *See* Case No. 81680 (Order Denying Petition). The Court was unwilling to find preemption when United's liability was only alleged and theoretical, but now that liability has actually been imposed and its rests on an asserted violation of plan terms, preemption has become unavoidable. *See Neurological Surgery, P.C. v. Aetna Health Inc.*, 511 F. Supp. 3d 267, 291-92 (E.D.N.Y. 2021) (lawsuit asserting that defendant failed to pay "the amounts that should have been paid" by health plan is preempted because plan terms are "the basis for the claimed benefits").[11]

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[11] To explain the liability in the terms discussed in this Court's prior opinion, the case as tried sought to establish a "right to payment" under the plans, rather than merely the "rate of payment" owed under an independent *non*-plan state-law obligation. In a non-preempted "rate" of payment case, "'the basic right to payment has already been

The trial record distinguishes this case from the lengthy string-cite of decisions proffered by TeamHealth. RB115-17 & n.60. Like this Court's prior decision, all but one of those decisions were issued at the pleading stage, where the courts *assumed* that plaintiffs *could* establish liability based on a distinct legal obligation disentangled from the obligation imposed on the health insurer or TPA under the plan itself.[12]

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established" by a non-plan source, such as an express or implied contract, leaving only a "remaining dispute" about whether the payer paid the full "rate" owed under the non-plan obligation. *N.J. Plastic Surgery Ctr., LLC v. 1199SEUI Nat'l Benefit Fund*, 2023 WL 5956142, at *20 (S.D.N.Y. 2023); *see Plastic Surgery Ctr., P.A. v. Aetna Life Ins. Co.*, 967 F.3d 218, 229-33 (3d Cir. 2020). "By contrast, 'right to payment' claims … 'implicate coverage and benefits established by the terms of the ERISA plans.'" *N. Jersey Plastic Surgery*, 2023 WL 5956142, at *20; *see Taylor B. Theunissen, M.D., LLC v. United Healthcare of Louisiana, Inc.*, 2023 WL 2913523, at *4 (E.D. La. 2023) ("A right of payment claim … is alleged when the provider is claiming … underpayment because the insurer denied full payment for 'medically necessary' services."). In short, "right of payment" claims are claims for "amounts that should have been paid" under health plan terms, *Neurological Surgery, P.C. v. Aetna Health Inc.*, 511 F. Supp. 3d 267, 292 (D.N.J. 2021), which is exactly what TeamHealth asserted at trial.

[12] The sole exception is *Long Island Thoracic Surgery, P.C. v. Bldg. Serv. 32BJ Health Fund*, 2019 WL 7598669 (E.D.N.Y. 2019), *report and recommendation adopted*, 2019 WL 5060495. But the plaintiffs there did not assert that the defendant withheld payments

Even accepting that premise, it has no application here, where the *actual* basis for United's liability rests directly on the putative "right to payment" under the health plans' "earmarking" of benefit-payment terms. *See Advanced Orthopedics & Sports Medicine Institute, P.C. v. Oxford Health Ins. Co.*, 2022 WL 1718052, at *8 (D.N.J. 2022) (explaining that "allegation[s] of an independent agreement for reimbursement of services at the [usual and customary] fee" do not withstand ERISA preemption when actual "facts suggest that Plaintiff's claims … flow from the insured's plan").

According to TeamHealth, its state-law claims do not implicate § 514 because they "do not impose direct obligations on ERISA plans." RB117. But as TeamHealth itself insists, its state-law claims as tried sought to *enforce* the health plans' terms—specifically, their terms governing reimbursement and disposition of plan assets. As shown above, ERISA preempts not only state-law claims that would expand plan obligations, but also claims that seek to impose supplemental

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earmarked by the health plans for the providers. *See* 2019 WL 7598669 at *14.

state-law remedies for the violation of existing plan obligations. *See supra* 84-86. Because the state-law claims here impose both compensatory and punitive remedies for United's supposed violation of plan terms, they are preempted on that basis alone, regardless of whether they *also* impose new obligations directly on the plans.

In any event, the judgment below does increase the health plans' legal obligations. Although the judgment in terms applies only to United, the payment obligation it imposes legally *must* be borne by the health plans or their sponsors, because the plans or sponsors have [redacted]. 143App.35,402, 35,404-05, 35,411-12.[13] Moreover, for self-

[13] While United is financially responsible for benefit claims related to fully-insured plans (less cost-sharing amounts owed by patients), this distinction does not matter because TeamHealth waived any argument that ERISA § 514's savings clause permits its state-law causes of action to be brought against fully-insured plans. *See Mulready*, 78 F.4th at 1193 n.5, 1204-05; *FMC Corp. v. Holliday*, 498 U.S. 52 (1990); *Nationstar Mortg.*, 133 Nev. at 752.

funded employee benefit plans, nothing in any plan document imposes on United an obligation to pay from its *own assets* the amount owed to healthcare providers. *See, e.g.*, *id.* at 35,404-05, 35,415-16 ([redacted]). Because the obligation to pay TeamHealth for healthcare provided to plan members rests solely with the health plans, the judgment below necessarily alters plan obligations.

TeamHealth's contrary argument relies on *Rutledge v. Pharmaceutical Care Management Association*, 592 U.S. 80 (2020), but *Rutledge* has no application here. Most importantly, the claims in *Rutledge* did not seek to impose state-law remedies for violation of plan terms governing reimbursements and disposition of plan assets. Nothing in *Rutledge* overrides 35-plus years of precedent—dating back to *Pilot Life*—squarely holding that ERISA preempts state-law tort claims that provide their own remedies for the violation of plan terms. *See supra* 85.

TeamHealth in any event misconstrues *Rutledge,* as do the various decisions cited by TeamHealth, *see* RB124-25. As other courts

have recognized, *Rutledge* does not create a "broad" exception to ERISA preemption, but trains narrowly on "state law actions that are merely about money and affect costs." *Huff v. BP Corp. N. Am.*, 2023 WL 8802698, at *2 (10th Cir. 2023); *see Mulready*, 78 F.4th at 1194, 1199-1201. *Rutledge* involved a state law that directly regulated "pharmacy benefit managers" ("PBMs"), which are specialty service providers often retained by health plans to provide prescription drug benefits to plan members. 592 U.S. at 83-84. As *Rutledge* explains, a PBM arranges for pharmaceutical benefits through two distinct express contracts. On one side, a PBM contract with pharmacies "typically set[s] reimbursement rates according to a list"—called a "formulary"—"specifying the maximum allowable cost (MAC) for each drug." *Id.* at 84. On the other side, a PBM contract with each health plan specifies "the amount that [the] plans reimburse" the PBM for the drugs. *Id.* The "difference" between the amount the PBMs pay the pharmacies and the amount they receive from the health plans "generates a profit for PBMs." *Id.*

The state regulation at issue required PBMs to pay pharmacies certain minimum amounts for their formulary drugs, which had the

indirect economic effect of increasing plan costs, to the extent a PBM sought to "pass along" its own higher mandated costs by negotiating for higher reimbursements in its plan contracts. *Id.* at 89. The PBMs argued that the indirect effect on plan costs was sufficient to trigger ERISA § 514 preemption, but the U.S. Supreme Court was unpersuaded. Section 514 was not implicated, the Court held, because the law did "not require plans to provide any particular benefit to any particular beneficiary in any particular way." *Id.* at 88-90.

Contrary to TeamHealth's submission, United's position is not "analogous" to the position of the PBMs in *Rutledge*. RB121-22. For one thing, as already noted, TeamHealth's state-law claims seek to impose a remedy for violation of plan terms, unlike the state law in *Rutledge*. Further, unlike the PBMs in *Rutledge*, United does not purchase emergency medicine services in bulk and resell them to health plans at higher rates, taking the difference as profit. Rather, under its plan agreements, United—both as TPA and insurer—simply approves payment for services at the benefit amount *dictated by the plan documents*. *See, e.g.*, 143App.35,405. And as shown above, self-funded

plans bear sole contractual responsibility for any increased reimbursement amounts. *See supra* 90-91. Accordingly, any state law obligation requiring emergency medicine providers be paid certain minimum amounts for services *necessarily* will be borne by the plan itself as a matter of law, not as an indirect economic effect. *See AMISUB (SFH), Inc. v. Cigna Life & Health Ins. Co.*, 2023 WL 8232887, at *9 (W.D. Tenn. 2023) (finding materially identical reimbursement claim preempted because they "would require the Court to interpret reimbursement procedures and rates of the self-funded plans themselves rather than the policy of an intermediary, as was the case in *Rutledge*"); *Griffin v. AT&T Servs., Inc.*, 2023 WL 3213550, at *6 (N.D. Ga. 2023) ("*Rutledge*, if anything, reinforces the notion that state laws cannot dictate ERISA-governed plan terms").

This case would be like *Rutledge* if the health plans had agreed to pay *United* a certain rate for emergency medicine services, and United in turn paid a lower rate to emergency-medicine providers, taking the difference as profit. Under those circumstances, a law increasing the rate United must pay providers would not directly affect plan benefits,

because the plan would still pay the same rate to United. But in this case, the plans and their members will *not* pay the same amount to United, because they do not pay United *any* amount. They instead will be compelled by their own plan terms to pay higher amounts *to* *TeamHealth*. Unlike in *Rutledge*, then, the plans cannot "provide benefits as they [see] fit," requiring preemption under § 514. *Mulready*, 78 F.4th at 1200-01; *see AMISUB*, 2023 WL 8232887, at *9.

VI.

UNITED'S HIGHLY SENSITIVE AND PROPRIETARY MATERIAL SHOULD BE PROTECTED

TeamHealth and its amicus curiae Reporters Committee for Freedom of the Press ("Reporters Committee") essentially assume that because judicial proceedings are presumptively public—an undisputed premise—then United's confidential business information necessarily must be disclosed. RB138-44; RC3-11.[14] They are incorrect. Under their rule, it would be essentially impossible for any business entity to

[14] RC refers to the Reporters Committee's brief.

vindicate its rights at trial without suffering severe collateral competitive injury. Fortunately, the law is otherwise: even in judicial proceedings, a private party's confidential information may remain confidential so long as the party demonstrates a need for confidentiality that outweighs the public interests in disclosure.

United easily satisfied that burden here. The material at issue involves protected trade secrets and other highly sensitive competitive business information, which TeamHealth wants unsealed *not* for any legitimate litigation-related purpose, but solely to create public spite and/or scandal. Writ24-66. Just four days after it filed this lawsuit, TeamHealth's CEO told United that it "pursued litigation as a strategy" and "the public fight is going to be ugly." 148ReplyApp.36430-31. With that threat echoing loudly, United understandably adopted a cautious approach to confidentiality designations—an approach starkly vindicated by TeamHealth's later conduct during discovery and trial.

United's appeal presents two issues.[15] The first is whether the

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[15] The sealing orders are appealable because they were

district court's disclosure order is justified by the record. United submits it is not, and that the order should be reversed, allowing United to maintain the confidentiality of its sensitive competitive information. The second is whether the district court conducted the correct analysis in mandating disclosure. It did not. At a minimum, if the order is not reversed outright, the Court should remand with instructions to re-analyze the protected materials under the proper standards and determine whether disclosure is required.

TeamHealth's principal response to both arguments—a response amplified by the Reporters Committee—is that United waived or lost its right to maintain confidentiality of the documents at issue. The argument is patently incorrect. United sought protection of the documents at issue before, during, and after trial. TeamHealth and the Reporters Committee cite cases holding that the right to protection is

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incorporated into the final judgment. In an abundance of caution to prevent public disclosure of the records, United filed a writ petition, which has been consolidated with this appeal. Dkt. No. 23-09597; AOB164. If the Court does not agree that the sealing orders are appealable, it should grant the relief requested in the writ petition.

lost when information has already been publicly disclosed, even if the party objected to the disclosure. But here, pursuant to agreement, both parties publicly disclosed on the trial livestream only portions of certain admitted exhibits—in many cases, only short passages. And United now seeks sealing only of confidential information that was *not* disclosed on the livestream. Cases rejecting protection for already-disclosed information have no bearing here.

TeamHealth and the Reporters Committee fare no better in defending the district court's sweeping, categorical approach to confidentiality determinations, which eschewed the careful balancing required by rule and precedent. Contrary to TeamHealth's submission, United is not questioning the public's presumptive right to access judicial documents. The issue, rather, is whether the district court properly balanced that right—which, critically, is only a *presumptive* right—against United's valid competing interests in protection of its highly sensitive business information and trade secrets. Rather than seriously consider United's interests, the district court relied on sweeping bright-line determinations that covered swathes of documents

without considering their content. Writ12, 18-21. The court certainly did not "meticulously review each redaction on each page of each document at issue," as TeamHealth asserts. RB142. Not even close.

This Court should reverse and order United's documents sealed or redacted. At a minimum, it should remand so that the district court can apply the correct standards to the sealing analysis.

A. United Did Not Waive Protection for the Confidential and Proprietary Information at Issue

TeamHealth's argument against continued protection of United's confidential information rests largely on the false factual premise that United did not adequately preserve its arguments for confidentiality below, and on the false legal premise that any exhibits admitted into evidence necessarily entered the public domain. RB139; RC19. On the true facts and the correct legal standards, United is entitled to maintain confidentiality of this proprietary information.

1. Documents Admitted at Trial Can Be Sealed If the Moving Party Sought Protection and the Information Is Not Accessible to the Public

TeamHealth and the Reporters Committee contend that once a document is admitted into evidence, it automatically loses any

entitlement to confidentiality. RB139-40; RC12-22. For that startling proposition, TeamHealth relies on a single case, *Phillips v. C.R. Bard, Inc.*, 2015 WL 3485039 (D. Nev. 2015). *Phillips* holds no such thing. The court there merely held that the materials at issue could not be sealed because the party seeking protection *did not move to seal* the information during trial. *Id.* But United *did* move to seal this evidence during trial. *See infra* 104-05. *Phillips* is therefore inapposite.

The Reporters Committee proffers an additional raft of citations, RC12-22, but they too are irrelevant. The Reporters Committee cites them only for the unexceptionable principle that judicial records cannot be sealed if the information is actually in the public domain, *id.*, which is not true here, *see infra* 102-07, 111-13, 115-16. Some of the cases merely hold—like *Phillips*—that if a party did not move to seal documents during trial, then they are effectively in the public domain and cannot be sealed post hoc. *See United States v. Posner*, 594 F. Supp. 930, 935 (S.D. Fla. 1984); *United States v. Carpenter*, 526 F. Supp. 292, 295 (E.D.N.Y. 1981). In the other cases, the public already had *actual access* to the information sought to be sealed. *E.g.*, *The Fla.*

Star v. B.J.F., 491 U.S. 524, 538 (1989) (government published information to media); *L.V. Rev.-J v. Eighth Jud. Dist. Ct.*, 134 Nev. 40, 44-45, 412 P.3d 23, 27 (2018) (press already obtained and published information); *Gambale v. Deutsche Bank AG*, 377 F.3d 133, 144 (2d. Cir. 2004) (prior publication that was "highly accessible"); *Va. Dep't of State Police v. Washington Post*, 386 F.3d 567, 578-80 (4th Cir. 2004) (media extensively reported on information publicly released by government); *In re Knight Publishing Company*, 743 F.2d 231, 235 & n.1 (4th Cir. 1984) (emphasizing actual public "availability" of documents); *Flores v. U.S. Immigr. & Customs Enf't*, 2018 WL 5825314, at 3 (W.D. Wash. 2018) (presumption of public access to court records cannot be overcome when "public has already accessed the documents").

These cases do not remotely suggest that a party's confidential information cannot be sealed merely because it has been admitted into evidence, *even when the party sought to have the information sealed*. To the contrary, they establish that sealing is permitted so long as the requesting party sought protection and *the information was not otherwise already available to the public*. Here, United sought prior

protection and the public has had no access to the confidential material, as the next section shows.

2. United Sought Protection Before, During, and After Trial

While TeamHealth and the Reporters Committee concede that United sought protection *after* trial, they contend that United waived protection *during* trial and is now seeking retroactive sealing of documents that are already public. RB33-35, 139-40; RC12-18. They are quite wrong.

Before trial, United sought to enforce the existing protective order's procedure for use of sensitive information at trial. Writ9-12; *see, e.g.*, 1SealApp.69-78 (United's objection to media request). The district court proclaimed at that time that any exhibit admitted at trial would not be sealed. Writ9-12, 41. Still, the court acknowledged that the courtroom could at times be sealed, but also announced that it would not always seal the courtroom to protect United's information because it did not want to "interrupt the presentation of [TeamHealth's] case." 1SealApp.238:19-39:4. Because that approach satisfied neither party,

United and TeamHealth brokered a deal to protect the contents of exhibits without having to close the courtroom: the parties would not identify on the record the contents of certain exhibits and only the jury, witness, district court, and attorneys could view the contents. Writ12-13; RB33; 2SealApp.493:22-494:15. TeamHealth itself recognized that the sealing issues would be resolved after trial and that this process preserved the sealing issues for this appeal. 1SealApp.112 (TeamHealth's proposal that the courtroom would not be closed included its promise to "not oppose any post-trial motions to seal the documentary evidence that comes into trial"); RB33-34.

During trial, the parties adhered to their agreement and United moved to seal all exhibits. TeamHealth nevertheless contends that United failed in various respects to protect its confidential material adequately at trial. TeamHealth's arguments lack merit.

First, TeamHealth first attempts to dilute the agreement to handle sealing issues post-trial, contending that United sought protection *only* for 19 "Attorneys Eyes Only" ("AEO") documents and then tried to "massively expand[]" that protection post-trial. RB33-34.

Incorrect. After the court vitiated the prior protective order, United sifted through the 400-450 documents on TeamHealth's pre-trial exhibit list to identify specific exhibits that needed continued protection. 2SealApp.493:22-494:4. TeamHealth's exhibit list had numerous gaps, which it filled in during the course of trial. *See, e.g.*, 26App.6495; 27App.6501-33 (Joint Pretrial Memorandum: TeamHealth "intentionally omitted" hundreds of documents from exhibit list, including PX299); 45App.11093:6-15 (Trial day 16: TeamHealth provided United with PX299 "yesterday or the day before"). TeamHealth also replaced listed exhibits with completely different documents. Because of the moving target, it was literally impossible for United to provide one single complete list of documents that needed to be protected. TeamHealth recognized this reality and raised no objections at trial when additional documents became subject to the parties' protection agreement. 37App.9,189:25-9,190:7 (TeamHealth conceding the "list grew during the course of trial" (cleaned up)); *e.g.*, 36App.8,904:1-10 (adding PX464); *id.* 8,917:17-8,918:5 (adding PX426); 38App.9,253:7-9,254:1 (adding PX403); *id.* 9,342:14-22 (adding PX76);

39App.9,536:16-22 (adding PX288). In the end, many more than 19 trial exhibits were not published or discussed in front of the jury, which ensured that their contents were never made public and therefore could be sealed post-trial.

Second, TeamHealth and the Reporters Committee contend that United's motion to seal was filed only *after* trial. RB34, 139; RC15. Wrong again. On November 10, 2021, *during trial*, the district court granted United's oral motion to seal all trial exhibits. 37App.9,034:14-9,035:10. United then supplemented that oral motion with a written motion *during trial* on November 11, 2021, which was also granted. 17SealApp.3824. And the district court expressly reminded TeamHealth *during trial* that United had a pending motion to seal all trial exhibits that would be resolved post-trial. 7SealApp.1727:12-17. The December 5, 2021 post-trial motion cited by TeamHealth explicitly noted that the court had "ordered that the trial exhibits would remain under seal until the parties could brief the issue" post-trial. 17SealApp.3893. That motion simply commenced the post-trial briefing process contemplated by the parties and district court.

Third, TeamHealth and the Reporters Committee assert that the trial exhibits were already publicly disclosed through the livestreaming of the trial. RB138; RC18-22. Wrong yet again. Specifically to ensure their continued protection, the trial exhibits *were not displayed on the livestream*, as TeamHealth recognized at trial. 32App.7,881:4-5 ("I am told these documents" i.e., trial exhibits, "are not being displayed … on the BlueJeans link.").[16] TeamHealth and the Reporter's Committee insist the exhibits' contents were nonetheless functionally disclosed on the livestream because every exhibit was "testified about extensively." RC16 (citing testimony regarding DX5499, DX4569, P073, P096, P473, and P025); RB34. But TeamHealth does not cite a single trial exhibit that United seeks to protect that was "discussed in open court" in a manner that disclosed confidential contents and thus waives protection. The Reporters Committee does proffer examples, but they only confirm that the documents were *not* all discussed extensively or in detail. One

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[16] The Reporters Committee cites articles reporting on the exorbitant punitive damages award, RC26-27, but they discuss only the *verdict*—none of the cited articles discuss the contents of any exhibit.

cited exhibit, DX5499, is a 182-page document concerning United's relationship with its self-funded-employer client; only *3 pages* were discussed at trial. *Compare* 5SealApp.1040-53, *with* 17SealApp.4042 (requesting to redact "limited highly confidential information"). Similarly, DX4569 is a multipage email containing commercially sensitive information; only 3 sentences from 1 email were discussed at trial. *Compare* 5SealApp.1054-61, *with* 17SealApp.4041 (requesting to redact "limited highly confidential information").

United is not seeking on appeal to protect exhibits and testimony that were read into the record in open court, only the confidential information that was not. *Compare* 34App.8,354:11:8-13 (admitting P073 without any testimony of its contents), *and* 5SealApp.1070 (discussing page 9 of P073), *with* 17SealApp.4001-02, 4030 (seeking to redact information that was not discussed before jury), *and* 15SealApp.3687 (denying redactions to pages 2-5). TeamHealth's focus on the relatively small amount of information that *was* discussed entirely misses the point.

Fourth, TeamHealth argues that United "subsequently *withdrew*"

its request for protection for "a number of exhibits" before the February 10, 2022 sealing hearing. RB139-40 (emphasis in original) (citing 2RA302-44). TeamHealth is referring to United's narrowing or removal of redactions to comply with the district court's prior order categorically denying protection requests. 2RA307-08, 313 ("To comply with the Court's rulings from the bench …, Defendants have … *removed* redactions" (emphasis in original)); *accord* RB37 (conceding that changes were product of "the application of the district court's ruling"). Those adjustments did not provide the public with access to the information. *See* 32SealApp.7644:2-7645:7 (removing public from February 10 motion to seal hearing). The information accordingly remains subject to protection.

B. The District Court Misapplied the Governing Standards

All agree that the presumptive right to access judicial records is not absolute. Writ30; RB140-41; RC12, 21; *Howard v. State*, 128 Nev. 736, 740, 291 P.3d 137, 140 (2012). The presumptive right of access derives from the public's interest in disclosure of the information, but "a court must determine the weight of this presumption as applied to a

particular judicial document." *Valassis Commc'ns, Inc. v. News Corp.*, 2020 WL 2190708, at *2 (S.D.N.Y. 2020). When the public's interest in disclosure of a private party's given document is outweighed by competing public and private interests in the continued confidentiality of certain information, protection is warranted. SRCR 3(4); *accord* RB140-41.

One important factor justifying protection is a threat that "court files might become a vehicle for improper purposes." *Kamakana v. City & Cty. of Honolulu*, 447 F.3d 1172, 1179 (9th Cir. 2006). The potential that pricing, profit, and customer usage information will be used against a company in contract negotiations can also provide a compelling reason to seal information. *See Apple v. Samsung Elecs. Co. Ltd.*, 727 F.3d 1214 (Fed. Cir. 2013). When a party shows that such interests would be implicated by disclosure, the court must then "conscientiously balance[] the competing interests of the public and the party who seeks" protection. *Kamakana*, 447 F.3d at 1179.

Contrary to TeamHealth's submission, the district court did not "meticulously review[]" United's protection requests to render the

"careful determinations" required by SRCR 3(4). RB142. The district court instead issued categorical pronouncements based on misunderstandings of the facts and law, which the parties had to interpret and then apply to individual documents. Writ12, 17-21. TeamHealth and the Reporters Committee's efforts to defend that approach are unpersuasive.

First, they contend that the court correctly applied a bright-line temporal rule in ruling that United's highly sensitive business information and trade secrets were stale and underserving of protection. RB143; RC19. That argument fails to appreciate that "confidential business information dating back even a decade or more may provide valuable insights into a company's current business practices that a competitor would seek to exploit." *Encyclopedia Brown Prods., Ltd. v. Home Box Off., Inc.*, 26 F. Supp. 2d 606, 614 (S.D.N.Y. 1998). TeamHealth musters just one half-century old precedent to justify a bright line staleness rule, RB143n.75 (citing *United States v. IBM*, 67 F.R.D. 40 (S.D.N.Y. 1975), but as one court subsequently observed in explicitly rejecting *IBM*, "it is terribly difficult to establish,

on any principled basis, temporal boundaries governing the protection to be accorded information," because "[o]ld business data may be extrapolated and interpreted to reveal a business' current strategy, strengths, and weaknesses," and thus "in the hands of an able and shrewd competitor, old data could indeed be used for competitive purposes." *Zenith Radio Corp v. Matsushita Elec. Indus. Co.*, 529 F. Supp. 866, 891-92 (E.D. Pa. 1981). Many other courts agree. Writ59-62 (collecting cases). In this case, documents from 2019 with a five-year roadmap of future business plans that contain financial targets still can easily be used against United by its competitors. Writ61. The district court erred when it categorically relied solely on the age of information to determine whether it was stale.

Second, TeamHealth argues that United's competitors would not benefit from disclosure of its confidential business plans because all companies in the insurance industry are essentially identical. RB143. The argument has no basis in the record or reality. *See* Writ46n.6. As in any identifiable "industry," different companies may compete to provide similar products, but as in any industry, each company's

product has its own unique features and each company has its own business priorities, pricing strategies, partnership objectives, customer targets, investment plans, and so on. *See Nev. Indep. v. Whitley*, 138 Nev. 122, 131, 506 P.3d 1037, 1045 (2022) (holding trade secrets are still protectable despite public's knowledge of competitors being identical in some fashion, e.g., their pricing of a good or service). Unsealing United's confidential business strategy documents would disclose to United's negotiating counterparts—e.g., providers, clients, or business partners—its geographic priorities, self-perceived strengths and vulnerabilities, contract-proposals, and the like, vastly weakening United's hand in commercial negotiations. 17SealApp.4009-10. These are precisely the reasons courts protect confidential pricing, profit, and customer usage information. *See Apple*, 727 F.3d at 1225.[17]

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[17] TeamHealth asserts that "United effectively conceded" at trial that it is identical to its competitors. RB143n.74. No, it did not. In the passage TeamHealth cites, United's counsel merely observed that it and its competitors all offer out-of-network cost control programs to attract self-funded employer business. 2SealApp.397:3-398:2. That hardly constitutes a concession that United and its competitors are identical in their business strategy, products, pricing and operations. As United's

Third, TeamHealth asserts that United's confidential business information lacks protectable value because United is a publicly-traded company that files public financial statements, Form 10-Ks and 10-Qs. RB142 (citing 31SealApp7493:17-20).[18] But public companies obviously do not publicly report every internal calculation they make about pricing, contract proposals, and business strategies. *See Whitewater W. Indus., Ltd. v. Pac. Surf Designs, Inc.*, 2019 WL 1590470, at *2 (S.D. Cal. 2019) (public companies maintain confidential financial metrics that are protectable). For example, PX273 is a 198-page presentation that contains internal operating income figures, including projections into 2026. 31SealApp.7467:9-25. These internal metrics are used for business planning purposes and are not publicly disclosed. *Id.*

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expert testified, United and its competitors all have "*some kind* of a program to control out-of-network" spend, but that the industry is "constantly changing" and is "never static." 46App.11,292:20:11-11,294:8 (emphasis added).

[18] The language quoted in TeamHealth's brief is not found at its citation to the district court's ruling. TeamHealth is quoting itself and assuming the district court adopted its argument. 12SealApp.2991:22-2992:1.

Disclosing them plainly would benefit United's competitors and thereby harm United. Writ23. The fact that United is publicly-traded utterly is irrelevant.

Fourth, TeamHealth contends that the lack of disclosure to the jury does not, by itself, justify sealing of evidence. RB141-42; RC16-18. United agrees—it has never argued that information not shown to the jury is *necessarily* entitled to protection. The point, rather, is that the public's interest in disclosure of information the parties did not consider important enough to publish to the jury is less weighty than the interest in disclosure of information actually used at trial, which more directly implicates the "public interest in understanding the judicial process." *Hagestad v. Tragesser*, 49 F.3d 1430, 1434 (9th Cir. 1995); *see* Writ33-36.

Courts recognize that because the information contained in judicial records "fall somewhere on a 'continuum,'" the appropriate weight to be given to the public's presumptive right to access depends on "the role of the material at issue … and the resultant value of such information to those monitoring" the trial. *United States v. Amodeo*, 71

F.3d 1044, 1049 (2d Cir. 1995). In particular, the public interest in "information as part of a court record is low" when that information "was irrelevant to the issues tried," *In re Nat'l Consumer Mortg., LLC*, 512 B.R. 639, 641 (D. Nev. 2014), or is not "the ultimate subject of a dispositive ruling," *Zenith Radio Corp.*, 529 F. Supp. at 907; *see United States v. Hubbard*, 650 F.2d 293, 317-18 (D.C. Cir. 1980) (sealing information because it would not increase public understanding of case). Those principles mandate substantial redactions in many trial exhibits here, but the district court failed to conduct the required balancing and order appropriate redactions.[19]

Starkly illustrating TeamHealth's careless attitude towards United's legitimate confidentiality interests in certain admitted documents, TeamHealth treats as exemplary one document that it

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[19] The Reporters Committee cites precedents mandating disclosure of information not presented to the jury, RC17, but the materials in those cases were either integral to the issue tried, *Posner*, 594 F. Supp. at 935 (tax returns in tax fraud prosecution), or otherwise relied upon by the court itself, *Carnegie Mellon Univ. v. Marvell Tech. Grp., Ltd.*, 2013 WL 1336204, at *5-6 (W.D. Pa. 2013). Neither circumstance applies here.

describes as "merely containing inspirational quotes from legendary football coach Vince Lombardi." RB27, *see* 140n.72. In fact, the document TeamHealth cites is a 119-page presentation containing business plans, financial analysis, and market analysis of zero relevance to this lawsuit. 125App.30965-1083. Yes, the material was presented with a whimsical quarterback theme—quoting Lombardi once on page 3, *id.*—but the material United seeks to protect is *the substantive business information* in the document, the vast majority of which was not discussed before the jury. *Compare* 125App.30965-1083, *with* 36App.8.915:3-19:25 (only five pages presented).

If this Court does not mandate redaction of this document or others on the existing record, it should at least direct the district court to consider whether and how public disclosure of every admitted exhibit without redaction would help the public understand the issues tried.

Finally, TeamHealth complains that the declarations United submitted in support of protection were too "nonspecific" and "scant" to establish that disclosure of the information at issue would cause United harm. RB143-44. But the declarations clearly advised the court that

the exhibits contained United's "[redacted]," as well as analysis of United's "[redacted]." 17SealApp.3952, 3960-61. The declarants also warned that the exhibits would give United's competitors "[redacted]." *Id*. That information was more than adequate to identify the competitive harms that would result from public release. *See Valassis*, 2020 WL 2190708, at 6-9 (finding sufficient declarations that informed court of "interest in maintaining the secrecy" and stated that disclosure "would harm [movant]'s competitive prospects"). The court did not deny protection because it lacked information about potential harms to United—it denied protection because it wrongly deemed business confidentiality interests unworthy of protection.

What remains after correcting the district court's errors is TeamHealth's quest to foment public spite and scandal through release

of United's highly sensitive business plans and trade secrets. 148ReplyApp.36431 ("the public fight is going to be ugly"). TeamHealth moved documents into evidence at trial for no purpose other than defeating United's confidentiality interests by admitting them into the record. *See, e.g.*, 36App.8,901:1-16 ("I just needed to admit it. We're not going to look through it."); Writ35. Under settled precedent, however, courts should "refuse[] to permit their files to serve as … sources of business information that might harm a litigant's competitive standing" or where "files might … become a vehicle for improper purposes," such as "to gratify public spite or promote public scandal. … or to release trade secrets." *Kamakana*, 447 F.3d at 1179; *see Amodeo*, 71 F.3d at 1051 ("Commercial competitors seeking an advantage over rivals need not be indulged in the name of monitoring courts"). This Court should vacate the district court's order and either order the documents protected or remand and instruct the court to review the confidential information using the correct legal standards.

CONCLUSION

For the foregoing reasons, the judgment should be reversed. The case should be remanded for entry of judgment for United, or in the alternative for a new trial. The Court should direct the district court to seal United's confidential and trade secret information.

Dated this 9th day of January, 2024.

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CERTIFICATE OF COMPLIANCE

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

2. I certify that this brief exceeds the type-volume limitations of NRAP 32(a)(7) because, except as exempted by NRAP 32(a)(7)(C), it contains 21,923 words.

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

DATED this 9th day of January, 2024.

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RULE 28(f) ADDENDUM OF OUT-OF-STATE DECISIONS

Tab	Document	Date	Pages
1	*Emergency Physician Services of New York, et al. v. UnitedHealth Group, Inc., et al.*, Case No. 1:20-cv-09183 (JGK), United States District Court (S.D.N.Y), Teleconference/Decision	08/11/22	1–11
2	*Emergency Group of Arizona Professional Corp., et al. v. UnitedHealthcare of Arizona, Inc., et al.*, Case No. CV 2019-004510, Superior Court of Arizona, Maricopa County, Rulings Re: Motions for Summary Judgment and Motion to Exclude Expert Witness	11/20/23	12–32

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
----------x

EMERGENCY PHYSICIAN SERVICES OF NEW YORK, *et al*,

Plaintiffs,

v. 20 Civ. 9183 (JGK)

UNITEDHEALTH GROUP, INC., *et al*,

Defendants. Teleconference/Decision

----------x

New York, N.Y.
August 11, 2022
3:30 p.m.

Before:

HON. JOHN G. KOELTL,

District Judge

APPEARANCES

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BY: DIMITRI PORTNOI
ETHAN M. SCAPELLATI

(Teleconference)

(Case called)

THE COURT: Who's on the phone for the plaintiff?

MS. DOWD: Good afternoon, your Honor.

This is Sarah Dowd of Binder & Schwartz, on behalf of plaintiffs. I'm joined by my colleagues Wendy Schwartz of Binder & Schwartz, and Justin Fineberg of Lash & Goldberg.

THE COURT: Who's on the line for the defendant?

MR. PORTNOI: This is Dimitri Portnoi of O'Melveny & Myers, on behalf of defendant. On the line is my colleague Ethan Scapellati.

THE COURT: All right. Good afternoon, all.

I wanted to talk to you because I felt some urgency because there are objections to discovery rulings by the magistrate judge and the request to make an immediate motion for summary judgment. So I'm prepared to rule on the objections to the magistrate judge's discovery rulings.

I'm familiar with the papers. Before I do, is there anything that the parties want to add to their papers?

MR. PORTNOI: Your Honor, Dimitri Portnoi, on behalf of defendants.

There's nothing in particular that we wish to add. Obviously if your Honor has questions, you know, that would be the most useful part of argument and presentation.

THE COURT: Plaintiff?

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MS. DOWD: Your Honor, this is Sarah Dowd.

There's nothing the plaintiffs have to add either.

THE COURT: Okay.

So let me take the discovery rulings.

The plaintiff, Emergency Room Clinicians, brought this suit against the defendants for allegedly underpaying thousands of claims for medical services the plaintiffs provided to patients covered by insurance issued or administered by the defendants. The defendants have brought objections to three discovery rulings by Magistrate Judge Netburn. See ECF Nos. 158 to 160.

The defendants also seek leave to file an immediate action for summary judgment, arguing that New York law bars the plaintiffs' unjust enrichment claim. The magistrate judge's discovery order must be upheld, unless it is clearly erroneous or contrary to law. Federal Rule of Civil Procedure 72(a).

Under this highly deferential standard, magistrate judges are afforded broad discretion in resolving nondispositive disputes, and reversal is appropriate only if discretion is abused. *Williams v. Rosenblatt Securities, Inc.*, 236 F. Supp. 3d 802, 803 (S.D.N.Y. 2017).

I should add that particular deference is given to the magistrate judges on discovery rulings because of their familiarity with the discovery process.

The defendants object to the magistrate judge's ruling

that the defendants must produce strategy and profit-motive documents. The defendants argue that these documents are nationwide and, therefore, irrelevant to the determination of the reasonable value of emergency medicine services rendered in the specific geographic regions within New York. Magistrate Judge Netburn expressly stated that the defendants must produce only documents that pertain to regions that are relevant to New York. See ECF No. 171-3 at 35.

These documents are relevant to the issue of how the defendants determined the amounts paid for the medical services provided, which is relevant to the plaintiffs' unjust enrichment claim. See *Id.* Accordingly, it was not clearly erroneous or contrary to law for the magistrate judge to require the defendants to produce these documents.

The defendants also object to the Magistrate Judge Netburn's ruling denying the defendants discovery of complaints or disputes from patients, hospitals, or other facilities about the amounts charged by the plaintiffs for their services. Such complaints are not relevant to the determination of a reasonable fee for the plaintiffs' services. Magistrate Judge Netburn reasonably concluded that such complaints are too speculative and fact-specific to bear on the reasonableness of the amounts charged by the plaintiffs. See ECF No. 171-2 at 45. Therefore, the defendants' objection to this ruling is also overruled.

The defendants also object to Magistrate Judge Netburn's ruling denying the defendants discovery on the plaintiffs' costs of rendering the services at issue. See ECF 158.

Under New York law, which the parties agree governs the plaintiffs' unjust enrichment claim, one factor for determining a reasonable fee for emergency medicine services is the usual and customary cost of the service. New York Financial Services Law, Section 604(f).

New York law defines usual and customary costs not by reference to the provider's cost of rendering the service, but rather by reference to the 18th percentile of all charges for the particular healthcare service performed by a provider in the same or similar specialty and provided in the same geographical area. *Id.* Section 6035.

Thus, the plaintiffs argue that reimbursement under New York law is a price-based rather than a cost-based determination, and that the plaintiffs' costs are not relevant to any disputed issue. But the plaintiffs' costs are relevant to determining whether the defendants were unjustly enriched.

Under New York law, to prevail on a claim for unjust enrichment, a plaintiff must establish:

One, that the defendant benefited; two, at the plaintiff's expense; and three, that equity in good conscience require restitution. *Beth Israel Medical Center v. Horizon*

Blue Cross and Blue Shield of New Jersey, Inc., 448 F.3d 573, 586 (2d Cir. 2006).

In this case, if the defendants reimburse the plaintiffs at a rate equal to or above the plaintiffs' costs for rendering the services at issue, then the defendants did not benefit at the plaintiffs' expense. This principle was recognized by the court in *N.Y.C. Health and Hospitals Corp. v. WellCare of New York, Inc.*, 937 N.Y.S.2d 540, 545 (Supreme Court 2011).

"Where a hospital is required by law to treat patients in emergency rooms, 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."

Judge Nathan relied on this holding in denying the defendants' motion to dismiss the plaintiffs' unjust enrichment claim. *See Emergency Physician Services of New York v. UnitedHealth Group, Inc.*, No. 20 Civ. 9183, 2001 WL 4437166 *12, (S.D.N.Y. Sept. 28, 2021).

Although Judge Nathan concluded that the plaintiffs stated a claim for unjust enrichment, whether the defendants are liable for unjust enrichment and whether the defendants benefited at the plaintiffs' expense are issues that are still subject to dispute. And while the plaintiffs' amended complaint focuses on the reasonable value of the plaintiffs'

services rather than the plaintiffs' actual costs, it is surely relevant to the plaintiffs' unjust enrichment claim to determine if the plaintiffs were reimbursed at a rate equal to or above their actual costs.

As the plaintiffs acknowledge, the plaintiffs are not suing under the New York Financial Services Law, and that statute does not provide the exclusive criteria for determining the compensation that the plaintiffs are entitled to under New York common law. Accordingly, the plaintiffs' costs of rendering the services at issue are relevant and the defendants' objection to this ruling is sustained.

That leaves the issue of the defendants' request to make an immediate motion for summary judgment concerning whether New York law bars the plaintiffs' unjust enrichment claim.

The defendants are permitted to make such a motion under the Federal Rules of Civil Procedure, and the defendants can proceed with the motion. However, the motion should not be used as an excuse to delay ongoing discovery. Accordingly, the Court will not stay discovery while the motion is being briefed. The defendants may make a motion for summary judgment within 21 days; the plaintiffs should respond 21 days thereafter; reply papers must be filed 14 days thereafter.

The Court has considered all of the arguments raised by the parties. To the extent not specifically addressed

above, the arguments are either moot or without merit.

For the reasons explained above, the defendants' objections are overruled with respect to the magistrate discovery rulings concerning, one, the defendants' strategy and mode of documents; and two, complaints about the amounts charged by the plaintiffs.

Defendants' objection with respect to the plaintiffs' cost information is sustained.

The defendants may file a motion for summary judgment consistent with the briefing schedule set out above, which will be reiterated in a scheduling order. Discovery will not be stayed while the motion for summary judgment is being briefed and under consideration.

So ordered.

I particularly wanted to talk to the parties about the scheduling of the motion for summary judgment.

I don't prevent parties from making a motion that they're entitled to make under the rules; so that's why the defendant has the right to make the motion for summary judgment. I question whether it's advisable to do that because, as I understand the scheduling order, discovery is going to be completed in January, isn't it?

MR. SCAPELLATI: Your Honor, this is Ethan Scapellati. That is correct.

THE COURT: So by the time the defendant makes a

motion for summary judgment, you're perhaps two months down the line, end of September perhaps, maybe a little later. I may not get to the motion or decide it before the end of discovery, at which time you may well want to make a more comprehensive motion. So one wonders why you would single this motion out.

It's troubling to me just from a case management standpoint, why, if this motion was so clear, and why, if it really didn't depend on the results of discovery, it was not made far earlier than the request to make it now. And that's one of the reasons why I thought it was appropriate not to stay discovery, because since the motion could have been made earlier, I didn't want any implication that the motion could be used as simply a means to derail discovery.

Now, I appreciate the argument that the law was not as clear as the defendants say that the law is now, but the argument was certainly there earlier.

So my bottom line is, you know, if you think that a motion is appropriate now, defendants have the right to make the motion; so you don't need any further premotion conference, I've given you a schedule. But in thinking about it -- and I'm not going to preclude you from making yet another motion for summary judgment just because this one may not be successful. But, again, I question whether from lots of standpoints it makes sense to make the motion.

MR. PORTNOI: Your Honor, this is Dimitri Portnoi for

defendant.

First, in addition to the law not being as clear, I wanted to clarify, having the disputed claims list and having the ability to compare those claims to plans, there were reasons why this wasn't raised in the motion to dismiss.

But I obviously take to heart and wish to consider your Honor's advisement on the wisdom and, you know, the fact -- and share with my client the -- your discussion, especially, you know, with regards specifically to timing. And if there is -- and we definitely, of course, thank you for giving us the opportunity to make that motion in 21 days.

I just want to know, if our client decides not to make that motion in 21 days, would you prefer that we simply let that lapse or would you prefer that we file a notice advising you that we will be --

(Indiscernible crosstalk)

THE COURT: First of all, a letter would be fine.

And second, I think 21 days is certainly sufficient to make the motion. If you ask for a little more tame to make the motion and the response and the reply, I'd be amenable to that. Of course, this brings you even closer to the cutoff of discovery.

MR. PORTNOI: Oh, I understand. That wasn't the import of my question. It was simply that with respect to timing, I meant your point that the motion may not be decided

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until close to the end of discovery regardless, given both the state of discovery and when your Honor will be able to get to that -- get to the motion. That's what I wanted to share with my client. I agree that I believe that a motion that is focused on a legal issue that is not focused on a dig into the facts, 21 days will be sufficient to do that.

THE COURT: Okay. Great.

Anything further from any of the parties?

No.

MS. DOWD: Not from plaintiffs, your Honor.

MR. PORTNOI: Not from defendants, other than to thank your Honor for hearing from us today and for the careful warning.

THE COURT: Sure.

Okay. Great. Bye now. Stay safe.

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Clerk of the Superior Court
*** Electronically Filed ***
11/21/2023 8:00 AM

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MARICOPA COUNTY

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HONORABLE CHRISTOPHER COURY

CLERK OF THE COURT
S. Ortega
Deputy

EMERGENCY GROUP OF ARIZONA PROFESSIONAL CORP, et al.

ROBERT D MITCHELL

v.

UNITEDHEALTHCARE OF ARIZONA INC, et al.

ROBERT M KORT

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ERROL KING
JENNIFER LEE-COTA
MALVIKA A SINHA
JOHN ZAVITSANOS
KATHERINE MANNINO
JUDGE COURY

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RULINGS RE: MOTIONS FOR SUMMARY JUDGMENT AND MOTION TO EXCLUDE EXPERT WITNESS

Multiple motions are pending before the Court. The Court has reviewed and considered all of the following:

I. United's Motion for Summary Judgment.

A. *United's Motion for Summary Judgment*, filed September 1, 2023 ("United's Motion"), together with the statement of facts and exhibits filed concurrently therewith;

B. *Plaintiffs' Opposition to United's Motion for Summary Judgment*, filed October 2, 2023, together with the controverting statement of facts and additional facts filed concurrently therewith;

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C. *United's Reply in Support of Motion for Partial Summary Judgment,* filed October 23, 2023;

II. MultiPlan's Motion for Summary Judgment.

D. *MultiPlan's Motion for Summary Judgment*, filed September 12, 2023 ("MultiPlan's Motion"), together with the statement of facts and exhibits filed concurrently therewith;

E. *Plaintiffs' Opposition to MultiPlan's Motion for Summary Judgment*, filed October 2, 2023, together with the controverting statement of facts and additional facts filed concurrently therewith;

F. *MultiPlan's Reply in Support of Motion for Partial Summary Judgment,* filed October 23, 2023;

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III. United's Motion to Exclude Opinions of David Leathers.

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G. *United Defendants' Motion to Exclude the Opinions and Testimony of Plaintiffs' Expert, David Leathers*, filed September 1, 2023 (the "Leathers Motion"), together with the exhibits filed concurrently therewith;

H. *Plaintiffs' Response to United's Motion to Exclude the Opinions and Testimony of Plaintiffs' Expert, David Leathers*, filed October 2, 2023, together with the exhibits filed concurrently therewith; and

I. *United Defendants' Reply in Support of Motion to Exclude the Opinions and Testimony of Plaintiffs' Expert, David Leathers,* filed October 23, 2023.

Additionally, the Court has reviewed and considered the arguments and authorities presented during the oral argument held on November 8, 2023.[1]

This claim involves the following basic facts. The two remaining plaintiffs identified in Paragraph 2 *infra.* (collectively "Plaintiffs") are entities that employ medical professionals who

[1] Plaintiffs also filed *Plaintiffs' Supplemental Memorandum in Opposition to United's Motion to Exclude the Opinions and Testimony of Plaintiffs' Expert, David Leathers* on November 14, 2023. Plaintiffs did not seek leave of Court prior to filing this. Briefing was closed and oral argument had concluded. This filing is not permitted by the *Arizona Rules of Civil Procedure* or by Court Order and will be disregarded as an impermissible Sur-Reply.

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provide emergency medical services in Arizona healthcare facilities. At the times of the claims asserted, Plaintiffs did not have a written contract with any of the United Defendants ("United") concerning reimbursement rates; therefore, they are deemed "out-of-network" providers. Plaintiffs have sued United and MultiPlan alleging that Plaintiffs have suffered millions of dollars in damages, calculated as the difference between what they received in payment from United and what they claim they should have been paid (the "Reduced Payment"). Plaintiffs' allege that the Reduced Payment resulted from a plan between United and MultiPlan to reduce payments.

Plaintiffs seek damages from United and MultiPlan under a number of theories. Defendants raise several challenges to these claims in the present motions. Both United and MultiPlan challenge Plaintiffs' standing to bring all of their claims. In addition, United raises substantive challenges concerning certain claims: Count I: Plaintiffs' Breach of Implied-in-Fact Contract claim; Count III: Plaintiffs' Unjust Enrichment claim; and Count V: Plaintiffs' Unlawful Acts claim asserted pursuant to A.R.S. § 13-2314.04. In addition to joining in United's motion, MultiPlan also raises its own substantive challenge, seeking dismissal of the sole claim asserted by Plaintiffs against it: Claim V: Plaintiffs' Unlawful Acts claim asserted pursuant to A.R.S. § 13-2314.04. Both United and MultiPlan argue that no genuine issue of material fact exists, and that Plaintiffs are without evidence to support one or more elements of each of the challenged claims. Plaintiffs disagree, arguing that the evidence supports the conclusion that a genuine issue of material fact exists and that the challenged claims should proceed to trial and be decided by a jury.

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Summary judgment is appropriate only if no genuine issue of material fact exists and the moving party is entitled to judgment as a matter of law. *See* Rule 56(a), *Arizona Rules of Civil Procedure*; *Orme School v. Reeves*, 166 Ariz. 301, 305, 802 P.2d 1000, 1004 (1990); *Hourani v. Benson Hosp.*, 211 Ariz. 427, 432, 122 P.3d 6, 11 (App. 2005). All facts must be viewed in the light most favorable to the nonmoving party. *See Grain Dealers Mutual Insurance Co. v. James*, 118 Ariz. 116, 575 P.2d 315 (1978); *Farmers Ins. Co. v. Vagnozzi*, 138 Ariz. 443, 448, 675 P.2d 703, 708 (1983). The moving party bears the burden of demonstrating through admissible evidence that no genuine issue of material fact exists. *See Nat'l Hous. Indus., Inc. v. E.L. Joes Dev. Co.*, 118 Ariz. 374, 377, 576 P.2d 1374, 1377 (App. 1978); *Sanchez v. City of Tucson*, 191 Ariz. 128, 130, 953 P.2d 168, 170 (1998); *Nat'l Bank of Ariz. v. Thurston*, 218 Ariz. 112, 180 P.3d 977, 981 (App. 2008). Additionally, "summary judgment is not proper where possible inferences to be drawn from the circumstances are conflicting." *Executive Towers v. Leonard*, 7 Ariz. App. 331, 439 P.2d 303 (1968).

THE COURT FINDS as follows:

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A. <u>Standing</u>.

1. United and MultiPlan argue that the two remaining Plaintiffs do not have standing to bring any of the claims asserted. The basis of this argument focuses on the fact that neither of the two remaining Plaintiffs are entities that ultimately suffered any of the alleged pecuniary injuries.

2. The two remaining Plaintiffs are:
   a. Emergency Group of Arizona Professional Corp.; and
   b. Emergency Physicians Southwest, P.C. ("EPSW").

3. Plaintiffs are correct that, in Arizona, there is no constitutional requirement to decline to hear a case on grounds of standing. As such, whether to deny standing, or to hear a case, "is a matter of 'prudential or judicial restraint.'" *City of Surprise v. Ariz. Corp. Comm'n,* 246 Ariz. 206, 209 ¶ 8 (2019) (quoting *Dobson v. State ex rel. Comm'n on Appellate Court Appointments,* 233 Ariz. 119, 121 ¶6 (2013)). Indeed, the Arizona Supreme Court has explained standing as follows:

> We have previously determined that the question of standing in Arizona is not a mandate since we have no counterpart to the "case or controversy" requirement of the federal constitution. In addressing the question of standing, therefore, we are confronted only with questions of prudential or judicial restraint. We impose that restraint to insure that our courts do not issue mere advisory opinions, that the case is not moot and that the issues will be fully developed by true adversaries. Our court of appeals has explained that these considerations require at a minimum that each party possess an interest in the outcome.

Armory Park Neighborhood Ass'n v. Episcopal Community Services in Arizona, 148 Ariz. 1, 6, (1985).

4. "The issue in Arizona is whether, given all the circumstances in the case, a party possesses an interest in the outcome of the litigation." *Citibank (Arizona) v. Miller & Schroeder Financial, Inc.*, 168 Ariz. 178, 182 (App. 1990) (citing *Armory Park,* 148 Ariz. at 6). "The concept of justiciability requires a court to decline a case if a dispute is so lacking and/or the parties are so situated that court's determination would be merely advisory." *Id.*

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5. Plaintiffs employ medical professionals, who are supplied to, and provide services at, emergency medical facilities (such as emergency rooms) in Arizona.

6. After emergency services are provided by Plaintiffs' medical professionals, the charges for the services are billed to insurance companies, including United, for payment. Plaintiffs, however, do not do the billing – that is done by another entity.

7. When United pays for the services provided by Plaintiffs, the funds are deposited into Plaintiffs' bank account.

8. After Plaintiffs' costs (employee salaries, expenses, etc.) are paid, every dollar collected by Plaintiffs is, and must be, transferred to a non-party – Quantum Plus, LLC ("Quantum"). The transfer occurs on a daily basis. It is Quantum which retains the right to keep 100% of the net collections from Plaintiffs' medical services.

9. During the time period covered by this lawsuit, it is undisputed that all of Plaintiffs' expenses have been covered, and all of the medical professionals who provide services on behalf of Plaintiffs have been paid in full.

10. Based on this arrangement – i.e. the undisputed fact that Plaintiffs retain no right to keep any additional sums of money in the event that United had paid more money in reimbursement for the services rendered – Defendants argue that Quantum, and not Plaintiffs, has the ultimate financial interest in the outcome of this litigation, under the circumstances.

11. Given the unique factual circumstances at issue in this lawsuit, the Court disagrees with both parties that standing must be determined as an "all or nothing" proposition. Rather, the Court believes that applicable law requires Plaintiffs' standing to be considered on a claim-by-claim basis to ensure that a decision on each claim is not purely advisory. *Citibank (Arizona)*, 168 Ariz. at 182.

12. With respect to Count I (Breach of Implied Contract), Plaintiffs allege that an implied contract exists and was breached. This alleged agreement is between United ***and Plaintiffs***, not between United and Quantum. Even though Quantum, through its separate contract with Plaintiffs, is contractually entitled to receive funds transferred from Plaintiffs daily, United still pays Plaintiffs (not Quantum) for services provided by Plaintiffs' medical professionals. Unlike Plaintiffs' unjust enrichment claims – which, as pled, focuses solely on the ultimate financial benefit and impoverishment – Plaintiffs' breach of implied contract seeks damages which are broader – loss of use of money. [Second Amended Complaint, ¶ 166] Plaintiffs' use of money before such

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funds are ultimately transferred to Quantum,[2] coupled with Plaintiffs' power to refuse to transfer money to Quantum (in breach of Plaintiffs' contract with Quantum) constitute substantial rights so as to create a justiciable controversy. The Court's determination about whether an implied contract exists, and if so, whether it was breached, is not an advisory decision. Plaintiffs have an interest in the outcome and, therefore, standing to assert Count I.

13. Because standing exists with respect to Count I, standing also exists for Count II: an alleged breach of the duty of good faith and fair dealing that is implied in law on the basis of every contract in Arizona.

14. With respect to Count III, standing does not exist. For Plaintiffs to be able to bring this claim, Arizona law requires that no contract exist between Plaintiffs and United. As such, for this claim, one focus is on the impoverishment suffered.[3] Because Plaintiffs, and the medical providers who provide services for Plaintiffs, have been fully compensated, and because it is undisputed that all funds were immediately transferred daily from Plaintiffs to Quantum, the impoverishment suffered plainly belongs to Quantum, and not to Plaintiffs. Quantum is not a party to this lawsuit. As such, the Court would be rendering an advisory ruling on Count III. Therefore, Plaintiffs lack standing to assert Count III.

15. The same analysis applies with respect to Count V. Count V is statutory. Standing therefore is defined by A.R.S. § 13-2314.04, and exists if Plaintiffs "sustain[] injury." For the same reasons set forth with respect to Count III, there is no injury sustained by Plaintiffs. Plaintiffs have no standing to assert Count V because all alleged pecuniary injuries were suffered by Quantum, not Plaintiffs.

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[2] For example, assume that Plaintiffs purchased a new printer for $500, and the printer had a $100 rebate. Plaintiffs would use all $500, and when the $100 rebate was received and deposited by Plaintiffs, only then would Quantum receive the $100. If United failed to reimburse $500 to Plaintiffs in breach of an implied-in-fact contract, Plaintiffs would suffer damages of a loss of use of money.

[3] The Court notes that the impoverishment suffered – which is entirely monetary and amounts to possession of ultimate profits from the services provided by Plaintiffs' medical professionals – is a different inquiry from the damages that are the focus of Count I. For an unjust enrichment analysis for Count III, the Court focuses on the ultimate entitlement to the monetary profits to evaluate impoverishment. Notably, Count III does not seek damages for "loss of use" of the money not paid by United. Moreover, it is undisputed that any additional funds not paid by United - i.e. profits not made – belong 100% to Quantum. The impoverishment belongs 100% to Quantum, not Plaintiffs, and as such, Plaintiffs have no interest in, or standing to bring, Count III.

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16. The remaining claim, Count IV, is a claim for declaratory judgment. Plaintiffs assert that United "routinely reimburse[s] claims for emergency medical care rendered by [Plaintiffs' medical practitioners] to [p]atients at amounts substantially below the billed charges." [Second Amended Complaint, ¶ 187] Plaintiffs further allege that "[a]n actual, justiciable controversy therefore exists between the parties regarding [United's] continuing obligation to reimburse [Plaintiffs] for future claims at amounts billed." [*Id.*, ¶ 189] Plaintiffs' Second Amended Complaint seeks the following relief: "[Plaintiffs] therefore request a declaration establishing the methodology by which [United] must calculate future reimbursement amounts." *Id.* at ¶ 190.

17. It is undisputed that Plaintiffs contend that reimbursement rates historically have been a percentage of billed charges. Plaintiffs assert that United acted improperly by making a change to its historical practices and by using Medicare reimbursement rates to calculate its own reimbursement rate. As such, resolving Count IV necessarily requires the Court to consider evidence of billed charges and Medicare reimbursement rates.

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18. A justiciable controversy may exist between United and Plaintiffs if the amount of the billed charges was determined by Plaintiffs. It is not. Rather, it is undisputed that Plaintiffs' contracts with Quantum confer upon Quantum the "exclusive authority" to determine fees and charges to bill for the services of Plaintiffs' medical professionals. [United Exh. 10, ¶3.5, at EPSW012117; United Exh. 11, ¶ 3.5, at EPSW012145] Plaintiffs have no authority to decide how much to charge for their services. To the extent that a reasonable reimbursement rate is based on the amount of billed charges – as Plaintiffs allege historically has been the case – Plaintiffs possess, at best, a nominal interest in the outcome of the litigation. Indeed, to prevent this Court's ruling on Count IV from being merely advisory given the precise facts and posture of the case, Quantum, not Plaintiffs, is the correct party that must bring Count IV. Rephrased, the dispute over how much should be billed for emergency services as part of the equation to determine what is reasonable is a dispute between Quantum and United, not Plaintiffs and United. To adjudicate this claim would result in an advisory opinion. Plaintiffs are without a stake in the outcome of Count IV, and therefore lack standing. *Aegis of Ariz., LLC v. Town of Marana*, 81 P.3d 1016-1021-22 (App. 2003). Count IV is properly dismissed for lack of standing.

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19. In sum, dismissal of Counts III, IV and V for lack of standing is appropriate and prudential in light of the unique facts and posture of this case.

20. Despite this, in light of both the substantial briefing presented to the Court, and the likelihood that appellate review will occur, the Court elects to consider and address the other arguments raised.

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B. Implied-in-Fact Contract (vs. United only).

21. United argues that Count I – Plaintiffs' implied-in-fact contract claim – fails as a matter of law.

22. It is undisputed that no written, express contract existed between Plaintiffs and United concerning reimbursement rates. It likewise is undisputed that Plaintiffs were out-of-network providers for United at all times relevant to the claims asserted in this lawsuit. Nonetheless, Plaintiffs argue that an implied-in-fact contract exists.

23. Implied contracts require proof of (1) certainty as to critical terms, (2) mutual assent, and (3) consideration. *Pyeatte v. Pyeatte*, 135 Ariz. 346, 353 (App. 1982). Generally speaking, such a contract may be proved by circumstantial evidence, as opposed to express oral and written terms. *Id.* The terms of an implied-in-fact contract may be inferred from the conduct of the parties. *Beaudry v. Ins. Co. of the West*, 203 Ariz. 86, 89 (App. 2002), as amended.

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24. United argues that Plaintiffs' implied-in-fact contract theory fails because the terms of the alleged contract are too indefinite. Specifically, United argues that the lack of agreement on (a) the critical terms of reimbursement rate, and (b) the duration of the agreement, each make any alleged implied-in-fact contract too indefinite to be enforced.

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25. With respect to reimbursement rates, it is undisputed that there was no uniformity or set percentage for reimbursement to Plaintiffs. Some services were reimbursed at a rate below 33% of billed amounts, while other services were reimbursed at a rate exceeding 90% of billed amounts. Nonetheless, Plaintiffs argue that a range of "average reimbursement" exists, and this range is between 77% and 80%. Even assuming *arguendo* that the Court accepted that the average reimbursement rate was an appropriate figure to use, these figures are not supported by the record before the Court.[4] At best, the record evidences a range of a 10% swing in the historical average annual reimbursement rates – an average 80% to 90% of billed amounts. Contrary to the 1.1% range in *Beaudry*, this 10% range to too indefinite to be enforceable.

[4] Plaintiffs cite to their Additional Statement of Facts ¶21 for the assertion that "[t]he course of dealing actually shows the range was between 77 and 80%." [Response at 12, lns.18-19] However, ASOF does not stand for that proposition. Plaintiffs' ASOF ¶ 25 asserts that, until "sometime in 2018, United had allowed 80%-90% of Plaintiffs' charges for out-of-network emergency services provided by Plaintiffs."

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26. With respect to duration, it is undisputed that there is no writing in the record that implies a termination date for the alleged implied-in-fact contract. United asserts two duration-based challenges to Plaintiffs' implied-in-fact contract theory. First, United argues that Plaintiffs believed the implied-in-fact contract was to run *ad infinitum.* Plaintiffs' disagree, and limit the duration of the alleged implied-in-fact contract to the following standard: the implied-in-fact contract would "continue for the foreseeable future absent an actual material change in market conditions." [Response at 12, lns. 15-16] Such a term also fails to provide the definiteness required by Arizona law. Rather, it is fraught with problems. What constitutes the "foreseeable future"? What is a "material change" in a contract which does not have a definite reimbursement rate? What makes a material change "actual"? Even with Plaintiffs' qualifier, the duration is too indefinite to support the conclusion that an implied-in-fact contract exists.

27. United's second challenge related to duration is a factual one based on communications from United to Plaintiffs in 2018-19. Pursuant to the very allegations in the Second Amended Complaint (¶¶65-71), United argues that it informed Plaintiffs that prior reimbursement rates would no longer be honored. In the face of these uncontested statements, no reasonable juror could conclude that any prior implied-in-fact contract with an average reimbursement range between 80% and 90% of billed amounts would continue. Any prior implied-in-fact contract had ended because there was no continuing mutual assent to such an arrangement.

28. An additional problem exists for Plaintiff EPSW because EPSW was not an out-of-network provider between 2015 and March 2019. Rather, EPSW had an "in-network" contract with United during this window. As such, historical reimbursement rates require analysis of rates prior to 2015 – an attenuated period. Moreover, United's statements clearly demonstrate the lack of mutual assent to re-entering a new implied-in-fact contract with EPSW according to the historical reimbursement rates occurring prior to 2015. There is no genuine issue of material fact that United did not assent or in any way commit to reimburse EPSW the way it previously had done after EPSW's "in-network" contract with United terminated in early March 2019.

29. This lawsuit illustrates why Plaintiffs arguments are untenable. Plainly, a dispute exists about whether United and Plaintiffs had an implied-in-fact contract. The only way to decide this through litigation. This lawsuit was filed in 2019, and has been pending for over four (4) years. The Court will not attempt to speculate about the cost, but can

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reasonably conclude that the litigation costs are not insignificant.[5] The Court questions the wisdom of the suggestion that a large commercial actor, like Plaintiffs, can impose an unwritten contract upon another large commercial actor, like United, for an undetermined period of time – and then subject the other to litigation of this magnitude about uncertain standards.

30. In sum, there is no written, signed contract. It is undisputed that there were unsuccessful attempts between United and at least one Plaintiff to negotiate a contract concerning prospective reimbursement rates. No agreement was reached. Plaintiffs now want this Court to impose an involuntary contract upon the parties, after an agreement could not be reached, to establish certain reimbursement rates and to then direct the parties about how long this contract remains in place. Not only is it bad policy for the Court to do this – particularly where there was no meeting of the minds – but this amounts to judicial overreach. The Court declines to do this.[6]

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31. Although the Court determines that no implied-in-fact contract exists, this is not to say the Court is not troubled by the practices – and possible gamesmanship – of both parties. The record paints a clear picture: in the 2018-19 time period, there was a substantial increase in Plaintiffs' average billed charges submitted to United. [Plaintiffs' Opposition at 3] In the same period, United began using the Data iSight system which, based on the record before this Court, was (at-best) a flawed system for valuing claims. At the end of the day, women, men and children who obtain emergency medical services in Arizona are entitled to treatment for their health conditions, and have a justified expectation that their providers will be compensated fairly. Arizona has a public policy interest of ensuring that the state has enough emergency medical providers to service the needs of the citizenry. And, to be clear, Arizona residents who purchase health insurance (through United and others) have an interest in an emergency health system that is free from alleged artificial "price-inflation" practices, and alleged "low-ball" reimbursement practices by insurers, to prevent their insurance premiums from skyrocketing.

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32. United is entitled to summary judgment on Count I – Plaintiffs' implied-in-fact contract claim.

[5] The Court notes that this case has a Special Discovery Master who has provided frequent, skilled assistance, as well as 11 attorneys representing Plaintiffs on this motion, 8 attorneys representing United on this motion, and 7 attorneys representing MultiPlan on this motion.

[6] If reimbursement rates were to be established (either actual amounts, or ceilings or floors) in the interests of public policy, this judicial officer believes this action more properly belongs to the legislative branch, not the judicial branch.

33. Because Plaintiffs' implied-in-fact contract claim fails as a matter of law, there is no contract from which the implied duty of good faith and fair dealing arises. As such, United is entitled to summary judgment on Count II – Plaintiffs' claim for the breach of the implied duty of good faith and fair dealing.

C. <u>Unjust Enrichment (vs. United only)</u>.

34. United argues that there is no genuine issue of material fact that Count III of Plaintiff's Second Amended Complaint – the unjust enrichment claim – fails. Plaintiffs disagree. Recognizing that this case presents an issue of first impression in Arizona, and recognizing the likelihood that appellate review will be requested for this decision, the Court addresses Plaintiffs' claim for unjust enrichment.

35. Both parties agree that, under Arizona law, unjust enrichment requires proof of (i) an enrichment, (ii) an impoverishment, (iii) a connection between the enrichment and impoverishment, and (iv) the absence of justification between the enrichment and the impoverishment, and (v) the absence of a remedy provided by law. *Wang Elec., Inc. v. Smoke Tree Resort, LLC,* 230 Ariz. 314, 318 (App. 2012).

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36. There are two benefits to United that Plaintiffs identify: (a) provision of medical services to members of United; and (b) avoiding "member abrasion" to United resulting from Plaintiffs' decision to follow United's direction to refrain from balance billing.

37. With respect to the first benefit alleged, Arizona's appellate courts have not yet addressed whether, under Arizona law, the provision of medical services to patients constitutes a benefit to an insurer (here, United). The Court previously found persuasive the argument that "plaintiffs provide a benefit only to their patients." Court decisions entered since the outset of this case further supports this conclusion. In *Physicians Surgery Ctr. Of Chandler v. Cigna Healthcare Inc.,* 609 F.Supp.3d 930, 940 (D. Ariz. 2022), the court concluded that the plaintiff healthcare provider "provided a benefit – medical treatment – to the plan members, not the defendant [insurer]." Other courts have reached this conclusion as well, as cited by United. Consequently, as a matter of law, a plaintiff medical provider cannot satisfy the "benefit" element of an unjust enrichment claim against a healthcare insurer based on providing medical care to an insured.

38. With respect to the second benefit alleged, both parties acknowledge the dynamic whereby insured patients become irritated when they receive a bill after the insurance company has finished reimbursing a provider for all amounts for which it will provide reimbursement ("balance billing"). This phenomenon of dissatisfaction is called

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"member abrasion." In legal terms, this essentially constitutes goodwill. In this case, there is evidence in the record that the Payment Remittance Advice ("PRA") that United issued to Plaintiffs specifically instructed Plaintiffs not to engage in balance billing of patients. In this context, there is evidence in the record that United received a benefit – paying less money and reducing member abrasion. There also is evidence that an impoverishment – receiving less money than historically had been received as an out-of-network provider for the same procedure – was suffered by Plaintiffs / Quantum. Because United instructed Plaintiffs to act in a certain way – i.e. to not engage in balance billing – a reasonable juror could conclude that Plaintiffs were not acting solely for their own benefit by declining to engage in balance billing, and that United received a benefit from this practice.

39. By Plaintiffs' not engaging in the practice of balance billing, evidence exists in the record of two types of benefits to United.

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a. First, there is some evidence in the record that United would pay the disallowed portion of the bill if a provider informed United that it intended to balance bill. *See, e.g. Opinion of David Leathers,* p. 26, ¶66. Unless Mr. Leathers' opinions are excluded, a reasonable juror could conclude that the balance of the bills not paid by United, or some portion thereof, were direct benefits United received from Plaintiffs declining to engage in the practice of balance billing as directed by United. Whether or not United is entitled to summary judgment on this theory rests on the Court's decision on *United Defendants' Motion to Exclude the Opinions and Testimony of Plaintiffs' Expert, David Leathers*, filed September 1, 2023. [*See* ruling *infra.*, at ¶¶ 64-78]

b. Second, the theory has been articulated that United also obtained a benefit to its goodwill - or more specifically, the absence of a loss of its goodwill – when Plaintiffs acquiesced to United's direction that Plaintiffs not engage in balance billing – a practice that a reasonable juror could conclude to be a cause of member abrasion. This also is a benefit compensable by a claim for unjust enrichment.[7] However, there is no admissible evidence of a benefit to United's goodwill created by the decision to abstain from balance billing. Plaintiffs' expert, Mr. Leathers, confirmed that this could be calculated, but that he had not attempted to value any goodwill gained (or not lost) by United in connection with avoiding member abrasion. There being no evidence, United is entitled to summary judgment on this second theory.

[7] The Court notes that these additional facts, and this additional dynamic, were not considered by the Court in *Physicians Surgery Ctr. Of Chandler.*

40. In sum, United, is entitled to summary judgment on all of the theories advanced to support Plaintiffs' claim for unjust enrichment – with the exception of one theory. The remaining theory – that Plaintiffs' unjust enrichment claim for benefits obtained by United by not balance billing hinges on the opinion of Mr. Leathers. As to all other theories of liability for unjust enrichment, no genuine issue of material fact exists and United is entitled to summary judgment.

41. However, as stated *infra.* at ¶ 78, Mr. Leathers' is unable to provide any competent evidence regarding the benefits of not engaging in balance billing. As such, there is no genuine issue of material fact that the record is devoid of competent evidence of damages for Count III.

42. United is entitled to summary judgment on Count III – Plaintiffs' unjust enrichment claim.

D. <u>The Unlawful Acts Claims Pursuant to A.R.S. § 13-2314.04 (United and MultiPlan)</u>.

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43. A.R.S. § 13-2314.04(A) establishes a claim for unlawful acts, and provides in pertinent part: "A person who sustains reasonably foreseeable injury to his person, business or property by a pattern of [unlawful] activity, or by a violation of [A.R.S.] § 13-2312 involving a pattern of [unlawful] activity, may file an action in superior court for the recovery of up to treble damages and the costs of the suit, including reasonable attorney fees for trial and appellate representation."

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44. Plaintiffs argue that they suffered damages from a pattern of unlawful activity[8] involving the representations made by Defendants about the Data iSight system. Defendants disagree.

45. When deciding the Motion to Dismiss filed earlier in this case, this Court wrote:

> There are serious problems with proximate causation here. Defendants convincingly argue that plaintiffs would have provided the exact same services, and United would have paid the same rates, irrespective of any statements by or about Data iSight. . . . Plaintiffs have difficulty explaining

[8] No crime of violence has been alleged in this matter. Consequently, the Court has written its decision in compliance with terminology limitations set forth in A.R.S. § 13-2314.04(S), and reminds the parties to meticulously adhere to these requirements in all future filings.

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> what they would have done differently, had they understood that the Data iSight rates were not tied to objective data.

[Minute Entry, September 22, 2021, at 8]

46. The uncontested evidence in the record confirms that Plaintiffs did not change how physicians saw and treated patients. Nor did they change how services were provided. [United SOF ¶ 117; MultiPlan SOF ¶106] The Court's prior findings – that Defendants provided the exact same services and United paid the same rates, irrespective of any statements by or about Data iSight – is supported by the record. Simply put, causation is absent.

47. The Court concurs with Defendants that there is no genuine issue of material fact that causation is missing when Plaintiffs' claim pursuant to A.R.S. § 13-2314.04 is predicated on a pattern of unlawful activity consisting of representations. No reasonable juror, based on the evidence in the record, could conclude that causation has been established for this claim. Rephrased, the record fails to support the notion that the representations in question proximately or legally caused reasonably foreseeable injury to Plaintiffs.

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48. In response, Plaintiffs argue that Defendants mistakenly narrow the pattern of unlawful activity to a pattern involving only representations. Indeed, in their *Opposition*, Plaintiffs have argued that the predicate offense supporting a pattern of unlawful activity must be considered more broadly. Plaintiffs recast their claim as ***a single scheme***, arguing that "***[t]he scheme*** involved two principal misrepresentations . . . ." [*Plaintiffs' Opposition to MultiPlan's Motion for Summary Judgment*, filed October 2, 2023, at 1:6 (emphasis added)] In other words, the entirety of Defendants' usage of, and representations about, Data iSight – the use of the program to reduce claims, the statements made to Plaintiffs, and the other representations made about the Data iSight program – constitutes a single predicate unlawful act: an overarching scheme or artifice to defraud in violation of A.R.S. § 13-2310. At oral argument, Plaintiffs confirmed this was an accurate formulation of Plaintiffs' claim.

49. The definition of Scheme or Artifice to Defraud is set forth in A.R.S. § 13-2310, which provides that this unlawful act is committed by "[a]ny person who, pursuant to a scheme or artifice to defraud, knowingly obtains any benefit by means of false or fraudulent pretenses, representations, promises or material omissions . . . ."

50. "Person" means a human being and, as the context requires, an enterprise, a public or private corporation, an unincorporated association, a partnership, a firm, a society, a

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government, a governmental authority or an individual or entity capable of holding a legal or beneficial interest in property. A.R.S. § 13-105(30). Each Defendant qualifies as a "person."

51. "Scheme or artifice to defraud" has been interpreted by Arizona's courts for purposes of A.R.S. § 13-2310 as follows: a "scheme" is a plan, while an "artifice" is an evil or artful strategy, and thus, a "scheme or artifice" is some plan, device, or trick to perpetrate a fraud. *State v. Haas*, 138 Ariz. 413, 419 (1983); *Ness v. Western Sec. Life Ins. Co.*, 174 Ariz. 497, (App. 1992).

52. United has argued that "Plaintiffs cannot prove that the relationship between United and MultiPlan went beyond an ordinary business relationship." *United's Motion*, at 19: 5-7] This misstates Arizona law. The "scheme or artifice to defraud" need not be fraudulent on its face, but it must involve some kind of fraudulent misrepresentations or omissions that are reasonably calculated to deceive persons of ordinary prudence and comprehension. *State v. Griffin*, 250 Ariz. 651, 656 (App. 2021).

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53. Plaintiffs' arguments broadening the definition of the scheme or artifice to defraud as a single scheme to include anything having to do with the Data iSight program is supported by Arizona law. Under Arizona law, a scheme to defraud implies the existence of a plan, and ***numerous acts may be committed in furtherance of that plan***. *State v. Suarez*, 137 Ariz. 368, 373 (App. 1983).

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54. Based on the evidence presented by Plaintiffs, a reasonable juror could conclude that there was a single overriding scheme or artifice to defraud, which was supported and implemented by a number of representations. The Court cannot articulate this better than Plaintiffs did in their *Opposition*: "pursuant to a scheme or artifice to defraud, United and MultiPlan acted in concert to divert money . . . to their own using the pretext of Data iSight to artificially reduce the rates United historically paid out-of-network ER doctors." Multiple acts existed to support a single scheme, all of which centered around the use of Data iSight. Reasonable jurors could conclude that, under this single plan involving Data iSight, Defendants did not do "anything to determine the value, or reasonable value, of healthcare services" and instead, MultiPlan allowed United to determine "the reimbursement rate [Data] iSight would generate" on requests for payment submitted by Plaintiffs. [*Plaintiffs' Opposition to MultiPlan's Motion for Summary Judgment*, filed October 2, 2023, at 1: 2-5, 13-24]

55. In sum, a genuine issue of material fact exists as to the existence of one of the two required predicate acts – namely, a single Scheme or Artifice to Defraud violating

A.R.S. § 13-2310 relating to the use of Data iSight.[9] As such, Defendants are incorrect that Plaintiffs cannot establish "any" predicate offense supporting a "pattern of [unlawful activity]."

56. However, that is not the end of the inquiry. To establish a claim pursuant to A.R.S. § 13-2314.04, Plaintiffs must prove one of two things: (i) a "pattern of unlawful activity" or (ii) "a violation of [A.R.S.] § 13-2312 involving a pattern of unlawful activity." Thus, a "pattern of unlawful activity" must be proven under either requirement.

57. "Pattern of unlawful activity" is defined in A.R.S. § 13-2314.04(T)(3). Some patterns of unlawful activity can be proven with a single predicate unlawful act. A.R.S. § 13-2314.04(T)(3)(b) (the "One Act Patterns"). Otherwise, a pattern of unlawful activity requires proof of the commission of at least two predicate unlawful acts. A.R.S. § 13-2314.04(T)(3)(a) (the "Two Act Patterns"). Under Arizona law, a predicate unlawful act must be "one of the illegal acts enumerated in the statute, and [must be] chargeable and punishable in accordance with the requirements of the statute." *State ex rel Corbin v. Pickrell*, 136 Ariz. 589, 596-97 (1983).

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58. A scheme or artifice to defraud in violation of A.R.S. § 13-2310 is one of the illegal predicate crimes upon which a pattern of unlawful activity can be predicated in order to support a claim pursuant to A.R.S. § 13-2314.04. It is included in the list of eligible unlawful acts in A.R.S. § 13-2314.04(T)(3)(a). A violation of A.R.S. § 13-2310, therefore, supports a Two Act Pattern. A.R.S. § 13-2301(D)(4)(b)(xx).

59. The record is devoid of any allegations or evidence from which a reasonable juror could conclude that a second predicate unlawful act occurred other than the violation of A.R.S. § 13-2310. Without a second predicate unlawful act, Plaintiffs cannot establish a Two Act Pattern, and therefore cannot establish a pattern of unlawful activity.

[9] Although not argued by the parties, the Court notes that the additional requirements are supported by the record. United and MultiPlan each are enterprises. A.R.S. § 13-105(17). Consequently, for an unlawful act to be punishable against United or MultiPlan, the requirements of A.R.S. § 13-305 must be satisfied. This statute provides, in pertinent part, that "an enterprise commits an offense if . . . the conduct undertaken on behalf of the enterprise and constituting the offense is engaged in, authorized, solicited, commanded or recklessly tolerated by the directors of the enterprise in any manner or by a high managerial agent acting within the scope of employment." A.R.S. 13-305(A)(2). A "high managerial agent" means an officer of an enterprise or any other agent in a position of comparable authority with respect to the formulation of enterprise policy." A.R.S. § 13-305(B)(2). A reasonable juror could decide from the evidence before the Court that a director or high managerial agent of United engaged in, authorized, solicited, commanded or recklessly tolerated the alleged scheme or artifice to defraud discussed *supra*.

Without a pattern of unlawful activity, Plaintiffs' claim pursuant to A.R.S. § 13.2314.04 fails as a matter of law as to both United and MultiPlan.

60. Plaintiffs assert that Defendants committed a violation of A.R.S. § 13-2312 – Illegal Control of an Enterprise. Even if true – a matter that the Court need not decide – this cannot legally constitute the second predicate felony to support a Two Act Pattern. Illegal Control of an Enterprise (A.R.S. § 13-2312) is ***not included*** as one of the unlawful acts that can be used to constitute a pattern of unlawful activity. A.R.S. § 13-2314.04(T)(3)(a). This offense is not listed in A.R.S. § 13-2301(D)(4).[10] Illegal Control of an Enterprise only can support a claim pursuant to A.R.S. § 13-2314.04 if it is premised upon a pattern of unlawful activity, and the record is devoid of evidence from which a reasonable juror could conclude that a pattern exists.

61. In sum, when Plaintiffs predicate their claim pursuant to A.R.S. § 13-2314.04 on alleged misrepresentations, causation is absent. On the other hand, when Plaintiffs take the (legally correct) steps to broaden their theory and use the representations to allege a single plan – a single Scheme or Artifice to Defraud – their claim pursuant to A.R.S. § 13-2314.04 still is deficient because a pattern of unlawful activity is absent. One way or another, there is no genuine issue of material fact – Plaintiffs' claim for unlawful acts pursuant to A.R.S. § 13-2314.04 is deficient as a matter of law and Defendants are entitled to summary judgment on this claim.

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E. <u>ERISA Preemption</u>.

62. United argues Plaintiffs claims are preempted by ERISA because they "would interfere with claims processing and the methodologies for calculating benefits already set forth" in a number of ERISA health plans. The Court disagrees. The Court agrees with Plaintiffs that their claims are not pre-empted and finds *Rutledge v. Pharmaceutical Care Mgmt. Assoc.*, 141 S.Ct. 474, 478 (2020) to be persuasive and controlling.

[10] MultiPlan argues that the conduct of United and MultiPlan does not constitute "lllegally Controlling an Enterprise" because no evidence exists to support the definition of "enterprise." It is unnecessary for the Court to reach this argument. The offense of Illegal Control of an Enterprise, standing alone, does not support a claim pursuant to A.R.S. § 13-2314.04. Enterprise means "any corporation, partnership, association, labor union or other legal entity or any group of persons associated in fact although not a legal entity." A.R.S. § 13-2301(D)(2). A "pattern of [unlawful] activity" involving the enterprise still must be proven pursuant to the plain language of A.R.S. § 13-2314.04. In sum, even if a question of fact exists concerning the existence of an enterprise between United and MultiPlan – a question this Court need not decide – this is insufficient to prevent summary judgment.

Plaintiffs' claims would be indirect. Plaintiffs correctly argue that the cost regulations at issue here are far different than central plan administration, and that the results of the litigation of the claims here are indirect.

63. United's request for summary judgment on all claims pursuant to ERISA is denied.

F. United's Motion to Exclude Testimony and Opinions of David Leathers.

64. Summary judgment has been granted on all claims.

65. Because Counts I and V, and all but one theory of Count III, have been dismissed on substantive grounds, the Court declines to consider the Motion to Exclude as moot.

66. The Court will consider Mr. Leathers' opinions relating to the theory asserted in Count III that Plaintiffs are entitled to assert a claim for unjust enrichment based on the benefits obtained by United that resulted from Plaintiffs not balance billing (the "Balance Billing Theory").

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67. For the Balance Billing Theory, Mr. Leathers has opined as follows:

> [United] benefitted as a result of the Plaintiffs forgoing their right to balance bill [United] Members by, for example, eliminating the member abrasion that [United] experiences when its Members are balanced billed. ***The value of such benefit can be measured by the difference between the Plaintiffs' billed charges and the amounts allowed by [United].*** [Exh. A to *Motion to Exclude*, (Opinion of Mr. Leathers, ¶ 13 (emphasis added))]

68. The Court's understanding of the methodology of Mr. Leathers' opinion is set forth by the following hypothetical, using the hypothetical numbers presented at oral argument:

Plaintiffs' billed service	$1,000.00
Less: United's reimbursement	<$ 200.00>
Difference that could be balanced billed by Plaintiffs (the "Difference")	$ 800.00

In this hypothetical, Mr. Leathers' opinion is that, by foregoing balance billing, Plaintiffs' unjust enrichment damages amount to the Difference (i.e., $800). Rephrased, Mr. Leathers opines that United benefitted in the amount of $800 that it did not pay, and that an impoverishment was suffered in the amount of $800 that was not received, for this service to a single patient.

69. Mr. Leathers' calculation of damages for the Balance Billing Theory presumes that balance billing would have occurred and simply adds the Difference for each and every service performed by Plaintiffs for United members during the time period in question.

70. In support of this opinion, Mr. Leathers opined: "I have reviewed evidence that demonstrates both that [United] and MultiPlan, through its Data iSight program, agreed to increase reimbursement to a provider's full billed charge when a provider balance bills a patient and does not reach a negotiated amount by accepting the discounted rates offered by [United]." [Exh. A to *Motion to Exclude*, (Opinion of Mr. Leathers, ¶ 66)] In other words, Mr. Leathers assumes based on some testimony in the case that United would have paid the billed charges in full for every claim billed by Plaintiffs in order to avoid "member abrasion."

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71. United has moved to exclude these opinions of Mr. Leathers on multiple grounds.

72. First, United argues that Mr. Leathers is not qualified to render this opinion. The Court agrees with United that Mr. Leathers lacks experience and training in the health insurance industry. He, therefore, cannot testify whether an insurance company would, or would not, pay the Difference if faced with a provider who engaged, or identified an intent to engage, in balance billing. He can, however, rely on testimony from depositions taken in this case, as he has done. The limitations on Mr. Leathers' testimony here goes to weight, and not to admissibility.

73. Second, Mr. Leathers' opinions with respect to the Balance Billing Theory are speculative for multiple reasons. Mr. Leathers' analysis assumes that Plaintiffs could have balance billed for every patient. This is not the case. Some of Plaintiffs' contracts with hospital facilities prohibited Plaintiffs from balance billing. Additionally, some of United's out-of-network plans do not require United to pay billed charges in full. Furthermore, United notes that Plaintiffs did not threaten to balance bill the patients and, in fact, had a "longstanding policy against balance billing." In response, Plaintiffs argue that Mr. Leathers is entitled to rely on assumptions, and that any deficiencies in his assumptions go to the weight to be given to his testimony, not its admissibility.

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74. United's second challenge is a close call. An expert is permitted to rely upon assumptions when formulating opinions. *Armer v. CSAA Gen. Ins.*, 2020 WL 3078353, at *9 (D. Ariz. June 10, 2020). Standing alone, this is not a reason to exclude Mr. Leathers' opinions.

75. However, a challenge predicated under Rule 702, *Arizona Rules of Evidence*, necessarily includes an argument that the expert's opinions and testimony "will help the trier of fact to understand the evidence or to determine a fact in issue." Rule 702(a), *Arizona Rules of Evidence.*

76. Mr. Leathers' opinion on the Balance Billing Theory is not helpful. Because Mr. Leathers' opinions are based only upon 100% of the Difference, and because there is no disclosed opinion or calculation reducing this amount by the number of facilities which prohibit balance billing, or by the number of patients whose United out-of-network plans do not require and/or permit balance billing of the Difference, the Court concludes that Mr. Leathers' opinion is not likely to help the trier of fact understand the evidence or determine a fact in issue.

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77. At oral argument, counsel for United also confirmed that the motion to exclude Mr. Leathers was being sought pursuant to Rule 403, *Arizona Rules of Evidence.* In addition to, and independently of, excluding Mr. Leathers' opinions on the Balance Billing Theory based on Rule 702, the Court is excluding Mr. Leathers' opinions and testimony on the Balance Billing Theory pursuant to Rule 403, *Arizona Rules of Evidence.* Simply put, Mr. Leathers did not do the relevant calculations to help the jury. Simply put, the probative value of Mr. Leathers' "100% reimbursement" calculation is substantially outweighed by the danger of unfair prejudice, confusion of issues, misleading the jury, undue delay and/or wasting time.

78. Mr. Leathers' opinions and testimony concerning the Balance Billing Theory shall be excluded, in their entirety.

Good cause appearing,

IT IS ORDERED granting *United's Motion for Summary Judgment*, filed September 1, 2023.

IT IS FURTHER ORDERED granting *MultiPlan's Motion for Summary Judgment*, filed September 12, 2023.

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IT IS FURTHER ORDERED granting-in-part and denying-in-part *United Defendants' Motion to Exclude the Opinions and Testimony of Plaintiffs' Expert, David Leathers*, filed September 1, 2023. This motion is granted as to Mr. Leather's Balance Billing Theory. The motion is denied as moot as to all other theories.

IT IS FURTHER ORDERED vacating the hearing set for January 9, 2023.

IT IS FURTHER ORDERED directing Defendants to lodge one consolidated form of Judgment on or before December 19, 2023. Any and all applications for attorneys' fees and costs shall be filed concurrently therewith. Any objections of Plaintiffs shall be filed by January 12, 2024. No Reply shall be permitted unless leave is granted by the Court.

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